Cambridgeshire and Peterborough
NHS Foundation Trust

How to Keep Safe

Guided self-help workbook for people with Binge Eating Disorder - to be completed prior to treatment

How to Keep Safe Programme

Contents

Introduction 1

Section 1: Introduction

What are Eating Disorders? 1

Diagnoses 1

Body Mass Index (BMI) 4

Movement between Eating Disorder Diagnoses 6

My Eating Disorder Symptoms 7

Options for Podcast 2 8

Section 2a: The Effects of Undereating

The Minnesota Study 1

Significance of the study for the eating disorders 4

Section 2c: Problematic Eating Behaviour

Problematic eating behaviours 1

Triggers to Binge Eating 2

Understanding the triggers to my binge eating 5

Chewing and Spitting 6

STOP and Reflect . . . 7

Monitoring sheet - Binge Diary 8

Section 3: Motivation to Change

Motivational States 1

Weighing up the Pros and Cons of my Eating Disorder 4

Section 3a: Personal Recovery Stories

Personal recovery stories 1

Personal story - Sandra 2

Personal Story - Becky 4

STOP and Reflect . . . 6

Section 4: Keeping Safe

Keeping Safe 1

Improving my wellbeing 2

Getting help from those who care about me 5
Further information to patient questions about symptoms 6
Keeping Safe Plan 7
STOP and Reflect . . . 12
Section 5: Managing my Eating
The Importance of Eating 1
B: Balance 2
R: Regular 12
A: Adequate 13
V: Variety 14
E: Environment 15
STOP and Reflect . . . 16
Section 6: Factors that influence weight and shape
Factors that Influence Weight and Shape 1
Dieting vs Disordered Eating 2
Premenstrual Syndrome (PMS) 4
The Role of Physiology - The Set Point Theory 6
Section 7: Body Image
Body Image 1
Use of social media 2
STOP and reflect . . . 4
Body Image Concerns and the use of Safety Behaviours 5
Body Checking Behaviours 6
Your Keeping Self Safe Plan 7
Recommended Reading List
Resource List
Acknowledgements

Introduction

This workbook is intended to be used in conjunction with the Keeping Safe podcasts as part of the Keeping Safe Programme. The Keeping Safe programme is the first step in your treatment. It has been developed to provide information to help you begin to make sense of your difficulties and to encourage you to take steps to minimise some of the unhelpful effects caused by your eating disorder whilst you are waiting for treatment.

The overall aims of the Keeping Safe programme are

- to provide information and promote understanding about eating disorders and their effects
- to give guidance about how to help you keep safe whilst you are waiting for treatment

The podcasts and workbook follow a psychoeducational approach which cover various aspects of your eating disorder, such as the symptoms and their effects. We have designed the Binge Eating Disorder programme so that you can select to listen only to the information and exercises that are of most relevance to you, so please listen out for the prompts and links which signpost you to information specific to Binge Eating Disorder. You will notice that you are sometimes signposted to different pages and / or sections of your workbook than those listening with other eating disorder diagnoses, as some of the information will not be relevant to you. However, you can listen to all the podcasts if you wish.

To get the most out of the programme, please follow the workbook at the same time as listening to each podcast. We will refer to the workbook throughout each podcast and pause in places to ask you to complete some specific tasks as we go along, so please have your copy with you when you are listening. We recommend you download (and save) the workbook and complete the exercises by typing your responses directly into your workbook or following the links. If using the links to complete the exercises, please note that your responses will be collated anonymously via Microsoft Forms when you press "submit" and will not be monitored or affect your treatment with your eating disorder team. If you type your own responses into the workbook, you can do so as follows, depending on your device:

- In Adobe – Click on Tool > Fill and Sign. This will create a text box to insert your responses
- In Google Drive – Download the document and use the **add text** option to create a text box
- On a Mac – Open PDF in preview. Select **Annotate** > **Text** > **A**

Handy tip *– always use the back button (as opposed to x a window) and make a note of your page.*

Each section consists of information to read, tasks to complete and an opportunity to reflect on your current situation. We recommend:

- You work through this workbook one podcast at a time, giving yourself time between each
- Complete each task before moving on to the next podcast

Although you may or may not feel ready to make any changes to your eating or symptoms right now, there's an emphasis on encouraging you to start to take steps to minimise the impact and potential harm of your eating disorder. Ultimately, it is your choice whether you want to make any changes whilst you are waiting for treatment, but we hope that you will find the information covered throughout the podcasts useful in helping you decide.

Before you start the programme

Please complete the following questionnaires which you can access by using the link below. Please do not include any identifiable information. Responses will be collected by CPFT who developed the programme and used to evaluate attitudes and behaviours towards engaging with harm minimisation recommendations whilst waiting for treatment.

- Knowledge Quiz
- Evaluation Questionnaire

Section 1

What are Eating Disorders? [1]
Diagnoses

Eating disorders are complex disorders, thought to develop as a result of a combination and interaction of a wide variety of psychological, environmental and genetic risk and protective factors. For the person with an eating disorder, they can be a sign of psychological distress, and a way of coping when life feels difficult.

Eating disorders are usually defined by several symptoms, including anxiety about eating, changes in food intake, fear and preoccupation with gaining weight and use of compensatory behaviours to try and lose / control body weight. Regardless of whether people experience a fear of gaining weight or not, many people report feeling dissatisfied and distressed by their body and / or general appearance.

Following your assessment, you have probably been told that your current symptoms meet the diagnostic criteria for an eating disorder. The type of diagnosis that you've been given depends on the frequency and intensity of symptoms. You may have been given a diagnosis that falls within the restrictive eating disorder group (e.g., Anorexia Nervosa or Atypical Anorexia Nervosa), or the binge/purge disorder group (e.g., Bulimia Nervosa, Binge Eating Disorder, or an Other Specified Feeding and Eating Disorder also known as OSFED) or Avoidant/Restrictive Food Intake Disorder (also known as ARFID). We will now briefly go through each of these, providing links to other reading if you would like further information about your particular diagnosis as we go:

Restrictive Eating Disorders
The restrictive eating disorders include Anorexia Nervosa, Atypical Anorexia Nervosa and Eating Disorder, unspecified. If you fall within the restrictive eating disorder diagnoses, you are likely to:

- Have a restrictive eating pattern.
- Have a very low body weight and / or have lost a significant amount of weight.
- Have an intense fear of gaining weight or becoming fat - even though you may be underweight.
- Attempt to maintain a low weight by engaging in one or more compensatory behaviours such as self-induced vomiting, laxative use, and / or excessive physical activity and exercise.
- Be concerned and preoccupied by your weight and shape.
- Feel distressed by your body and/or have a distorted perception of body size – such as seeing yourself as being much larger than others see you.
- Some people may also experience episodes of binge eating
- In women, the menstruation cycle may cease so that periods stop or become light or irregular, and men may experience a reduced need to shave or the absence of early morning erections.

Bulimia Nervosa
People who experience the following symptoms are considered to fall within the binge and purge eating disorder group. These are diagnoses including Bulimia Nervosa, Atypical Bulimia Nervosa and Eating disorder, unspecified. Your diagnosis will be dependent on the frequency and intensity of the following symptoms including:

- Recurring episodes of binge eating.
- Engagement in behaviours in an attempt to prevent weight gain – for example, dieting or restricting food intake, inducing vomiting, using laxatives or exercising excessively in order to manage their weight and shape concerns.

[1] Diagnostic criterion adapted from the Diagnostics and Statistical Manual of Mental Disorders (DSM – 5) and the International Classification of Diseases (ICD – 10).
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* Arlington, VA: American Psychiatric Publishing.
World Health Organisation (1994). *ICD-10 Classification of Mental and Behavioural Disorders*. WHO, Geneva.

- Concern or distress about weight and shape, despite perhaps being within the healthy weight range.
- A desire to lose weight.
- Your sense of feeling okay about yourself - your self-esteem - may depend on how you feel about your weight or shape, which may be within the normal to overweight range.

The term "binge eating" describes episodes of over-eating. Objective binge eating is a clinical symptom characterised by eating an unusually large amount of food in a short space of time, which is bigger than most people would normally eat, and eaten in a way that is rushed and feels very out of control. It may also leave people feeling physically uncomfortable, embarrassed, or guilty and disgusted.

Sometimes people report eating what others would consider a normal portion of food, or perhaps smaller than a normal portion of food, but it still feels out of their control, and like a binge. This is called subjective binge eating.

People can experience a mixture of objective and subjective binge eating episodes, which leaves them feeling anxious about eating, fearful of certain "trigger" foods, and preoccupied by persistent thoughts of food and eating, even when not hungry.

Binge Eating Disorder

- People with Binge Eating Disorder experience regular episodes of binge eating. Similarly, this means eating an usually large amount of food in a short space of time, which is objectively bigger than most people would eat, and feeling out of control when doing so:
    - Large amounts of food may be eaten in the absence of hunger
    - Can result in feelings of physical discomfort
    - Associated with feelings of embarrassment, guilt and/or self-disgust
- Sometimes, but not always, problems with binge eating may be accompanied with obesity.

ARFID

ARFID stands for Avoidant/Restrictive Food Intake Disorder (ARFID). This diagnosis describes a disorder where an individual struggles to maintain a normal weight or obtain adequate nutrition in the absence of symptoms that characterise the other eating disorders, such as fear of weight gain and/or preoccupation with weight and shape. Difficulties maintaining a healthy weight or obtaining adequate nutrition may be due to a range of factors including a lack of interest in food or lack of appetite, an aversion to certain food textures and colours, or a fear of the consequences of eating – such as being sick - which are not weight or shape related. If you have been given a diagnosis of ARFID, you may find the following resource useful in helping you start to make sense of your diagnosis and explore the issues that are relevant to you. Although it has been developed for people recently diagnosed with ARFID who attend their service, The Sussex Eating Disorder Service's (SEDS) self-help starter guide has some useful exercises and links to further information**.** The SEDS ARFID guide can be accessed here.

For further information about the eating disorder diagnoses, please follow the link to the Centre for Clinical Interventions (CCI) handout on "What are Eating Disorders," which can be accessed here.

Queries or questions about my symptoms

Make a note of any questions, observations or concerns you have about the diagnosis you have received and your current symptoms. You can contact your eating disorder service, your GP or wait until your next appointment or try and find out the information yourself by contacting Beat or accessing useful psychoeducational websites such as the Centre for Clinical Interventions which you can access here

………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………
………

Body Mass Index (BMI)

When you were assessed by your local eating disorder service, your weight and height will have been taken in order to calculate your Body Mass Index (BMI). A person's BMI is calculated by dividing weight (in kilograms) by height² (in metres) and is used as a general measure of someone's weight.

The Body Mass Index is widely used by health care services as a measure to work out if your weight is healthy, so it is useful to know about the ranges and how these apply to you (e.g., whether you are underweight, healthy weight, overweight etc). You can find more information about the Body Mass Index, and how to calculate your own BMI, on the NHS website, which you can access here.

Body Mass Index - a cautionary note

The BMI calculation can be misleading for certain groups - including males, trans women, body builders, pregnant women - and does not account for other factors such as age, gender, or ethnicity. As a result, clinical judgement needs to be used when interpreting the significance of the BMI when working with individuals from these populations.

Although the BMI classification can help to provide information about a person's physical health and associated risks, it is only one source of information that is used by eating disorder services. Please talk to your eating disorder clinician or health care professional if you feel undue significance has been placed on your BMI in terms of determining your treatment or access to services.

Eating disorders in men

Men make up between 25-40% of the eating disorder population and whilst most of the material presented here is just as applicable to men, there are some differences. These will be highlighted as we work through the material in each podcast but If you would like additional information, please read the CCI handout on Eating Disorders in Men, which can be accessed here.

You may also find further information and support from the organisation "Men Get Eating Disorders Too" which can be accessed here and Beat, which can be accessed here.

One presentation that has a higher prevalence in men than women that is not explicitly covered in the programme is Muscle Dysmorphia and muscularity-orientated disordered eating (MODE). This is because Muscle Dysmorphia is not classified as an eating disorder, although it shares many similar features. This includes:

- Body dissatisfaction (a tendency to see oneself as too small, rather than too large).
- A drive for muscularity and / or leanness, which is expressed through:
    - Extreme changes in eating.
    - Exercise routines.
- Efforts to increase muscularity may also be accompanied using protein supplements and anabolic steroids.

If these symptoms resonate with you, please continue to listen to the podcasts as some of the following information may be relevant to you – particularly podcasts 2b, 5, 5a, 6 and 7.

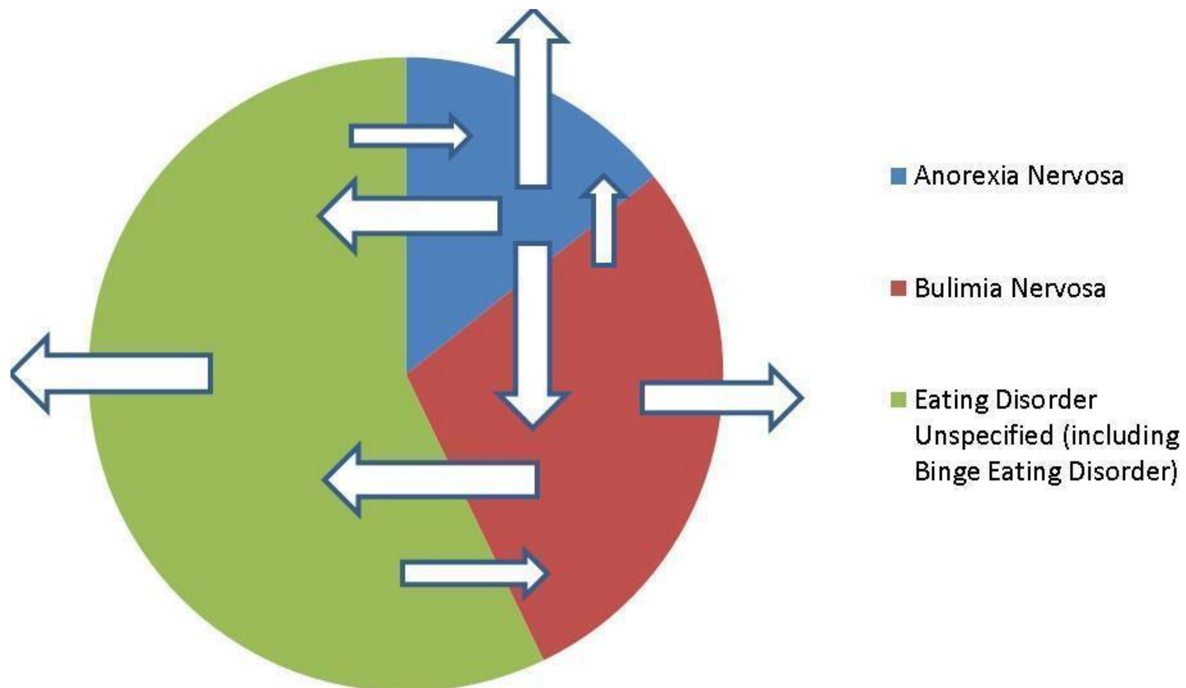
My eating disorder symptoms past and present

Have your eating disorder symptoms changed over time? Take a moment to reflect on the signs and symptoms you noticed when your eating disorder developed, and the signs and symptoms that you currently experience. Complete the table below to see if and how your symptoms have changed over time or access the link to the exercise here.

My eating disorder symptoms in the past	My eating disorder symptoms Now

Movement between Eating Disorder Diagnoses

Movement between eating disorder diagnoses is common, and many people experience a change in their symptoms and/or diagnosis over time. As a result, there has been a move towards thinking "trans diagnostically" about the similarities and differences across all the diagnoses.



Adapted from Fairburn, C (2008). *Cognitive Behaviour Therapy and Eating Disorders.* London: The Guildford Press

The graph above has been taken from literature published in 2008. Although the research indicates that the incidence of eating disorders has dramatically increased since then - particularly during the Covid pandemic - it is generally assumed that the overall diagnostic pattern has remained largely consistent within this increase.

The data suggests that 10-15% of the eating disorder population have a diagnosis of Anorexia Nervosa, approximately 30% have a diagnosis of Bulimia Nervosa, and the majority (60%) of the eating disorder population meets the criteria for Eating Disorder Unspecified, including 10% of the population who meet the diagnosis for Binge Eating Disorder.

The arrows represent the typical movement between the diagnoses – the thicker the arrow, the more common the change in direction. As well as noting the change in direction, you can also see a number of arrows pointing out of the diagnostic circles. These arrows represent the number of people who recover from their eating disorder, and no longer meet the diagnostic criteria for an eating disorder.

My Eating Disorder Symptoms

Look at the list of symptoms and place an X against those symptoms that you currently experience or access the link to the exercise here.

Attitudes and behaviour related to eating

- Increased preoccupation with food
- Planning meals
- Tendency to hoard
- Change in speed of eating (faster / slower)
- Increased hunger / appetite
- Depression
- Anxiety
- Irritability
- Apathy
- Neglected personal hygiene

Social and sexual changes

- Withdrawal / avoidance from others
- Reduced sense of humour
- Feelings of social inadequacy
- Isolation
- Strained relationships
- Reduced sexual interest and activity

Cognitive changes - difficulties with:

- Concentration
- Alertness
- Comprehension
- Making decisions / poor judgement

Physical changes

- Gastro-intestinal discomfort
- Reduced need or ability to sleep
- Dizziness
- Headaches
- Hypersensitivity to noise and light
- Decreased muscle strength
- Oedema (swelling)
- Hair loss
- Reduced tolerance for cold temperatures
- Abnormal tingling/prickling sensations in hands and feet

Physical activity

- Tiredness
- Weakness
- Listlessness

Options for Podcast 2

The Keeping Safe programme is aimed at helping you become more aware of the symptoms you are experiencing, and the risks associated with them. In the next podcast, you have a choice. We have created 3 sections about the different sets of symptoms so that you can select the podcasts that are of most relevance or interest to you. They include a podcast on the effects of significantly restricting your intake and having a very low body weight (i.e., Anorexia Nervosa), a podcast on the use of compensatory behaviours, such as inducing vomiting or excessively exercising, and a podcast on problematic eating behaviours, including binge eating and chewing and spitting, and the factors that can trigger binge eating.

If you have a diagnosis of Binge Eating Disorder, we recommend you select to listen to Podcast 2c to hear the information that may be relevant to you. As noted below, you may also be interested to listen to Podcast 2a even though the behaviours and symptoms may not directly relate to you

Podcast 2a

This podcast is relevant to you if you limit or restrict your intake and / or have a low body weight (e.g., within the Anorexia Nervosa range). It is also relevant to anyone who has tried to diet / undereat (but may not have a very low body weight). In this podcast, we discuss a key piece of research that investigates the effects of starvation on the body, psychological functioning, and relationships with others. We discuss the risks associated with restricted eating and low weight, as well as how to take steps to reduce the harm and symptoms.

Podcast 2b

In this podcast, we cover the range of behaviours people often use to try and compensate for their food intake and / or try to lose weight, such as making yourself sick, taking laxatives and/or engaging in lots of physical activity or exercise. We discuss the risks of each, as well as how to take steps to reduce their use and the harm that they can cause.

Podcast 2c – Section 2c pages 1-7

This podcast is relevant to you if you have a diagnosis of Binge Eating Disorder and / or lose control of your eating. In this podcast, we will define what constitutes binge eating, cover some of the common triggers to losing control of our eating and introduce some tips on how to identify your own triggers in order to take steps to reduce it. We also discuss other problematic eating behaviours such as chewing and spitting.

Please note - we recommend that everyone makes themselves familiar with the Minnesota study, regardless of eating disorder diagnosis. Although it may not appear directly relevant to those with Binge Eating Disorder, it is a key piece of research that informs about the effects of restricting our eating, weight loss on our physical and psychological functioning. You will find a summary on the next 5 pages of this workbook (Section 2a).

Section 2 (a) The Effects of Undereating

The Minnesota Study

Read the following study - Effects of semi-starvation on behaviour and physical health: The Minnesota experiment.[2]

The Minnesota study was a key experiment into the effects of starvation on the body and psychological functioning that was conducted in the 1950's. The results have been used to educate the academic and clinical field about the effects of starvation in people with eating disorders.

There is a remarkable similarity between many of the experiences seen in people who have experienced fairly long periods of semi-starvation and those seen in people with anorexia nervosa or bulimia nervosa. In the 1940's to 1950's, Ancel Keys and his team at the University of Minnesota in America studied the effects of starvation on behaviour. What they found both surprised and alarmed them.

The experiment involved carefully studying 36 young, healthy, psychologically normal men, both during a period of normal eating, and during a longer period of fairly severe food restriction, and after the food restriction was lifted. During the first three months of the experiment, the subjects ate normally whilst their behaviour, personality and eating patterns were studied in detail. Over the next six months, the men were given approximately half the amount of food that they needed to maintain their weight and they lost, on average, 25% of their original body weight. Some participants actually went down to a BMI of 14. Following this, there were three months of rehabilitation during which time the men were re-fed. Although the individual responses to the experiment varied greatly, the men experienced dramatic physical, psychological, and social changes as a result of the food restriction. Of note was the fact that for many, these changes persisted even after weight returned to normal after the food restriction period.

Attitudes and behaviour related to food and eating

The men's change in relationship to food was one of the most striking results of the experiment. They found it increasingly difficult to concentrate on more normal things and became plagued by persistent thoughts of food and eating. Food became a principal topic of conversation, of reading, and of daydreams. Many men began reading cookbooks and collecting recipes, whilst others became interested in collecting various kitchen utensils. One man even began rummaging through rubbish bins in the hope of finding something that he might need. This desire to hoard has been seen in both people and animals that are deprived of food. Although food had been of little interest to the men prior to entering the experiment, almost 40% of them mentioned cooking as part of their post experiment plans. Some actually did change their career to a career focussed on food once the experiment was over.

The men's eating habits underwent remarkable changes during the study. Much of the day was now spent planning how they would eat their allocated food. Plus, in order to prolong their enjoyment of the food eaten, it would take them vastly longer amounts of time to eat a meal. They would eat in silence and would devote their total attention to the consumption of the food.

The subjects of the study were often caught between conflicting desires to gulp down their food ravenously and to consume it so slowly that the taste and smell of each morsel of food would be fully appreciated. By the end of the starvation period of the study, the men would dawdle for almost two hours over a meal that they previously would have consumed over a matter of minutes.

Another common behaviour was that they would make unusual concoctions by mixing different foods together. Their use of salt and spices increased dramatically, and the consumption of tea and coffee

[2] Reference: Handbook of Treatment for Eating Disorders, Second Edition, Edited by David N. Garner and Paul E Garfinkel (1997)

increased so much that they had to be limited to 9 cups per day. The use of chewing gum also became excessive and also had to be limited.

During the 12th week re-feeding phase of the experiment, most of these abnormal attitudes and behaviours to food persisted. Some of the men had more severe difficulties during the first six weeks of re-feeding. The free choice of ingredients stimulated “creative” and “experimental” playing with food; for example, licking off plates and very poor table manners persisted.

Binge eating
During the restrictive phase of the experiment, all of the volunteers reported feeling more hungry. Whilst some appeared able to tolerate this fairly well, for others it created intense concern or even became intolerable. Several of the men failed to stick to their diet and reported episodes of binge eating followed by self-reproach. While working in a grocery store, one man:

> “Suffered a complete loss of willpower and ate several cookies, a sack of popcorn, and two overripe bananas before he could ‘regain control’ of himself. He immediately suffered a severe emotional upset, with nausea, and upon returning to the laboratory he vomited. He was self-deprecatory, expressing disgust and self-criticism.”

After about five months of re-feeding, the majority of the men reported some normalisation of their eating patterns, but for some the difficulties in managing their food persisted. After eight months, most men had returned to normal eating patterns, although a few still had abnormal eating patterns. One man still reported consuming around 25% more than he did prior to the weight loss and “once he started to reduce but got so hungry, he could not stand it”.

Emotional changes
It is important to remember that the subjects were psychologically very healthy prior to the experiment but most experienced significant emotional changes as a result of semi-starvation. Many experienced periods of depression; some brief whilst others experienced protracted periods of depression. Occasionally elation was observed, but this was inevitably followed by “low periods”. The men’s tolerance that had prior to starvation been high was replaced by irritability and frequent outbursts of anger. For most subjects, anxiety became more evident; many of the formerly even-tempered men began biting their nails or smoking if they felt nervous. Apathy was a common problem, and some men neglected various aspects of their personal hygiene. Most of the subjects experienced periods during which their emotional distress was quite severe, and all experienced the symptoms of “semistarvation neurosis” described above.

Both observation and personality testing showed that the individual emotional response to semistarvation varied considerably. Some of the volunteers seemed to cope very well whilst others displayed extraordinary disturbance following weight loss. As the emotional difficulties did not immediately reverse once food was in ready supply, it may be assumed that the abnormalities were related more to body weight than to short term calorie intake. So, we can draw the conclusion that many of the psychological disturbances seen in anorexia and bulimia nervosa may be the result of the semi-starvation process itself.

Social and sexual changes
Most of the volunteers experienced a large shift in their social behaviours. Although originally quite gregarious, the men became progressively more withdrawn and isolated. Humour and a sense of friendship and comradeship diminished markedly amidst growing feelings of social inadequacy.

> “Social initiative especially, and sociability in general, underwent a remarkable change. The men became reluctant to plan activities, to make decisions and to participate in group activities…they spent more and more time alone. It became ‘too much trouble or too tiring’ to have contact with people.”

The volunteers' social contacts with women also declined sharply during semi-starvation. Those who continued to see women socially found that the relationships became strained. One man described his difficulties as follows. "I am one of about 3 or 4 who still go out with girls. I fell in love with a girl during the control period, but I see her only occasionally now. It is almost too much trouble to see her even when she visits me in the lab. It requires effort to hold her hand. Entertainment must be tame. If we see a show, the most interesting part of it is contained in scenes where people are eating."

One subject graphically stated that he had "no more sexual feeling than a sick oyster". During the rehabilitation period the men's sexual interest was slow to return. Even after three months they judged themselves to be far from normal in this area. However, after eight months some or virtually all the men had recovered their interest in sex.

Cognitive changes
The volunteers reported impaired concentration, alertness, comprehension, and judgement during semi-starvation.

Physical changes
As the six months of semi-starvation progressed, the volunteers exhibited many physical changes including the following: gastro-intestinal discomfort, decreased need for sleep, dizziness, headaches, hyper-sensitivity to noise and light, reduced strength, oedema (an excess of fluid causing swelling), hair loss, decreased tolerance of cold temperatures (cold hands and feet) and parasthesia (abnormal tingling or prickling sensations, especially in the hands and feet). There was an overall decrease in metabolism (decreased body temperature, heart rate and respiration). As one volunteer described it, he felt as if his "body flame was burning as low as possible to conserve precious fuel and still maintain life processes".

During rehabilitation, the metabolism speeded up again, especially in those who had the larger increases in food intake. Subjects who gained the most weight described being concerned about their increased sluggishness, general flabbiness, and the tendency for the fat to accumulate around the stomach and buttocks.

These complaints are very similar to those that people with bulimia and anorexia describe as they gain weight. However, after approximately a year the men's body fat and muscle levels were back to their pre-experiment levels.

Physical activity
In general, the men responded to semi-starvation by reducing their activity levels. They became tired, weak, listless, apathetic, and complained of a lack of energy. Voluntary movements became noticeably slower. However, according to the original report,

> "Some men exercised deliberately at times. Some of them attempted to lose weight by driving themselves through periods of excessive energy in order to either obtain increased bread rations… or to avoid reduction in rations".

This is similar to the practice of many patients, who feel that if they exercise strenuously, they can allow themselves a bit more to eat.

Significance of the study for the eating disorders

All the volunteers were psychologically and physically healthy prior to the experiment and as such, the symptoms experienced by them as the experiment progressed can be attributed to the period of starvation and its consequences. We know then that many of the symptoms faced in Anorexia Nervosa and Bulimia Nervosa are a direct result of the food restriction, rather than the illnesses themselves. It is important to recognise that these symptoms are not just limited to food and weight, but extend to virtually all areas of physical, psychological, and social functioning. It is crucial therefore, that a person with an eating disorder returns to a normal weight (if underweight) in order to allow these symptoms to reduce significantly/completely. It is also important for both therapist and patient to become aware of and address any emotional problems that underlie or previously triggered the eating disorder.

It is also important to think about how the men's relationship with food was not normal, even after they returned to eating freely available food. In the short term, they felt out of control with much of their food intake and were unable to identify when they felt hungry or when they felt full. Many of these symptoms continued after they reached a normal weight and, for some, took several months and years to normalise. It is therefore helpful when recovering from anorexia nervosa or bulimia nervosa to understand that you cannot just expect your body to return to being able to regulate food intake on its own. We know that consuming a well-balanced and nutritionally complete food intake, spread out over regular points during the day, encourages a return of the body's ability to recognise when it is hungry and when it is full.

Below are some other symptoms and consequences often reported by people who have an eating disorder which you may also identify with:

- Heightened obsessiveness – both food specific & more generally.
- Lowered ability to recognise hunger and fullness.
- Reduced metabolic rate.
- Fluctuating energy levels – increase in binge eating.
- Low mood.

There are several short-term and long-term symptoms associated with restricting our food intake.

One symptom is a low blood sugar, which can lead to feelings of weakness, dizziness and even episodes of fainting. A drop in blood sugars can also lead to an increase in binge eating, so it is a good idea to try and ensure that we eat to prevent a drop in blood sugar in order to reduce our likelihood of losing control over our eating and binge eating.

Section 2c: Problematic Eating Behaviours

Problematic eating behaviours

There are several forms of eating behaviour including:

Objective binge eating: an episode of eating during which an unusually large amount of food is consumed, even if not hungry, associated with a feeling of loss of control. Episodes are usually characterised by eating very rapidly, or in secret and associated with physical discomfort and feelings of distress, guilt, or disgust.

Subjective binge eating: eating what others would consider to be a normal portion of food, or perhaps smaller than a normal portion of food, associated with a feeling of a loss of control.

Over-eating: eating a large amount of food, but where the person feels in control of their eating and can choose to stop if they want to.

Grazing: eating little and often in an unstructured, repetitive manner throughout the day. Grazing occurs between meals in an unplanned way, and not in response to feelings of hunger or sensation of fullness.

Chewing and spitting: chewing food - often of a subjective enjoyable quality and / or calorie-dense content - and then spitting it out before swallowing, as a means to avoid ingesting unwanted calories

Objective binge eating is the only eating behaviour that is included as a diagnostic criterion (e.g., for Bulimia Nervosa, Binge Eating Disorder). However, people with eating disorders may engage in one or more of these types of eating behaviour.

Everybody tends to over-eat and/or graze at times. These types of eating can become problematic if they become established patterns of eating which overtime, may lead to weight problems.

Triggers to Binge Eating

Triggers are events that occur before the problematic behavioural response (e.g., binge eating). Common triggers to binge eating include:

1. Hunger
2. Emotional states
3. Disinhibition
4. Exposure / access
5. Thoughts / thinking style

Hunger

Hunger is caused by restricting intake and / or leaving long gaps between eating. By restricting our intake and/or leaving long gaps between eating, we significantly increase our risk of binge eating. This is because we are not taking in enough energy and as a result, our blood sugar levels drop. This drop in blood sugar sends a strong signal to the brain that you need to eat something. If you don't not respond, or leave it for too long before eating again, you may find yourself craving sugary and/or high fat foods, which increases the risk of overeating and / or binge eating.

Emotional states

Both negative and positive emotions can trigger binge eating. Common triggering emotions include anxiety, anger, stress, boredom and / or loneliness. Feelings of happiness, excitement and joy can also trigger a binge for some people. Overtime, binge eating may become a way of managing emotions - binge eating may be used to help avoid having difficult feelings and / or occur in response to difficult feelings. If we continue to manage our feelings in this way – either by trying to avoid them, or by pushing them away through eating - we don't learn other, more adaptive ways of dealing with our feelings.

Disinhibition

This refers to a state where we are less in control, or able to make good decisions. For example, if we drink too much alcohol, take heavy medication and / or feel very tired. It is not just the effect these substances have on our concentration and attention which lowers our resistance to fighting urges to binge, but also the effect they have on our blood sugar / energy levels and subsequent appetite.

Exposure / access

Many people report losing control of their eating when they are exposed to food and / or it is easily accessible. For example, all-you-can-eat buffets, being alone in the house when the kitchen cupboards are full of treats, or going to the supermarket, especially when hungry. If food is readily available, it can make it harder to resist urges to binge, especially if your risk to binge eating is already high due to some of the other triggers above (e.g., irregular, or restricted eating, negative mood state or disinhibition).

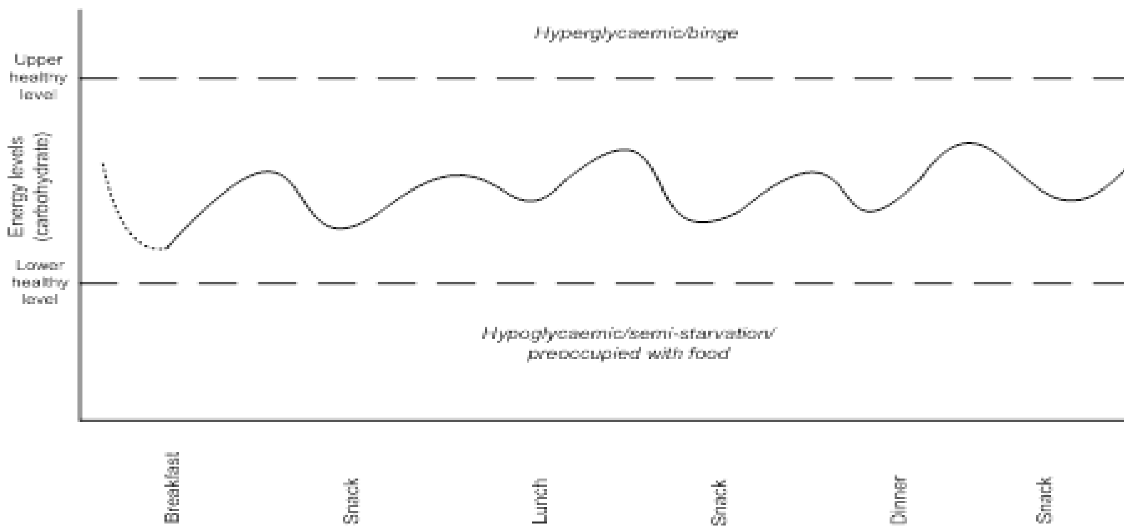
Thoughts and thinking style

Binge eating can be triggered by how we think / our thinking style. For example, giving ourselves permission to binge because we've done well to stick to our food rules all day. In short, we may binge as a reward. Or we may binge in response to breaking a rule – for example eating a food that we normally avoid and then thinking "oh well, I've blown it now, I may as well continue", thus allowing the binge to proceed. Both are examples of types of thinking that frequently underpin binge eating – known as permissive thinking and all-or-nothing thinking.

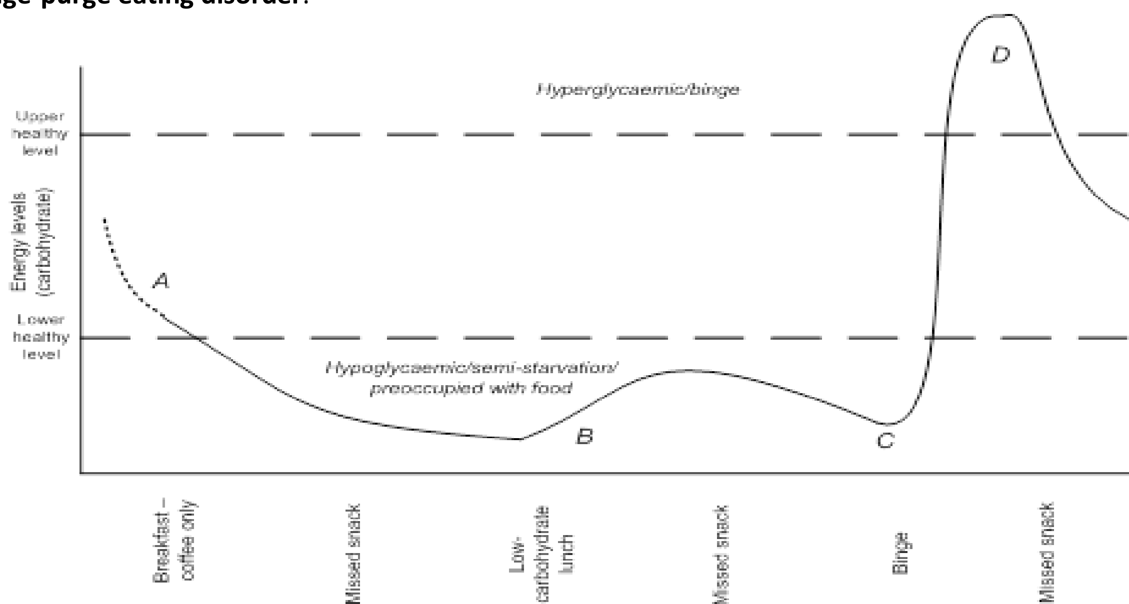
Energy Graphs[3]

Energy graphs relate to blood sugar levels, which is a key player in appetite control. After 3 to 4 hours since eating your last meal / snack, your blood sugar will start to drop as the energy our bodies take from this has been used up. This drop in blood sugar sends a strong signal to the brain that you need to eat something. If you leave it for longer than this, you may find yourself craving sugary and / or high fat foods, which increases the risk of overeating and / or binge eating.

Below is an example of someone's energy graph that is eating the **recommended** energy requirements (i.e., 3 meals, 1-3 planned snacks including a regular carbohydrate intake).



The following graph shows the energy levels that are **typically seen in someone with a binge or binge-purge eating disorder**.



[3] Taken from pages 147-149 of Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V & Russell, K (2007). *Cognitive Behavioural Therapy for Eating Disorders. A Comprehensive Treatment Guide.* Cambridge: Cambridge University Press.

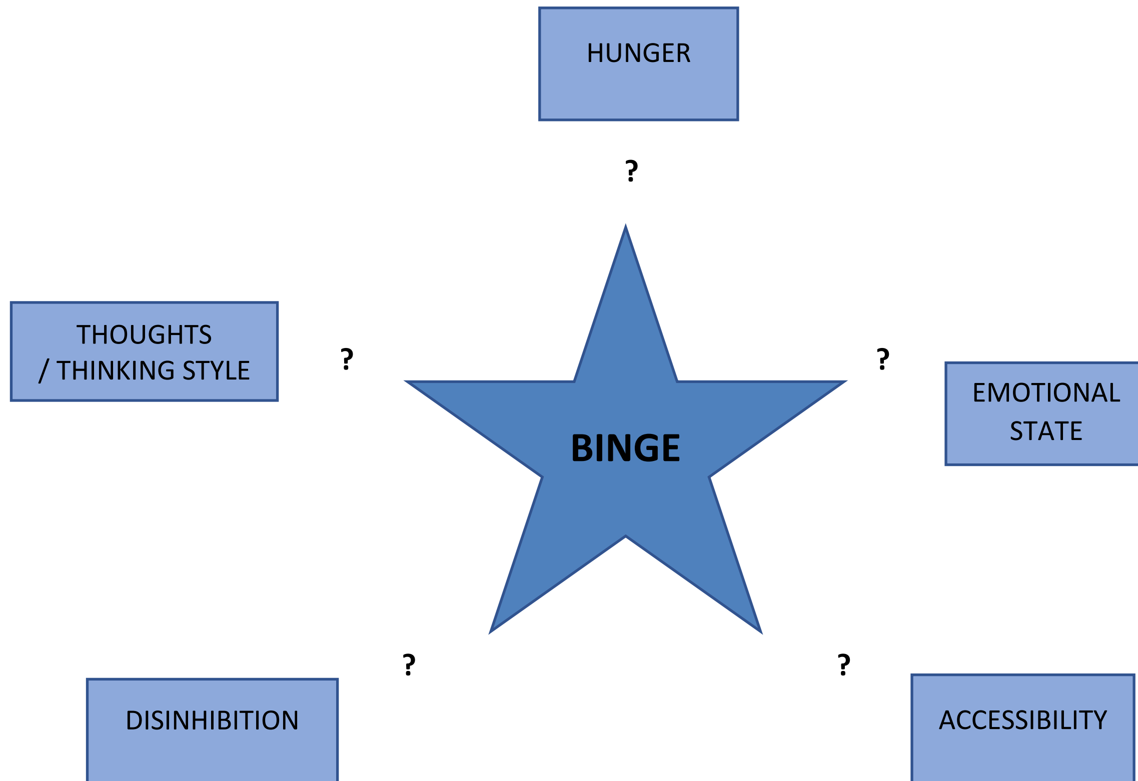
Safe and Feared Foods

Use the table below to record the types of foods you currently include in your diet and what foods you tend to avoid eating or access the link to table here.

Foods I feel okay eating	Foods that make me anxious and / or I avoid eating

Understanding the triggers to my binge eating

Next time you lose control of your eating, use the diagram below to try and identify what triggered it. Ask yourself questions around each potential trigger - for example: When did you last eat before the binge? How were you feeling just before you lost control? Were there lots of opportunities to eat, even though you hadn't planned to? Did you have enough sleep or breaks during the day? Had you been drinking? Did you break a food rule or feel bad about something you ate earlier?



(N.B: Remember, there can be more than one trigger to a binge)

The trigger(s) to my binge was:

The lesson I learned from this is:

Next time I can reduce the risk of losing control by:

Chewing and Spitting

People chew and spit in order to enjoy the flavour of food, without ingesting the calories. Chewing and spitting has some similarities with bingeing, because it often involves ingesting larger than intended quantities of high-calorie foods. However, it also shares some elements of the restrictive eating disorders because the food is not consumed. Chewing and spitting is often not talked about as a problematic eating behaviour and can be accompanied with feelings of shame and embarrassment.

Although calories may not be consumed, chewing and spitting can still result in weight gain due to the inadvertent tendency to overeat later in the day.
While it might seem like a less problematic behaviour when compared to other eating disorder behaviours, the physical consequences of chewing and spitting can have serious physical effects including:

- **Dental problems**: Erosion of tooth enamel, cavities and gum disease can result when teeth are exposed to frequent contact with sugary foods

- **Stomach problems**: Chewing food triggers the stomach to start producing acid, in readiness to start digesting food. As food is not swallowed and no food is available for digestion, excess or redundant stomach acid could potentially lead to ulcers or acid reflux.

- **Swollen saliva glands**: Chewing also increases the production of saliva from the salivary glands. The major and minor salivary glands are located all around your mouth and throat, under your tongue, behind your jaw and inside your cheeks. Chewing excessively can result in the overproduction of saliva, which may then lead to swollen salivary glands. Swollen salivary glands can have an additional adverse effect of making the face look rounder, potentially triggering a person to fear or inaccurately conclude that they have gained weight.

It is a good idea to try and reduce the frequency of chewing and spitting - if you cannot stop it completely - and to continue to practise good oral hygiene. For example, NHS guidelines suggest brushing your teeth with fluoride toothpaste at least twice a day, using floss and an interdental brush once a day, and making sure you visit your dentist regularly.

STOP and Reflect . . .

What can we conclude?

- There are several common triggers to binge eating including
    - Physical (hunger, disinhibition)
    - Psychological (mood, thoughts, disinhibition)
    - Environmental (access)
- Risk of binge eating increases if we are exposed to one or more of these triggers
- The urge to binge is often driven by biological processes which tend to be stronger than eating disorder thoughts or intentions to try not to eat.
- Ensuring that we are eating adequately and regularly is the first and most effective step in reducing binge eating behaviour

Prompt questions

Take some time to consider the following and note your thoughts below. Alternatively, you can complete the exercise by accessing the link to the exercise here.

- What have I learned about the factors that contribute to why I binge?

- Which of those factors would I most like to target?

- What actions can I take now?

If you would like to learn more about your pattern of binge eating, you might find it helpful to monitor for a few days. You can find a monitoring sheet with instructions on how to use it on the next page.

Monitoring sheet - Binge Diary

Use the monitoring box below to mark (x) when and how many times you binge over a week. Alternatively, you can access a link to the monitoring sheet here.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8am- 9am							
9am – 10am							
10am – 11am							
11am – 12pm							
12pm- 1pm							
1pm - 2pm							
2pm – 3pm							
3pm – 4pm							
4pm – 5pm							
5pm – 6pm							
6pm- 7pm							
7pm – 8pm							
8pm – 9pm							
9pm – 10pm							
10pm – 11pm							
11pm - 12pm							
12pm - 8am							

Do you notice a pattern to your bingeing (e.g., do you binge at a certain time of the day or day of the week?) What factors increase your risk of bingeing? What factors help you reduce your risk of bingeing?

Factors that increase my bingeing:

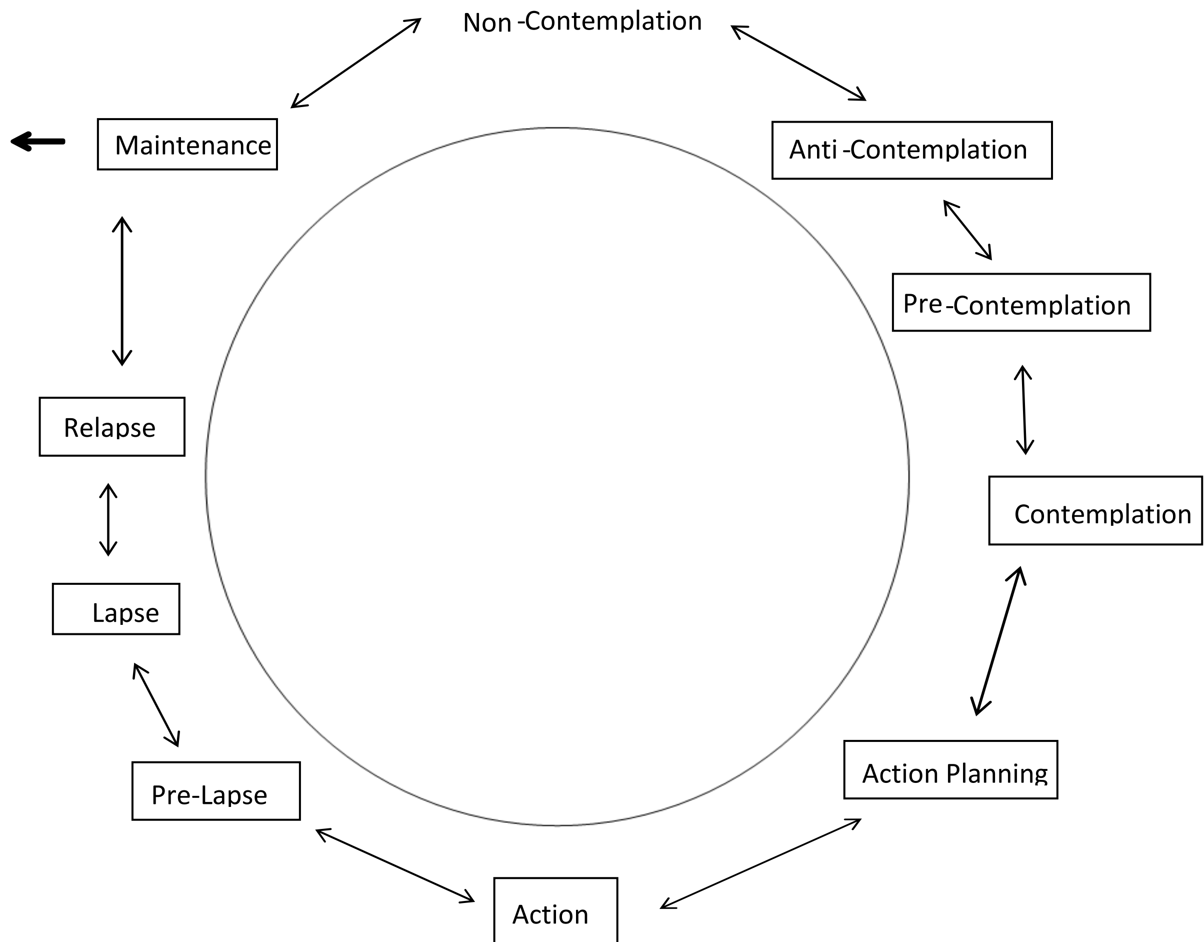
Factors that help me reduce bingeing:

Section 3

Motivational States

The Stages of Change model was originally created by Prochaska and DiClemente in 1983[4] and later developed into the Motivational States model by Freeman and Dolan in 2001.

The Motivational States model attempts to describe the states of motivation a person goes through when embarking on change. See diagram below.



[4] Prochaska, J. and DiClemente, C. (1983) Stages and processes of self-change in smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 5, 390–395.

Freeman, A. & Dolan, M. (2001). Revisiting Prochaska and DiClemente's stages of change theory: An expansion and specification to aid in treatment planning and outcome evaluation. *Cognitive and Behavioral Practice*. 8, 224-234.

Motivational States Continued

The following descriptions provide more information about each motivational state:

Non-contemplation: this describes the state when a person is unaware that a problem exists.

Anti-contemplation: this describes the state where a person is not willing to consider change.

Pre-contemplation: this describes the state where a person may have fleeting thoughts about the possibility, purpose, and consequences of change.

Contemplation: this describes the state where a person is actively considering change. Although considering the possibility of change, it is usual for people to experience ambivalent feelings about doing so.

(**Ambivalence** means the simultaneous coexistence of positive and negative feelings and thoughts which may be conflicting and contradictory. People often experience ambivalence as feeling in two minds, as though being torn in two different directions. This may make it difficult to decide one way or the other and can be experienced as psychologically unpleasant and/or uncomfortable)

Action planning: this describes the state where a person identifies what needs to change (e.g., a focus for treatment) and initiates active planning for that change (e.g., treatment planning).

Action: this describes the state where actual behavioural change is being made.

Pre-lapse: this refers to a state during which thoughts and urges to return to old behaviour occur – a person may be evaluating whether the changes made in the Action stage are beneficial or necessary.

Lapse: this describes a blip in behaviour, and the person has temporarily reverted to using some of their old behaviours. People are often able to get themselves back on track (with or without support).

Relapse: this describes the state in which efforts to sustain new behaviours and change breaks down, and the person slips back to problematic behaviours.

Maintenance: occurs when any new behaviours become stable. At first, this requires conscious effort and attention but over time, becomes habitual behaviour.

You and Your Eating Disorder

Take some time to consider the following questions and make a note of your thoughts below. Alternatively, you can access the link to the exercise here.

1. Which motivational state - or states - best describe your current situation in terms of engaging in treatment for your eating disorder?

2. What thoughts, feelings or behaviours do you notice that suggest you are in this particular state?

3. What would help you to move forward in the direction of change?

4. Can you identify any factors that prevent you from moving forward in the direction of change?

Weighing up the Pros and Cons of my Eating Disorder

Using the table below (or accessing the link to the table here which you will find in Section 2 after the previous questionnaire), make a list of the advantages and disadvantages of your eating disorder (i.e. how does my eating disorder help me and what are the negative consequences of my eating disorder?).

When thinking about our motivation to change, it can be helpful to think of the short-term and long-term advantages. It can be difficult to think too far into the future, and you may find it useful to have a look at an example on the next page to help you complete the bottom 2 boxes.

Advantages **List the positive aspects of your problem** *What are the helpful aspects of your eating disorder? For example, does it help you manage painful feelings?*	**Disadvantages** **List the negative consequences of your problem** *What difficulties do you currently experience because of your eating disorder?*
Now and near future In the long-term	Now and near future In the long-term
List the personal benefits you expect if you overcame your eating disorder *How would your life change in a positive way if you overcame your eating disorder? E.g., perhaps you would feel less cold and tired, or be able to enjoy eating out with friends?*	**List the personal costs you expect if you change** *What would you need to give up or do differently in order to change? Change may mean giving up some of the advantages the eating disorder has given us – or learning new ways of coping for example.*

Weighing up the Pros and Cons of my Eating Disorder

Example

Advantages **List the positive aspects of your problem** *What are the helpful aspects of your eating disorder? For example, does it help you manage painful feelings?*	**Disadvantages** **List the negative consequences of your problem** *What difficulties do you currently experience because of your eating disorder*
Now and near future • *Eating helps me cope with how I'm feeling* • *I love food / eating - it is one of my biggest pleasures in life* • *Bingeing gives me something to look forward to* In the long-term • *? I'm not sure there are any different advantages to those I've mentioned above*	Now and near future • *I'm gaining weight and feel awful about this* • *I can't control my eating; it makes me feel like a failure* • *I feel so ashamed and guilty after I have binged* • *It is costing so much money* • *I'm scared of going out for dinner with friends in case I can't stop eating* In the long-term • *I'll continue to gain weight* • *My health will deteriorate* • *I'll continue to feel bad about myself*
List the personal benefits you expect if you overcome your eating disorder *How would your life change in a positive way if you overcame your eating disorder? For example, perhaps you would be able to enjoy eating out with friends?*	**List the personal costs you expect if you change** *What would you need to give up or do differently in order to change? Change may mean giving up some of the advantages the eating disorder has given us – or learning new ways of coping for example.*
• *I will feel SO much better about myself* • *I'll have more control over my eating and my weight* • *I will feel healthier* • *I will be able to socialise and enjoy my friends* • *I'll have more money!*	• *I'm going to miss the feeling of being really full* • *I'm going to have to learn to eat differently* • *I'm going to have to learn how to deal with how I feel rather than avoid it - and this feels scary to me.* • *I'm going to have to fill my life with other things*

Section 3a: Personal Recovery Stories

Personal recovery stories

Below is a list of people's stories about their recovery from their eating disorder that feature on podcast 3a. The details of personal stories 1 to 6 have been shaded out as they may not be as relevant to you (but you are welcome to listen to these if you wish). We recommend that you listen to personal stories 7 and 8.

Personal story 1

Alice is in her early 20's. In her story, Alice talks about how she struggled with Anorexia Nervosa from the age of 12, and how it took several years to seek treatment.

Personal story 2

Antonia is in her late 20's. In her story, Antonia describes how it took her time to recognise that she was suffering from Anorexia Nervosa and the difficult process of whether to seek treatment.

Personal story 3

Hope is in her early 30's. In her story, Hope talks about some of the difficult early experiences she encountered and how these, in addition to struggling with her feelings, contributed to the development of her eating disorder.

Personal story 4

Simon is in his late 40's and writes about his recovery from an eating disorder that was initially restrictive but then later developed into Bulimia Nervosa.

Personal story 5

Mary is in her mid-20's. In her story, Mary talks about the circumstances within which her eating disorder developed at the age of 18, and how, after a previously unsuccessful attempt of seeking treatment, she eventually engaged with services and recovered from Anorexia Nervosa.

Recovery story 6

Kelly is in her late 20's. In her story, Kelly talks about her recovery from Bulimia Nervosa. She describes how her early experiences increased her vulnerability to developing issues with her appearance, self-esteem and ultimately her eating.

Recovery story 7 - page 2 (and on podcast 3a at 49mins 23secs)

Sandra is in her mid-50's. In her story, Sandra talks about how she comfort ate from an early age and struggled with her weight as a consequence. She highlights how secrecy and shame got in the way of seeking treatment, and how she eventually accessed treatment for Binge Eating Disorder (BED) through a weight management service.

Recovery story 8 - page 5 (and on podcast 3a at 59mins 25secs)

Becky is in her early 40's and recently completed treatment for BED. In her story, she talks about her life-long struggle with her weight and eating, and how being given a diagnosis helped to give her the confidence to seek treatment. She discusses her anxieties about attending group therapy and the changes she made to reach the early stages of recovery.

Personal story - Sandra

I grew up in a family where food had a starring role. My Mum was a fantastic cook and enjoyed feeding us all. We always sat down to eat together, and mealtimes were big, happy occasions. Mum would also make sure we had food with us if we were going out for the day. She'd also give me nice things to eat if I had done something well or when I was feeling upset. Looking back, I guess I grew up associating food and eating with being happy, receiving a reward, being sad or needing comfort. This probably explained why I was bigger than my friends, although I wasn't really bothered about it until I hit puberty. My body started developing around the age of 10 – earlier than any of my friends - and I remember feeling really self-conscious. I felt big – and compared to my friends, I was - but now when I look back at photos of myself, I can see that I wasn't as fat as I thought I was at that age.

How I felt about my body had a real effect on me – I used to dread the summer because I'd worry about having to wear lighter or fewer clothes. I'd also worry about sweating, and people thinking it was because I was fat. I wore clothes that were loose and baggy and couldn't wear the sorts of clothes my friends wore because I thought I'd look hideous in them. I can laugh about it now, but I also used to refuse to take off my jumper or coat unless I really had to, which must have looked really odd in the hot weather…

I wasn't bothered about attracting boys at this point – I was too shy and self-conscious – but I did worry about what people thought of me. I was bullied for a while – nothing serious, but a few boys used to laugh at me and comment on my size, which really hurt. I couldn't tell anyone, because I didn't want to admit it to myself. At around this time, there was also lots of falling out between friends – typical for teenage girls perhaps - and I was often left out. I felt lonely and unpopular. I started buying chocolate and sweets on the way home from school and eating them alone in my bedroom when I got home. I'd often secretly eat 3 or 4 chocolate bars in a row and hide the wrappers, so my family didn't find out. On top of that, Mum was always baking nice treats and stuff, which I also ate. I was gaining weight but didn't really connect how I was eating with what was happening to my weight. In fact, I never weighed myself – I avoided it, out of embarrassment – so didn't have any idea of what was really happening to my weight.

I became more sociable when I went to Uni and spent a huge chunk of my late teens and early twenties getting drunk. I think drinking probably helped me overcome my shyness. I can't really remember what my eating was like at that time, but I do know that it was pretty poor – I was mostly living off convenience foods, ready meals and family sized packs of Maltesers. I was quite unhappy during this period of my life and continued the habit of buying treats to eat in the evening if I didn't have anything to do, or if my mood was low - it gave me something to look forward to. My weight continued to increase but I don't know how much because I still didn't weigh myself. I also stopped buying new clothes and avoided looking at my body in the mirror. Subconsciously, I don't think I really wanted to think about my weight or realise that it was becoming a problem.

I eventually realised that I needed to do something about my weight when I hit my 30's. I was shocked to discover how large I had become when some friends showed me their wedding photos, and I'd been in some of the pictures. I was embarrassed by how I looked and what I was wearing - big tent-like clothes, compared to the gorgeous dresses worn by the other girls - and it was obvious by the way I was standing – or hiding – that I felt awkward and self-conscious.

Shortly after, I went on my first diet – the first of many – with rules about what I could and couldn't eat. I could stick to most diets for a while, and on some occasions, I did actually lose some weight, which gave me a boost, especially when people noticed or complimented me on my weight loss.

But it got too difficult to stick to the rules and knowing what “good” or “bad” foods were - there was just so much conflicting advice - that after a while, I’d get overwhelmed and always end up giving up after a couple of weeks. I’d feel like a failure – unable to control my eating AND my weight.

Fast forward a few years, and I found myself married. My eating had improved in some respects, but my husband often worked away during the week, and I’d often spend nights at home on my own, eating. He frequently made comments about my diet and weight, especially if he saw me eating foods he thought I shouldn’t be eating. Looking back, I felt insecure throughout most of my marriage and ate to make myself feel better. Food had always been there for me in the past and it was like a comfort blanket when I needed it. But on some level, I must have known it was unhealthy because whenever my husband did come home, I’d feel ashamed and go to great lengths to hide any evidence of what I’d been eating whilst he was away.

My eating definitely got worse when my marriage started to break down – and this was the first time my eating really felt out of control. Before this, I kind of knew I was overeating, mostly in secret. However, I distinctly remember the first time I couldn’t stop eating and properly binged. I was really shocked and pretty frightened. Although I had planned to eat a few biscuits, I just couldn’t stop. I ate the whole packet and then way more after that. I felt horribly full and uncomfortable afterwards. I also felt ashamed and disgusted with myself. It felt like rock bottom, and I couldn’t work out why I had done it, or why I hadn’t been able to stop myself. After that, it started happening more frequently. I became anxious around food and started to avoid eating out with friends in case it happened when I was out. It really got me down and became a vicious cycle - the worse I felt, the more I ate. The more I ate, the more I gained weight. And the more I gained weight, the more negative I felt about myself and the more I’d turn to eating to make myself feel better and so on.

It was impossible to talk to anyone about my eating, and I kept it secret for years – I felt so ashamed and embarrassed about it. I got help by accident really, after I broke down during an appointment with my GP. I’d been feeling very anxious and depressed following my divorce and was feeling really bad about myself and my weight. As well as prescribing antidepressants, my GP referred me to a weight management clinic where they asked lots of questions about what and how I ate. It felt easier talking to people who knew about overeating and comfort eating. They also asked if I sometimes lost control and couldn’t stop eating - which no one had ever asked me before – and made it a lot easier to admit. Apparently, I had something called Binge Eating Disorder. It was a relief to give it a name, and to find out that there was actually some treatment for it.

I had to go to a different service – my local eating disorder service – for help. Although I felt anxious, I was also relieved that there was a name for my problem, and it wasn’t just me “being greedy”. The therapist was kind and helped me understand some of the reasons behind my eating habits. I can see now that I was eating to manage the way I felt, and that this was an entrenched pattern dating back to my childhood. As well as re-learning how to eat in a more normal way, it was the first time I had really thought about my feelings and how I could find other ways of dealing with them. I also recognised that I had some long-standing issues with low self-esteem and anxiety that I needed to work on, which I did by learning to be more kind to myself, and by connecting with other people.

I now feel so much better about my eating – I no longer binge or lose control – and I’m far less anxious about eating. I feel happier in myself and have made some changes to the way I live and relate to others. I’m still working on my weight but I’m learning to do this in a healthier way by being less critical of myself and with the support of the weight management service. I know from first-hand experience that it can be really difficult to admit to eating too much, but it is important to remember that it is an eating disorder and that you can get treatment for it - and get better!

Personal Story - Becky

I was diagnosed with Binge Eating Disorder (BED) late last year and have just finished the treatment programme, so I am still very early on in my recovery journey. Honestly, it was a relief to get the diagnosis as prior to that, my critical inner voice would tell me: "I'm just weak and greedy"; "I'm just a failure at dieting"; "binge eating disorder is not a real thing". Having the diagnosis was the start of me being able to tell that critical voice to just be quiet and enabled me to access treatment. I have also subsequently been diagnosed with Emotionally Unstable Personality Disorder. Suddenly, everything has started to make sense and I feel that my struggles have been heard and validated.

For me, the seeds of BED were sown in early childhood. I was a different size and shape from the rest of my family, and from early on, I felt that I literally didn't fit. This was then compounded when, aged around 7-8 years old, I was put on my first "diet" by the school nurse. There followed years of embarrassing and traumatic experiences at height and weight clinics where I felt belittled and like a failure. I just couldn't stop gaining weight. My self-esteem gradually eroded, and my body image was decimated by bullying from peers, strangers and even adults. I would have limited success with diets (each one would be THE answer) but would soon gain even more weight. I developed an unhealthy Love/Hate relationship with food. Childish rebellion led to me sneaking food at home to eat in secret or spending pocket money on the "bad foods" to scoff before I got home. I can vividly remember and still feel the intense shame of when these binges would be discovered by a parent. However, I didn't know what to do with those feelings and so the bingeing would re-emerge after a period of "being good".

In my early adolescence, I discovered self-harm and would punish myself for bingeing, for being weak and not good enough. I continued to use bingeing and self-harm, alternately and together, as coping strategies for stress; for regulating my unidentified difficult emotions; for quietening racing thoughts; and for dealing with, or escaping from, daily life throughout early adulthood. In my thirties, I managed to stop self-harming, or so I thought. Instead, my bingeing morphed into a form of self-harm; I would eat until I physically hurt and beyond.

Over the years, my weight has fluctuated (although I have been classed as extremely obese ever since I can remember). During the pandemic, my bingeing became even more uncontrolled and severe and my weight subsequently increased. I worried, not about actually dying from Covid-19, but about what people on social media would say afterwards. For example, "she deserved to die from Covid-19 because she's lazy and fat". In spring last year, I was diagnosed with fatty liver and pre-diabetes (both a result of being overweight through binge eating). My mental health spiralled downwards, and I realised my eating felt totally out of control. I had read about BED although I didn't feel I deserved help or treatment as there were so many others poorly with anorexia nervosa and bulimia. Late one night, utterly distressed after yet another binge-eating episode, I approached a local eating disorder charity via email. They replied and informed me that the frequency of my binges meant I needed to be referred to the local Adult Eating Disorder Service. I was surprised and convinced I would be rejected because I didn't have a "real eating disorder". However, my GP surgery referred me to the Community Mental Health Team (CMHT), who after their own assessment referred me to the local eating disorder service.

I then had a long wait for assessment – around 8 months. During this time, anxiety and depression led to a worsening of my BED. I was extremely nervous prior to my assessment (done virtually via Teams). However, I found the process to be validating and the person I spoke to was non-judgemental and very empathetic. Being diagnosed by a professional with BED in the severe range was a bit of a shock but it enabled me to start fighting back against the bullies inside my head.

After my assessment and diagnosis, I was told I could either opt for individual or group treatment of Cognitive Behaviour Therapy for Binge Eating Disorder - or CBT for short - which is a specialist therapy to treat eating disorders. My initial reaction was one of horror at Group CBT. I felt so ashamed and embarrassed about my eating that the thought of talking about it in front of strangers seemed impossible. I was put on both waiting lists. It so happened that the Group therapy treatment option became available first. Having had a month to digest the diagnosis (no pun intended), I seriously reconsidered my position. There were benefits, namely: that it was starting soon, and treatment duration was twice the length of individual therapy. Desperate to start treatment, I accepted a place on the Group programme. I am so glad I did, despite feeling super anxious about it.

The Group programme was delivered virtually by facilitators who provided information. There was also small group work (in breakout rooms) and individual "homework". There was never any pressure to share more than you were comfortable with. Each week would start with a "check in" which we, as a group, decided would be a good way to start sessions (to see how everyone was feeling). The people in the group became more and more familiar over the weeks, so that I gradually became increasingly comfortable to share my own experiences. It was a relief to find that other people shared similar experiences and I was not as alone and isolated as I felt. BED has so much shame and loneliness attached to it. It felt freeing to be able to be open about it and my feelings of shame reduced slightly every time someone said something that resonated with me and/ or vice versa.

Another benefit from Group therapy is that we have set up a WhatsApp chat to continue to support each other until our 3-month follow up (and beyond, hopefully). I feel really lucky to have found a group of people so supportive and understanding. This will definitely help me to keep focused on recovery.

So, where am I now? I have just finished the Group CBT programme and have a follow up session in 3 months. I am feeling hopeful and positive about recovery and am sure I will utilise the support of others from our Group to keep on track. I am learning self-compassion and working towards body neutrality as a first step to improving my body image and self-esteem. I am following the regular eating as recommended and feel more energised and less preoccupied with food and diet culture. And, for the first time since I was 7 years old, I can firmly say I am not on a diet and that feels fantastic. Ironically, I have also lost weight since not being on a diet and although that is not one of the main aims of the programme, it is a very happy coincidence. I feel healthier and will hopefully have reduced my level of pre-diabetes. Having struggled with disordered eating since early childhood, I know I cannot be fully recovered after just 3 months. However, I am definitely on my way and feeling motivated by the changes I have already made. If you are starting on this journey, well done! Be brave and it will make a difference for you, as it has for me.

STOP and Reflect . . .

Spend some time reflecting on the story or stories you have listened to, and where you are in terms of considering making change or your recovery. Below are some useful questions to help you. Make a note of your thoughts below or alternatively, access the link to the exercise here.

- What aspects of Sandra's / Becky's story most resonated with me?
- What feelings did it invoke for me?
- What does recovery mean to me?
- What do I most want to change?
- How much do I want to change (0-100%)?
- What do I imagine will be the most challenging aspect of making change(s)?
- What will help me make the changes I have identified?

Section 4

Keeping Safe

Improve your general wellbeing

There are lots of ways we can work on feeling better about ourselves, such as:

- Connecting with others
- Seeking support from others
- Getting enough rest and sleep
- Getting involved in meaningful activities
- Engaging in exercise and keeping active
- Allowing ourselves to have fun
- Developing interests and hobbies
- Seeking out information and knowledge (e.g., self-help reading)
- Seeking additional specialist support (e.g., your GP, Beat etc.)

Improving my wellbeing

In addition to ensuring that we are eating regularly, below are a number of areas that have been shown to impact on our general sense of wellbeing. Take some time to consider each before completing the exercise on the next page.

Connecting (with others)

Research has shown that connecting with others is good for our emotional and physical health. Connecting with others can provide many benefits including feeling valued, giving us a sense of belonging, reducing feelings of isolation and loneliness, providing a potential source of joy, happiness, and laughter, and creating opportunities for developing new interests, insights, and areas of personal growth. We can connect with others in small ways - such as sharing a smile or saying hello - and in more sustained ways including friendships and relationships. However, feelings of connection don't always have to be with a person or group of people, we can achieve a close sense of connection through our relationship(s) with nature, religion, or a pet or animal for example.

Seeking support

There is a wealth of information highlighting the positive effects of seeking support. Seeking support may be informal – though friends and family, or formally via your GP, local services, or national charity. In order to be able to receive support, we need to be able to express how we feel and / or be able to tell others what we think we need or might help us. Sometimes we may not know exactly how we are feeling or what might help - but remember, it can be helpful to reach out in a non-specific way (e.g., a friendly chat about nothing in particular, rather than telling people about your problem), as just connecting with others can be helpful.

Getting enough rest and sleep

We all need to get enough rest and sleep in order to function properly and cope with demands of everyday life. Lack of rest and sleep can have a wide range of negative consequences on our functioning including our mood, concentration, energy levels, appetite, and libido amongst others. Have a think about how much sleep and rest you get each day – is this something you could improve?

Meaningful activity

Meaningful activity refers to any physical, social and leisure activity that is in line with a person's needs and preferences. They can range from activities of daily living (e.g., dressing, cleaning), leisure activities (e.g., reading, going to the cinema) and social activities (seeing friends, volunteering). Activities can include planned commitments or spontaneous activity, with the potential for providing emotional, creative, intellectual, and spiritual stimulation. Being engaged in meaningful activity can help to improve physical fitness, improve mood, and help to combat feelings of depression and anxiety, reduce loneliness, and improve the quality of sleep. Have a think about the kinds of activities that you spend your time on - how many are meaningful and/or provide a sense of fulfilment? Is this an area of your life you could improve?

Exercise

There are many benefits to exercising, including proven improvements to our physical health, mood, and self-esteem. The Department of Health recommends the following as a minimum for the general population:

How much: 30 minutes a day.

How often: At least 5 days of the week.

How intense: Moderate - the person should be warm and slightly out of breath during activity and still be able to hold a conversation. This level will be different for everybody.

What counts: Activity can be regular, organised exercise (e.g., a tennis class, aerobics) but also includes activities of daily living (e.g., walking to the bus stop, housework).

The motivation: The healthiest reason people exercise is because they enjoy it. People may want to improve their physical health, including toning up, or perhaps even losing a little weight, but this is not the primary motivation to exercise.

For more information on the recommended levels of exercise for the general population (including guidelines for children and adolescents, adults, and older adults), please visit the NHS website which you can access here.

Having fun

It can be easy to overlook the importance of having fun and we often neglect to make time for it, but having fun gives us an opportunity to connect, be creative and reduce stress. It can also help us connect with others and improve our relationships. Challenges to having fun may include battling with low mood, poor health, dealing with adverse life events or simply just finding it hard to allow ourselves to enjoy ourselves. But we can try and work towards being more open and receptive to the experience of having fun in all sorts of small - and bigger - ways.

Hobbies and interests

We all benefit from doing things we enjoy, or that give us a sense of satisfaction, achievement, or enjoyment. Maybe you like animals (have a pet, dog walk); enjoy the challenge of testing yourself (e.g., crosswords, quizzes); are artistic (e.g., painting, needlework), musical (e.g., playing an instrument or listening), enjoy theatre & cinema (e.g., performing, watching); travel and culture (e.g., learning a language); sensory activities (e.g. yoga, tai-chi) or politics (debating, canvassing) etc? Alternatively, you may have been overly focussed on other areas of your life and given little thought and attention to this aspect of your life and have little experience of finding out what you enjoy or give you satisfaction. Is this an area of your life that you can develop further?

Seeking out information and knowledge (e.g., self-help reading)

We can all feel overwhelmed, confused, and fearful if faced with a new problem or area in our lives that we know little about. Finding out information gives us the knowledge which can be helpful in guiding us to know how to approach problems or dilemmas. Good sources of information about eating disorders are given at the end of this workbook. In addition, you may choose to undertake some self-help reading about any other issues or problems you feel are relevant to you. A list of evidence-based self-help reading guides has been included at the end of this workbook on a wide range of commonly occurring problems. You may find it helpful to order a copy from your local library or bookstore and do some additional reading about any other aspect of your problem whilst you are on the waiting list for treatment.

Improving my wellbeing

Review your engagement in the different areas below, and mark (x) your level of participation in the appropriate box – no activity, partial activity and full engagement – or access the link to the exercise here.

Area	No - not at all	Partially – could do more	Yes - as well as I can
Connecting with others			
Seeking support			
Getting enough rest and sleep			
Meaningful activity			
Exercise			
Having fun			
Hobbies and interests			
Seeking information			
Total			

Have a look at your answers. Is there any area you feel it could be beneficial to engage more fully with? If so, how would you achieve this?

Area(s) I would like to further develop:

How I could achieve this:

Getting help from those who care about me

Take some time to consider the following note your thoughts down below. Alternatively, you can access the link to the exercise here which you will find after the previous questionnaire under Section 2.

1. Think about the people who care about you - a partner, parent, family member, work colleague, flatmate. Choose the two that are the most important to you at the moment and write down their names.

2. Write down up to three things that each of these people could start doing to help you.

3. Write down up to three things that each of these people could stop doing to help you.

4. For each person, choose one from the 'start doing' list and one from the 'stop doing' list. Communicate this to them - could you talk to them about it, or if this is difficult text / email / write to them?

5. At the same time, signpost them to some carer support materials, e.g. BEAT's Friends & Families booklet which you can access here and/or Keep Your Head's 'FAQs for carers' which you can access here. This information will help them understand your eating disorder better, and help them to help you.

6. After a week, let them know if it is helping. If things are going OK, you could suggest something else from your list.

Further information to questions about symptoms

1. ***I am a vegetarian and am concerned about missing out on nutrients***

   For further information on vegetarian diets and eating disorders, follow the link to the CCI handout on "Vegetarian Diets and eating disorders" which can be accessed here.

2. ***I suffer from abdominal pain and bloating when I eat, which puts me off eating. Why do I suffer from this and what can I do to reduce it?***

   If you would like more information about eating disorders and gastrointestinal changes, please access the link to the CCI handout on "Gastrointestinal Changes" here.

3. ***Is it possible to fall pregnant even though I'm not having any periods? Should I be using contraception?***

   It is possible to conceive even if due to your eating disorder you are not menstruating, so please discuss contraception with your GP.

   Pregnancy

   - It is important that the people who will be delivering your antenatal care understand your difficulties and are aware of your eating disorder in order for them to support you, recognise potential problems early and give you appropriate advice. It is very important that you share this information with your GP, midwife, health visitor and obstetrician.
   - It may be appropriate for you to see a dietician for nutritional advice as your diet is very important in pregnancy.
   - You may be referred to specialist eating disorder services who would be able to offer specialist advice to other medical staff. If you are receiving treatment from specialist eating disorder services, it is important to inform them of your pregnancy.

   For more information on pregnancy and eating disorders, please follow the link here to access the CCI handout entitled "Eating Disorders and Pregnancy" and here for the handout on "Eating Disorders and Hormones".

4. ***I cannot stop eating at night. What can I do?***

   Regular eating will protect against the physical vulnerabilities of binge eating at night.

Keeping Safe Plan

On the next page you will find a sample Keeping Safe Plan. Please read through this and begin to think about how a Keeping Myself Safe Plan could be helpful to you.

You can find a blank plan following the example. Using the information and knowledge you have gained during podcasts 1-3 so far, can you begin to develop your own plan? You can also include any advice or information you received from your local eating disorder service.

As you will notice, this is **not** a plan about how to get better. Instead, it is a plan of how you **can look after yourself** whilst things remain as they are.

You are asked to:

- Identify things you can do to ensure you keep yourself safe
- Identify things you can do to reduce some of your anxieties about eating, your weight or body shape. If you wish, you can also use this section to consider actions you can take to reduce some of your symptoms
- Identify some of the early signs you might notice which suggest your symptoms are worsening
- Start to create a plan about what you will do in the event you need additional help

Please remember to download and save your Keeping Safe Plan, as we will be returning to this later in the programme.

SAMPLE - Keeping Safe Plan

Name: Jilly Bloggs **Address:** 13-15 Cathedral Street Norwich, Norfolk	**DoB:** 19/08/1991

The things that I will do in order to keep myself safe are:

- I will make a GP appointment if I begin to feel unwell.
- I will arrange to meet up with Sarah (my friend) when I feel low in mood because it is important for me to be around others even if I don't feel like it at the time.
- I will ask my partner not to discuss food with me during mealtimes as I do not find this helpful.

The things that I could try to reduce my anxiety or symptoms are:

- I will not weigh myself after every meal as this is not a true reflection of my weight and makes me feel more anxious
- I will try not to buy Heat magazine as looking at models to compare my shape is not helpful to me.
- I will try to reduce my caffeine intake as this makes me feel very anxious.
- I will re-read this plan and the psycho education resources when my eating disorder feels particularly strong.
- When I have the urge to binge, I will have a bath. If this does not reduce this urge, I will complete a Sudoku puzzle.

The things I could do or try and improve my general wellbeing are:

- I will arrange to see my friend Sarah more often.
- I will try to go to bed on time and not spend hours looking at social media sites late into the night
- I will re-join the cinema club, which meets weekly to see/discuss new films

Early Warning Signs:
What might I notice which means I need to seek medical attention?

- If my bingeing gets worse, I will tell my doctor
- If my mood deteriorates, I will see my GP

What might others notice which may mean I need to seek medical attention?

- If my work friends notice that I am having longer lunch breaks than usual, this could mean I am feeling more out of control around food.
- If my partner or friends notice that I am being more secretive about food / hiding wrappers / spending more time alone, particularly in the evenings.

If I feel unwell I will:

- Consult my local pharmacist or make an appointment with my GP
- In case of a medical emergency, I will dial 999 or attend my local A&E department
- In case of a mental health crisis, I will call 111, option 2

If I feel unwell:

I would contact: mum (Sheila Bloggs) **Tel Number:** 0300 300 3000

My GP's Details are:
Dr. Smith
The Surgery,
Norwich

My local A & E is:
Norfolk and Norwich University Hospital

My Care Coordinator is: **Tel Number:** 0300 300 0142

I do not have a Care Coordinator but the person who assessed me is Mary John and I will contact her if I need to get in touch with the service.

Other Relevant Details:
My next of kin are my parents: Sheila and Brian Bloggs

My Keeping Safe Plan

You can access a link to your Keeping Safe Plan here

Name:	**DoB:**
Address:	

The things that I will do in order to keep myself safe are:

The things that I could try to reduce my anxiety or symptoms are:

The things I could do or try and improve my general wellbeing are:

Early Warning Signs:

What might I notice which means I need to seek medical attention?

What might others notice which may mean I need to seek medical attention?

If I feel unwell I will:

I would contact:	**Tel Number:**

My GP's Details are:

My local A & E is:

My Care Coordinator is: **Tel Number:**

Other Relevant Details:

STOP and Reflect . . .

You and Your Eating Disorder:
After everything you have covered in section 4, do you have any concerns? Make a note of any concerns or queries below, or access the link to the exercise here.

Sometimes it can be useful to monitor your behaviour – keeping a diary can be the best way to do this.

Section 5

The Importance of Eating

In order to function and survive, our bodies need adequate, balanced nutrition. The acronym **BRAVE** can be useful when considering the important aspects or principles of eating which ensure we are receiving an adequate and balanced intake. BRAVE stands for:

B: Balance
R: Regular
A: Adequate
V: Variety
E: Environment

Throughout this section, we will use these headings to review what this might mean for how and what we eat.

How our bodies use food and energy

The average female needs 2000 kcals (energy) per day and the average male needs 2500 kcals (energy) per day. Transgender or non-binary individuals require the calorie quota guidelines for the biological sex they were initially assigned at birth unless they have undergone hormone therapy or surgery and / or have been advised differently. This is because our physical bodies have biological needs, regardless of gender.

How our bodies use this is governed by our metabolism and categorised as:

1. Maintenance of life – the functions of our body. (i.e., the brain alone requires 500 kcal per day. Failure to do so explains why our thinking changes the lower our weight / poorer our diet becomes)
2. Voluntary activities – day to day life, general activity. (i.e., voluntary physical activity requires approximately 300 – 600 kcals per day (dependent upon the intensity, duration, and our own body weight)
3. Special purposes – (i.e., growth, pregnancy/ breastfeeding etc.).
    - Pregnant normal weight women require an additional 200 kcals in the last trimester. If underweight, you will need to gain approximately 3 stone by the end of your pregnancy. If you are normal weight, you will need to gain approximately 2 stone during pregnancy and an additional 1 stone if overweight
    - If you intend to breastfeed, you will need to increase your calorie intake in order to produce enough milk. Breastfeeding can also increase your appetite – so it is important to listen to your body and increase your intake
    - Premenstrual syndrome: at this time, we need approximately 250 – 300 kcals increased energy requirement.

Eating in respect to our bodies needs

Our bodies are 24-hour machines; 12 hours awake, 12 hours asleep. Enough food should be consumed during the 12 waking hours in order to cater for the 12 hours we are resting / asleep. This is because our bodies need energy throughout the night to keep our hearts beating, ensure our lungs keep breathing etc. The average person uses 400 – 500 kcals whilst asleep.

B: Balance
The Eatwell Plate

Eating healthily means eating a balanced intake which includes every food group. The food groups are proteins, carbohydrates, fats, fruits, and vegetables. Contrary to what popular diets dictate or lead us to believe, everything is OK in moderation, and no foods or specific food groups should be excluded**.** The Eatwell plate shows how much of what we eat overall should come from each food group to achieve a healthy, balanced diet. The idea is not necessarily to achieve this balance with every meal, but to illustrate how we should all aim to get the balance right over a day or even a week.

You will notice that all foods – including fats and treats – are included. The Eatwell plate suggests that no foods are bad and that treat foods can be eaten occasionally.

There are variations of the Eatwell plate including:

- The Vegan Eatwell guide (which you can access here)
- The African and Caribbean Eatwell guide (which you can access here)
- The South Asian Eatwell guide (which you can access here)

What should I include in my diet?[5]
Basic nutritional facts and principles

We need to include: **Protein, Carbohydrate, Fat, Fruit** and **Vegetables**.

Proteins

Summary of functions of proteins in the body

These are some of the key things that protein does in the body:

- Serves as a building block for growth and repair of the body
- A major component of skin, tendons, membranes, muscles, organs, and bones
- A major part of enzymes, hormones, and antibodies
- Integral in the formation of blood clots (to stop bleeding)
- Maintains fluid and electrolyte (body salts) balance
- Maintains acid base balance (to keep body fluids at the right concentration)
- Provides energy
- Transports nutrients around the body

How much energy does protein provide?

- 1g of protein provides 4 kcal
- An average portion of protein food (e.g., meat, fish, eggs) contains around 15-20g of protein

How much protein do we need?

This tends to remain fairly stable, but there are some factors that increase how much protein we need:

- Pregnancy
- Breastfeeding
- Growth in children and adolescents
- Returning to a normal weight from being underweight
- Chronic infections
- When the body needs to repair itself after major physical trauma (e.g., a car accident). However, the level of protein in the average diet covers all these needs (unless someone is in hospital with a major health problem, e.g., pneumonia), so it is not necessary to add more if your diet already includes:
- Eating a normal sized portion of a protein food (for example, meat, fish, eggs, nuts and seeds, pulses such as lentil and kidney beans) at each main meal (lunch and dinner)
- Also, having enough dairy-based foods (most people need 3 portions a day - one portion = 1/3 pint/200ml milk, one carton yoghurt, 1 oz/25g hard cheese, average portion of milk sauce (e.g., custard, cheese sauce)

---

[5] Taken from pages 422-430 of Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V & Russell, K (2007). *Cognitive Behavioural Therapy for Eating Disorders. A Comprehensive Treatment Guide.* Cambridge: Cambridge University Press

Carbohydrates

Summary of functions of carbohydrates in the body

These are some of the key things that carbohydrate does in the body:

- Provides the body's preferred source of energy. It can use other energy sources (e.g., fat, protein, and alcohol, but does not work as well on them in either the short or the long term)
- Provides energy for the brain and central nervous system
- Regulates blood sugar levels
- Prevents the use of protein to meet energy needs
- Prevents the formation of dangerous by-products (ketones) when fat is burned for energy
- Provides dietary fibre to protect against heart disease and cancer
- Contributes to feelings of fullness
- Provides fibre to prevent constipation

How much energy does carbohydrate provide?

- 1g of carbohydrate provides 3.75 kcal.
- An average portion of carbohydrate food (e.g., 2 slices bread) contains around 30-35g of carbohydrate

How much carbohydrate do we need?

Carbohydrates should be around half of the total energy we eat each day. For the average female who needs around 2000 kcal a day, this works out to be around 250-300 g of carbohydrate. The majority of this should be from starchy carbohydrates, milk sugars and natural sugars (e.g., in fruit). This means that each main meal and many snacks should be based on starchy carbohydrates (e.g., rice, pasta, breakfast cereal).

Healthy eating guidelines also allow the consumption of small amounts of foods with added sugars (e.g., chocolate, cakes), and foods that are naturally high in sugar (e.g., fruit juice or honey). Generally, these kinds of foods (and other treat foods like crisps) can be eaten 1-3 times a day.

If you would like to find out more information on the role of carbohydrate in our diet, please follow the link to the CCI's handout on "Carbohydrates – Myths and Facts," which you can access here.

Fats

Summary of functions of fats in the body

These are some of the key things that fat does in the body:

- Body fat keeps us warm
- It protects internal organs (e.g., kidneys) from impact, like falls or knocks
- Dietary fat provides the essential fatty acids linoleic acid and linolenic acid (also known as omega 3 and omega 6 fatty acids). We need to eat these daily because:
  - They are very important in improving brain function when returning to a normal weight after being a low weight
  - They are essential for brain function, including the brain development of unborn babies
  - They also have a role in preventing heart disease
- Fats provide the fat-soluble vitamins A, D, E and K, all of which are essential
- Fats contribute to the structure of blood vessels and form a major component of the cell wall. A low-fat intake will therefore increase the risk of bruising very easily and affect skin health

- Fats transport cholesterol around the body. Many people who are a low weight can have a high cholesterol level, which reduces if fat is added to the diet and weight is gained
- Fat contributes to the structure of hormones, such as oestrogen. A lack of oestrogen will lead to a lack of periods, which increases the risk of osteoporosis. Therefore, a diet low in fat may delay the return of menstruation, or the body may need to be a higher weight before periods return if a low-fat diet is consumed
- Fats provide a concentrated form of energy, including as an emergency source of energy when food is not available
- Dietary fat helps increase feelings of fullness, therefore reducing the risk of bingeing
- Fat gives taste and aroma to food, as well as making it tender

How much energy does fat provide?

- 1g of fat provides 9 kcal.
- An average portion of fat food (e.g., the margarine on 2 slices bread) contains around 10g of fat

How much fat do we need?

Healthy women need to consume, on average, between 65 and 77g of fat per day, whereas men need to have an average between 83 and 97g of fat a day to meet basic requirements. Around half of dietary fat should come from foods naturally high in fat (e.g., cheese, oily fish, meat, nuts, seeds, etc.), and the rest should come from fats added to foods or used in cooking (e.g., oils, butter, margarine).

What are healthy levels of fat in the body and in the diet?

A healthy fat level is approximately 20-25% of body weight for females and 10-15% for males. Levels lower than this are likely to lead to reduced resistance to disease, weakness, irritability, increased risk of bingeing and reduced fertility.

If you would like more information on the role of fats in our diet, please follow the link to the CCIs handout on "The Facts on Fat," which you can access here.

Fruit and Vegetables

Why do we need fruit and vegetables?

Fruit and vegetables provide the following nutrients:

- Vitamin C is important for protecting against infection
- Carotenes (plant source of vitamin A) important for cell development and healthy vision
- Folates - a B vitamin, important for healthy skin and muscle
- Dietary fibre - important for normal bowel function
- Some carbohydrate, a very healthy form of energy

How much do we need per day?

Generally, we need to aim for five portions of fruit and vegetables per day. As fruit and vegetables can be very filling, but are relatively low in energy, very low-weight people may suffer from bloating and feeling full very quickly if they eat excessive amounts of fruit and vegetables. This also means that it can be difficult to eat other nutritious foods (like starchy carbohydrates and protein foods). Eating too much fruit and vegetables may also lead to diarrhoea or constipation depending on your individual situation and other components of your diet. Eating too much fruit (and possibly vegetables) may increase the risk of dental problems, due to the acid and sugar content of fruit.

What counts as fruit and vegetables?
All the following choices count as fruit and vegetables:

- Fresh, frozen, and canned fruit and vegetables
- Dried fruit
- Fruit juice (counts as only one portion per day - see below - due to its high sugar and low fibre content)

What counts as a portion?
Based on NHS guides, these are examples of suggested portion sizes of servings of fruit / vegetables –

Fruit	Vegetables
One average piece of fruit (e.g., apple, orange, banana, pear) Two small pieces of fruit (e.g., clementines, kiwi fruit, plums) Half a large piece of fruit (e.g., grapefruit) Small handful of grapes (around 10) 3 large pieces of dried fruit (e.g., apricots, prunes, dates) 1 tablespoon small, dried fruit (e.g., raisins) One small glass (100-150 ml) fruit juice	2 - 4 heaped tablespoons cooked vegetables (e.g., peas, beans, carrots) Small bowl (cereal bowl) of salad ½ large courgette or pepper 1 medium tomato 2-inch piece of cucumber

Alcohol

Alcohol is not an energy source that the body has a specific need for (unlike carbohydrate, protein, or fat). Furthermore, it does not provide any essential nutrients that cannot be supplied by other foods or drinks. Therefore, it is an optional extra, to be taken on top of the basic diet rather than substituting for that diet.

Some people feel they need to avoid alcohol during their recovery. However, if you do not want to go down that route, then this sheet aims to help you drink appropriately and safely, and to provide information regarding its physical effects.

What is the recommended limit for alcohol consumption?

- New Government guidelines published in 2016 now state that men and women should have no more than 14 units a week. Please see the Government website for further details, which you can access here.
- Avoid binge drinking, have no more than 2-3 units a day
- If you do drink more than this in one evening, you are advised to avoid alcohol for a couple of days following this to give your liver time to recover

Managing alcohol during recovery from your eating disorder

- Alcohol is likely to make you feel hungrier (through lowering your blood sugar levels) and at the same time reduces your ability to be in control of your impulses (i.e., it is harder to say no to things). Therefore, it may increase your desire to overeat or binge
- When you start treatment, you may find it best to avoid alcohol until your eating pattern has become more regular and balanced, and you feel you can completely understand the effect this will have on your weight and appetite. This may take a few weeks or several months, so it is a good idea to talk to your clinician to decide if you are ready to reintroduce alcohol
- As alcohol is an optional extra, and because it is likely to increase your levels of hunger and inability to manage urges to binge, it is very important not to reduce food intake to compensate for the amount of alcohol drunk. This will be discussed further in treatment

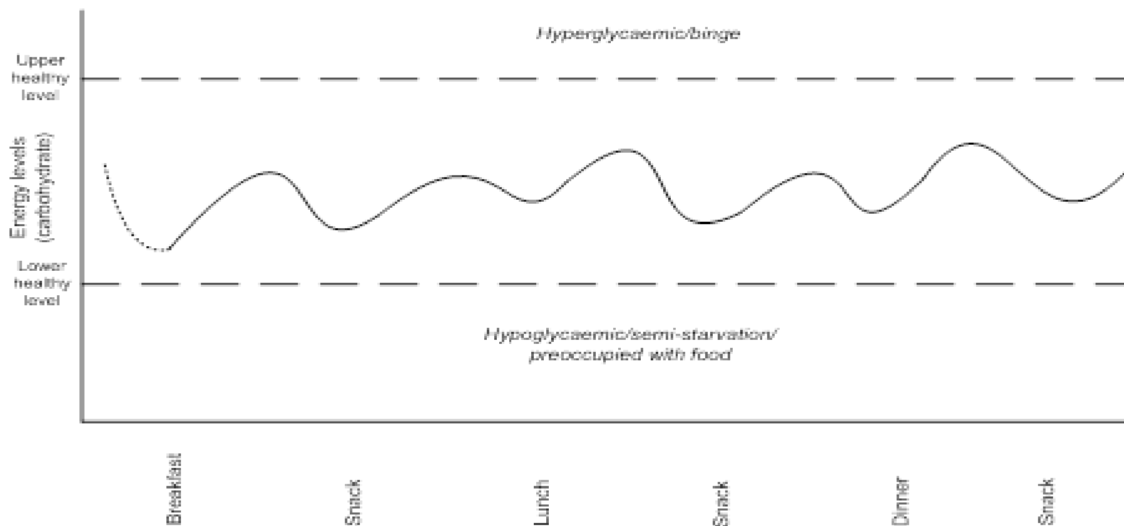
The effect of alcohol on weight

- Alcohol taken in moderation will not drastically affect weight, except if higher calorie drinks are usually chosen (e.g., liqueurs)
- If you drink more than the recommended levels (see above), then this is much more likely to lead to an increase in your weight, especially if you are also bingeing

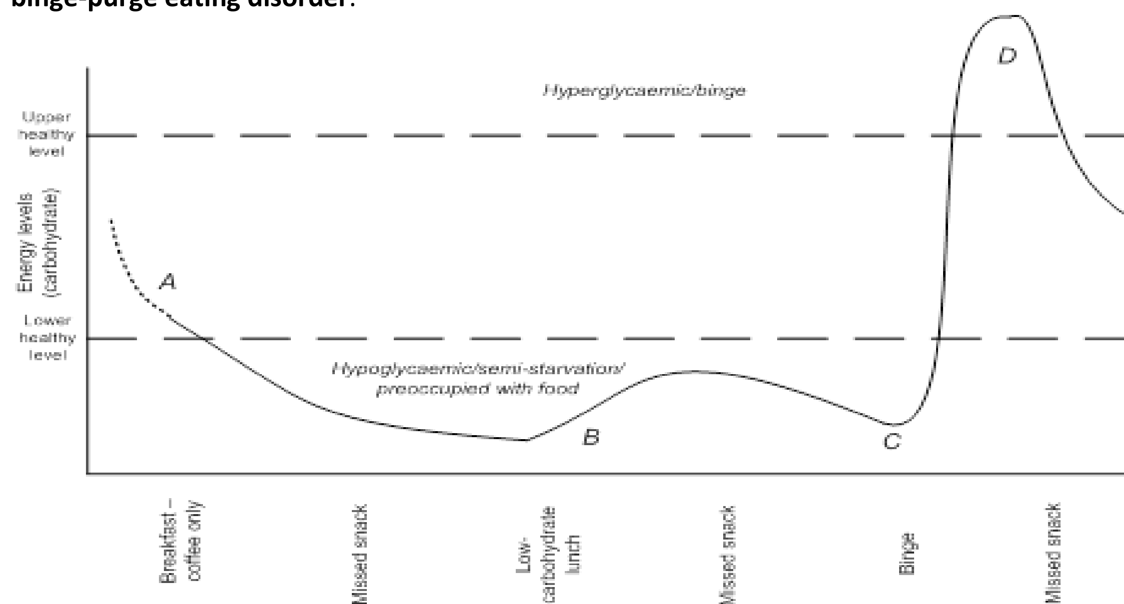
Energy Graphs[6]

Energy graphs relate to blood sugar levels, which is a key player in appetite control. After 3 to 4 hours since eating your last meal / snack, your blood sugar will start to drop as the energy our bodies take from this has been used up. This drop in blood sugar sends a strong signal to the brain that you need to eat something. If you leave it for longer than this, you may find yourself craving sugary and/or high fat foods, which increases the risk of overeating and / or binge eating.

Below is an example of someone's energy graph that is eating the **recommended** energy requirements (i.e., 3 meals, 1-3 planned snacks including a regular carbohydrate intake).



The following graph shows the energy levels that are **typically seen in someone with a binge or binge-purge eating disorder**.



[6] Taken from pages 147-149 of Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V & Russell, K (2007). *Cognitive Behavioural Therapy for Eating Disorders. A Comprehensive Treatment Guide.* Cambridge: Cambridge University Press.

Understanding my Food Diary

After monitoring your eating for a couple of days, have a look to see what you notice. Make a note of your observations below, or access the link to the exercise here.

1. Are you eating regularly?

2. Does every day look the same or is your eating pattern different every day?

3. Are you leaving long gaps between eating? If so, what do you hope to gain by doing so?

4. Do you lose control of your intake and binge eat?

5. If you lose control of your eating, does it happen when you are hungry or are there any other triggers?

6. Are you avoiding carbohydrates but then tend to binge on these when you lose control?

7. Are you avoiding any specific food groups?

8. Have you noticed whether your concentration, mood, hunger and / or preoccupation with food and eating is affected by how and when you eat?

9. Do you find it easier or more challenging to eat with others?

10. Are some foods easier to eat than others?

11. Do you have any specific rules about what you will eat and when?

Monitoring my Food Intake

Keep a food record of your eating for a day. Some people use a notebook or make a record of what they eat using their mobile phone to maintain privacy. Below you will find an example of a food diary. Overleaf, you will find a blank copy for you to copy and use for your own monitoring.

If you would like further information on how to monitor your eating, please follow the link to the CCI handout on A Guide to Self-Monitoring, which can be accessed here.

(NB: If you become distressed whilst completing your diary, please do not carry on with it at this time.)

Food and drink diary[7] (Record of everything that you eat and drink across 24hours)

Day: ____________________ Date: _____________

Time	Food and liquids consumed: Type and amount (Including alcohol)	Place	Binge	Context and triggers that influenced my eating: (THOUGHTS AND FEELINGS) What was going on at the time? What was I feeling? What was going through my mind (thoughts, images)?
9:45am	1 Banana and a black cup of coffee	My kitchen		Going to have a small breakfast today (because I lost control last night) and try to have a good day. Feeling bad about last night
10.50am	3 rich tea biscuits	Work		Feeling peckish - someone offered these around at tea break. Having a stressful day
12.45pm	2 rounds of sandwiches, pkt of crisps and a yoghurt	Work		Packed lunch that I'd taken in. Didn't have much time to eat it, had a bit of indigestion after. Feeling rushed and stressed about how much I have to do.
3.30pm	KitKat	Work		Needed a break - went to the shops to get a KitKat and some things for later….
5.30pm	3 family sized crisps, ½ loaf bread with p-nut butter, 1 pkt biscuits, 1 tub of ice-cream	Home	Yes	Felt stressed all day, bought things earlier to have when I got home to look forward to. Started eating but couldn't stop

[7] Taken from Centre for Research on Eating Disorders Website (http://credo-oxford.com/pdfs/F5.3_Blank_monitoring_record.pdf). Accessed 19.02.2016

Food and drink diary (Record of everything that you eat and drink across 24 hours)

Day: ___________________ Date: _____________

Time	Food and liquids consumed: Type and amount (including alcohol)	Place	Binge	Context and triggers that influenced my eating: (THOUGHTS AND FEELINGS) What was going on at the time? What was I feeling? What was going through my mind (thoughts, images)?

R: Regular
Regular Eating

What is regular eating?
Eating 6 times throughout the day (leaving no more than 2-3 hours between eating) including **3 meals** and **1-3 snacks**.

Some advantages of regular eating:
1. 'Solves' the primary triggers to binge eating (i.e., hunger)
2. Gaps between meals are more manageable – e.g., preoccupation with food and eating decreases as we do not allow ourselves to get too hungry
3. Helps regulate feelings of hunger and fullness – enables mechanisms to return to natural reflexes
4. Helps minimise short term weight fluctuations – usually associated with fluid retention
5. Helps normalise your metabolic rate – under-eating causes your metabolism to slow down
6. Helps with portion control and the psychological challenge of eating more - you don't have to contend with a large amount of food all in one go
7. Puts structure into your day / food intake – and takes away the feeling of loss of control. You are also less likely to overeat, or binge eat (see energy graphs)
8. Improves concentration and mood

Common problems with regular eating
- Often requires one to eat when not "hungry" and / or to tolerate feelings of being uncomfortable, full and "bloated" which many people find psychologically challenging
- People with eating problems often lose the ability to know when physically hungry &/or full, leading to increased anxiety or discomfort
- Our feelings can have a direct effect on hunger and fullness
- People usually feel fearful or anxious at the prospect of reintroducing foods they have avoided and / or cut out of their diet
- Some people struggle to stop eating between meals and snacks. If you do lose control of your eating between meals, it is important to get back on track with your eating plan as soon as possible. Do not miss your next meals/snacks to compensate - after all, the extra that you have eaten is unlikely to affect your weight dramatically, whereas missing meals/snacks is likely to lead to further uncontrolled eating, which is likely to affect your weight

Introduce changes gradually. Think about when you are least vulnerable, chaotic and / or you feel more secure about your eating and then start there.

How do I know if I'm hungry?
- Hollow tummy
- Feelings of edginess and irritability
- Thinking about food and / or eating
- Salivation
- Feeling light-headed
- Searching for food
- Unable to concentrate
- Feeling physically shaky
- Any, none, or all these things

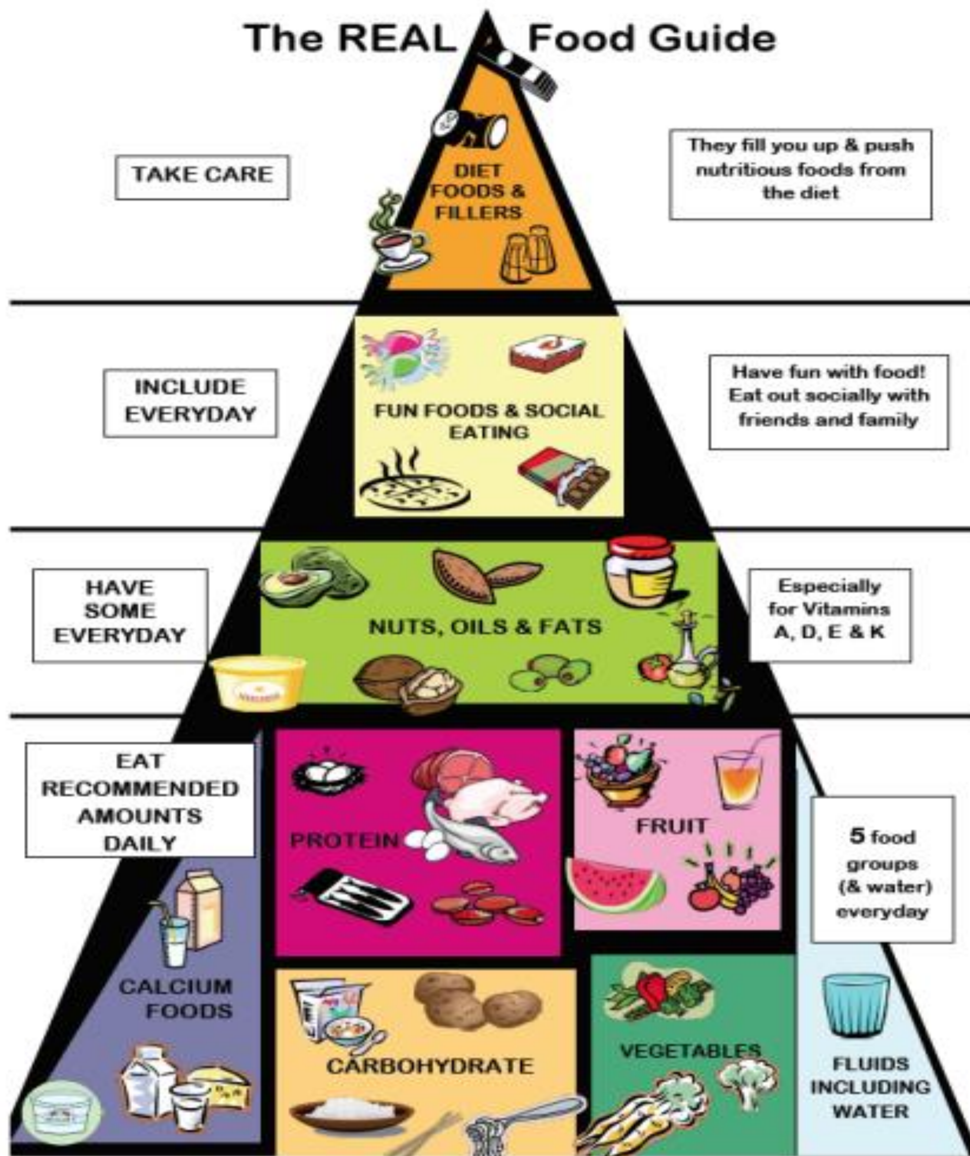
Do not rely on hunger to tell you when to eat. Eating disorders often cause hunger perceptions to become distorted and unreliable.

For more tips and information about regular eating, please follow the link to [the CCI handout on Regular Eating for Recovery which you can access here.]

A: Adequate

Thinking about starting to make changes to my eating

For people with eating disorders, it can often feel difficult to know where to start or how much to include of the different food groups. You may find it helpful to follow this link here to the CCI handouts on The Recovery from Eating Disorders for Life Food Pyramid (below), which has been created as a meal planning guide for individuals with eating disorders. Under the section "Information about Eating", which you can access here, you will also find helpful handouts on a range of issues including counting calories, portion sizes, clean eating and normal vs. disordered eating.



Taken from: THE REAL Food Guide for CBT-T Clinicians: Basic Food and Eating Training for Eating Disorders Susan Hart and Caitlin McMaster in Brief Cognitive Behavioural Therapy for Non-Underweight Patients. CBT-T for Eating Disorders. Waller, G., Turner, H., Tatham, M., Moutford, V and Wade, T. (2019)

V: Variety

Safe and Feared Foods

Use the table below to record the types of foods you currently include in your diet and the foods you tend to avoid eating, or access the link to the table here.

Foods I feel okay about eating	Foods that make me anxious or avoid eating

E: Environment

Making changes to my eating

Now that you have learnt more about your eating, use the table below (or access the link to the exercise here) to note any changes you would like to or feel able to make over the next few weeks. Once you have identified any changes you would like to make, spend some time thinking about how and when you will start to implement them. Once you've had a go at making the change, complete the final column which asks how it went.

Changes I would like to make to my eating *e.g., adding in a new food or meal? Eating out or in a different venue?*	**What do I need to do to make this change?** *e.g., Go shopping, arrange to eat with others?*	**When will I make the change?** *e.g., What time of day? What day of the week?*	**How did it go?** *e.g., What was tricky? What are the benefits?*

STOP and Reflect . . .

Given what has been covered in section 5, go back to your Keeping Self Safe plan, and consider whether there is anything else that you could add. For example, could you improve the structure / regularity of your eating? Make a note of your thoughts and observations below, or access the link to the exercise here.

Please remember to download and save your Keeping Safe Plan, as we will be returning to this later in the programme.

Section 6

Factors that Influence Weight and Shape

Many people with an eating disorder feel concerned and anxious with their weight and/or shape:

- Weight refers to how heavy a person's body is, which can be measured using a pair of weighing scales. When people feel anxious about their weight, they often find themselves drawn to weighing themselves frequently, which can be unhelpful. Alternatively, some people might avoid weighing themselves, for fear of finding out their weight and / or whether they have gained weight.

- Body shape refers to the size and shape of a e person's body, which is mostly determined by our genes and biological sex. As such, although there are certain characteristics associated with different groups of people, such as whether we are male, female or of European or Eastern origin, our body shape is unique to us. When people feel concerned or unhappy about their body shape, they may find themselves focusing on the body parts they don't like, or even trying to hide those parts of their body. They may also engage in a number of behaviours or activities to try and alter their shape.

There are numerous factors that can directly influence our weight and shape, some of which we can change, and others that we can't. In previous sections we have already considered:

- The mathematical equation – input/output.
- Our food intake and eating disorder symptoms.

What other factors may influence our weight or shape?

- Dieting / disordered eating
- Exercise
- Premenstrual syndrome
- Compensatory behaviours
- The Set Point Theory

Dieting vs Disordered Eating

Diets[8]:
A diet is often characterised by having strict rules about one (or more) of these three aspects:
- WHEN - Rules are about when we eat. For example, “I will not eat anything after 6pm”
- WHAT - Rules are about what food groups one is allowed to eat “I will not eat any fats or carbohydrates”
- HOW - Rules are about how one eats in order to try and reduce food intake “I will chew each bite 100 times before swallowing”

Disordered eating:
Disordered eating refers to when food rules are taken to an extreme and applied in a rigid, all or nothing way.

It is easy for someone with an eating disorder, especially if they happen to have a weight higher than the recommended level, to feel that dieting is the answer to their problems. However, there are many reasons why this may not be the case.

[8] Taken from pages 412-420 of Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V & Russell, K (2007). *Cognitive Behavioural Therapy for Eating Disorders. A Comprehensive Treatment Guide.* Cambridge: Cambridge University Press.

Why is dieting unhelpful?

- They do not work (less than 5% success)

- An overly restrictive diet can act as a trigger to binge eat because we are hungry. Anything less than 75% of the recommended calorie intake for males and females will tip the body into a starvation state, increasing the risk of binge eating/overeating later. Someone who is of a higher body weight will need more calories than this to prevent this from happening

- Foods that are "off limits" are more tempting, making bingeing/picking/overeating more likely

- Diets and food rules can take over our lives and make us preoccupied with food

- Following a diet can lower our metabolism

- Following a diet regime can disrupt normal hunger signals

- Any weight loss achieved during the dieting period is usually regained once the person resumes their previous eating habits and behaviours

- Because diets are almost impossible to succeed at in the long-term, it can make us feel worse about ourselves, leaving us with a sense of failure

- The language used by many dieting regimes (i.e., ''good,'' ''bad,'' ''cheat'' 'Syns'') reinforces this

- Diets can be an easy focus for feelings of guilt and shame that belong to other issues and emotions, thereby providing a means of avoiding the issues that underlie the eating problem

For further information on the role of dieting and eating disorders, you can follow the link to the CCI handout on "Why Diets do not work" here

Premenstrual Syndrome (PMS)

Premenstrual syndrome (PMS) affects about 40% of today's women, anywhere from ten to a few days before their period.

Common symptoms include:

- Feeling bloated and ''feeling fat'' often fluid retention can occur (leading to a sudden weight increase)
- Feeling more moody than normal, perhaps becoming more critical of oneself, or feeling hopeless about life. This is probably due to hormonal changes
- Feeling more tired than normal
- Getting more headaches than normal, which may be related to hormones, tiredness, hunger or all three of these factors

Increased energy needs and PMS

As discussed previously, in the time before a period is due there is an increased energy requirement of around 250-300 kcals a day (Wurtman, 1989[9]). This increased energy requirement leads to increased hunger, often manifesting as cravings for sugary foods (commonly, many women feel hungrier for chocolate just before a period).

In addition, women often misread the increased bloating as ''feeling fat,'' which leads to an urge to cut down on their food intake. So just at the time when they need more food, they are eating less than normal. The result is that there is an increased risk of bingeing/ overeating, especially because women may be feeling moody or irritable.

Weight changes in PMS

As stated above, weight may suddenly increase just before a period. Usually this is in the region of 1 1.5 kg (2-3lbs), but some women report larger weight increases than this. This is due to hormonal changes, which increase fluid retention. Many women also get more constipated just before a period, which will also potentially lead to an increase in weight.

Once the period starts, within a day or two the change in hormone levels leads to a normalisation of body fluid levels, and weight returns to its original level.

Coping with PMS

The first thing to do is to work out whether you are one of the 40% of women who suffer from PMS. For example, many women think they get the premenstrual weight gain, but on examining their weight changes around menstruation, they realise they were mistaken. To work this out, it is important to keep a diary of when you menstruate and compare it to your weight chart, as well as your food and mood diary.

Once you have worked out that you do experience PMT, the following may be of help:

- Be aware that it will happen and be prepared for it. Even if menstruation is irregular, remembering what symptoms you experience can help you keep one step ahead
- Be aware that your body's physical needs will be different just before a period
- Do not restrict food intake just before a period. In fact, allowing yourself slightly more substantial snacks/meals may help reduce the cravings (e.g., a Greek yoghurt instead of a low-fat one)

---

[9] Reference: Wurtman, J. (1989). Carbohydrate therapy for premenstrual syndrome. *American Journal of Obstetrics and Gynaecology*, 161, 1228.

- If you fancy chocolate, allow yourself to have one snack sized bar, as this will help you control the urge to overeat
- Avoid reading too much into your weight changes around the time your period is due
- Remember that PMS only lasts for a few days, after which things return to normal
- If you really feel you struggle with PMS, speak to your doctor to see if there is anything else that may help

Does dieting and exercise really impact on weight/shape in the long term?
The Role of Physiology - The Set Point Theory

Research suggests that our weight cannot be significantly altered over the long term. The Set Point Theory suggests that we all have a weight which is optimal for our body. When your weight is around this optimal level, your body is most healthy and most productive.

The 'set point' is genetically determined and is stable. If you diet and reach a body weight that is lower than your set point, your body will actively try and encourage you to regain weight so it can reach its optimal level again. It will do this by:

- increasing sensations of hunger, making one more likely to eat
- lowering its metabolic rate, so calories are burnt more slowly, and fat is retained

Why is this relevant to me?

The Set Point Theory encourages us to work towards accepting our body weight and shape, and to consider how dieting below our set point will inevitably result in a constant fight between mind and body. This "fight" might be experienced as persistent hunger, urges to eat, preoccupation with thoughts of wanting to eat, attempts to control or curb appetite, which can be challenging, uncomfortable and tiresome.

Our body often knows what is best for us. Accepting one's set point encourages us to begin to trust in our bodies again. If we eat a healthy regular diet and engage in a reasonable level of exercise, our bodies will gravitate towards our own particular set point weight and fluctuate around that.

Consider the following questions and make a note of your responses below. Alternatively, you can access the link to the exercise here.

- Do you find yourself batting against your body, in order to be slimmer?

- What signs or symptoms do you notice?

- Are there any consequences on your everyday functioning? (e.g., mood, energy)

- Would you be willing to tolerate or endure these symptoms in the long term in order to keep your weight below its natural set point?

- What are some of the personal costs of doing so?

For further information on the Set Point Theory, you can access the link to the CCI handout on "Set Point Theory" here.

What are your thoughts on the Set Point Theory?

Spend some time reflecting on this theory. You might find the questions below helpful in terms of applying what you have learned to your situation. Write down your thoughts below, or access the link to the exercise here which you will find after the previous questionnaire under section 2.

- How does the theory apply to me?

- What are the implications for my recovery?

- What challenges does this raise for me?

- Do I need any further information / discussion about this?

Section 7

Body Image

Body image refers to the way we perceive, think, and feel about our body / appearance. This can be influenced by many things, including:

Social media:
The types of images and messages we receive play a role in shaping the expectations and judgements we make about ourselves. These may be stereotypical messages about what men and women "should" aspire to look like and usually fail to represent the wide and varied range of different looks, body shapes and gender identities. Such images can leave us feeling alienated if we feel we do not fit – or choose to fit – into these stereotypical archetypes.

Many of the images we see are unrealistic and biased – in the media, it is not uncommon for photographs to have been altered in some way, such as airbrushing out perceived imperfections, or altering body size and shape. This promotes unrealistic aspirations, and it is no wonder that many people tend to feel dissatisfied with themselves and about the way they look. If we continue to try to aspire to these images, we may find ourselves on an impossible and self-defeating treadmill.

Past experiences:
Early negative experiences – such as having been teased or bullied about our weight or physical appearance – can affect the way we perceive and feel about ourselves, which can sometimes be resistant to change as we grow older.

Current experiences:
Certain occupations and professions may place high importance on body size and physical appearance, resulting in a heightened self-consciousness or pressure to look a certain way. Similarly, we may ourselves in relationships or friendships where weight, shape or general physical appearance and body size may be considered to be very important. This can also place pressure on us to be more concerned or careful about how we look, for fear of rejection.

Gender identity:
For some people, their sense of body dissatisfaction may be related to an incongruence between the gender they most strongly identify with, and the biological sex they were assigned to at birth. Transgender people may struggle with those aspects of their bodies and engage in eating disorder behaviours in an attempt to change or accentuate the characteristics of their physical identity, which may also include weight and shape concerns.

Body checking behaviours:
When people feel anxious about their weight or shape, they may engage in a range of behaviours designed to keep a check on their weight and shape, such as frequent weighing, mirror checking or comparing themselves (unfavourably) with others. Although people find that these activities may help reduce their anxiety in the short-term, they paradoxically serve to maintain – or even increase – anxiety and preoccupation.

Body image work is a critical component in the treatment for eating disorders. You may find it helpful to explore and address the factors that affect how you feel about your body, size, and appearance with your therapist.

Use of social media

Do you seek out images that you aspire to? How often do you look at these during the day? How does it make you feel? Does it make you feel better about yourself – or less satisfied with yourself? You might find it helpful to learn more about your use of social media and the impact it has on you.

Because social media has become an integral part of everyday life, we may not recognise how much or when we are even using it. Try to complete the monitoring form (overleaf) in real time for a day (e.g., as it happens throughout the day), to get an accurate picture as possible.

If you would like to read more about how to change your use of social media so that you can feel less anxious about food and eating, or your weight, shape and physical appearance, please follow the link to the South London and Maudsley NHS Foundation Trust's leaflet on Social Media and Apps - Friends or Foes, which you can access here.

Below is an example of how you could monitor your use of social media:

Time of day	Mood (0-10)	Social media platform	Duration of use	Images	Thoughts	Mood (0-10)
7.34am	7	Instagram	35mins	In bed - looking at Emma's, Susie's and Mandy's latest photos	They are all looking really great - I'm really worried about looking fat next to them when we go out tomorrow night. Emma's lost loads of weight	3
8.45am	6	Youtube / Instagram	25mins	On the bus to work - looking at diet recipes, checked Emma's latest photo of what she had for breakfast this morning	Really feeling fat this morning, especially after seeing what Emma eats for breakfast - hardly anything!	4
10.30am	8	Mail online	15mins	Looking at the daily newspapers online during my break - found "before and after" pictures of various celebs.	God, they look so much better for having lost weight. Feeling anxious and envious about how they did it. I also feel guilty about thinking they all look better after they've lost weight (except DM) and find it hard to believe they let themselves get into that state. But that's me now - I feel dreadful, I must look hideous	3

Use of social media monitoring form

Try to complete the monitoring form below in real time for a day (e.g., as it happens throughout the day), to get an accurate picture as possible.

Time of day	Mood (0-10)	Social media platform	Duration of use	Images	Thoughts	Mood (0-10)

STOP and reflect . . .

If you monitored your use of social media for a day or two, what did you notice? Take a few moments to make a note of your observations below, or access the link to the exercise here.

- What sort of images or messages do you seek out or get distracted by?
- Are they true or unrealistic images?
- How much time do you spend on social media?
- Is there a relationship between how and when you use it, and how you feel about yourself?
- Would it be helpful to consider reducing when and how you look at social media?
- Could you balance the sites you look at with more realistic sources of information? For example, the Health at Every Size website which you can access here, or the Dove Self Esteem project for young people, which you can access here.

Body Image Concerns and the use of Safety Behaviours

People with eating disorders often have concerns about their weight and shape, and it can become a major preoccupation and source of anxiety. They may use a range of behaviours to keep a check on their weight and shape. However, these can be unhelpful and are often inaccurate.

Unhelpful "Safety" Behaviours
"Unhelpful" behaviours are strategies people use to reduce their anxiety in the short-term, but actually increase anxiety in the long term. These include:

- **Frequent weight checking**

This encourages attention and concern about inconsequential and insignificant fluctuations in weight, thereby maintaining anxiety and efforts to diet.

Short term fluctuations in weight occur daily / weekly and can be due to a number of factors including hormonal changes, fluid balance, types of food eaten, menstrual cycle, and when you last went to the loo!

Frequent weight checking can lead to preoccupation with weight and the number on the scales.

If you would like advice about issues around weighing, you can access the CCI handout on "Weekly weighing" here.

- **Frequent body/shape checking**

Regularly or repeatedly checking our weight or shape increases preoccupation and anxiety.

The ways in which people measure their body is often subjective (i.e., using clothes, clothes size, pinching) and therefore not a reliable measurement.

- **Comparisons with others**

This involves comparing oneself to unrealistic others / ideals (i.e., celebrities, models, others suffering with an eating disorder). We tend to look for features in others that confirm our (negative) beliefs about ourselves.

People with eating disorders tend to compare themselves *negatively* to others (as opposed to positively). This encourages and maintains body dissatisfaction.

Safety behaviours - and how they maintain the problem
If you would like to learn more about how safety behaviours play a role in maintaining problems, you can read the CCI handout on "What are Safety Behaviours?" which can be accessed here.

For more information about the factors that affect body image, you can access the link to the CCI handouts under the section Body Image here.

Body Checking Behaviours

Do you check your weight and shape? Or do you avoid checking your body altogether? Complete the questionnaire below (or access the link to the exercise here) before considering whether these behaviours are helpful.

Body checking behaviour	**No, never**	**Yes, sometimes**	**Yes, a lot**
Weighing myself			
Checking my reflection in the mirror			
Measuring parts of my body			
Wearing baggy clothes			
Comparing myself with others			
Wearing certain clothes to test tightness			
Taking selfies			
Checking my reflection in windows / other surfaces			
Pinching parts of my body			
Other……..			
Other……			

- Is checking your body weight or shape helpful?

- Is avoiding looking at your body helpful?

Your Keeping Self Safe Plan

Based on what you have learned during the Keeping Self Safe Programme, please review your Keeping Myself Safe Plan and consider the following. Make a note of your thoughts below, or access the link to the exercise here which you will find after the previous questionnaire under Section 2.

- Is there anything you might have missed that may be helpful in keeping yourself safe whilst things remain as they are?
- How likely is it that you will follow your plan? If not, why not?
- Is your plan realistic? (i.e., is it achievable?). If not, what do you need to do to make it more realistic?
- Can you think of things/ways that might help you to use your plan effectively?

Please return to your plan to make any necessary changes. You may find it helpful to save / print a copy of your Keeping Safe plan. It can now be used to help you maintain any changes you may have made – or intend to make – and remind you of any helpful actions you can take whilst you wait for treatment.

You have now completed your Keeping Safe Workbook

You have created your own plan on how to keep yourself safe whilst things remain as they are. We recommend that you continue to follow your plan and any recommendations made by your local eating disorder service at your assessment. You may also find some of the additional self-help literature and recommended reading below helpful whilst you wait for the next step in your treatment.

Now that you have completed the programme

Please complete the following questionnaires which you can access by using the link below. Unless advised differently, your responses will be collated by Cambridgeshire and Peterborough NHS Foundation Trust NHS Trust who developed the Keeping Safe Programme. Please do not include any identifiable information. Responses will be anonymous and used to evaluate attitudes and behaviours towards engaging with harm minimisation recommendations whilst waiting for treatment.

- Knowledge Quiz
- Evaluation Questionnaire
- Feedback Questionnaire

Recommended Reading List

The following is a list of self-help books that you may find helpful. Most of them have been based on research and are frequently recommended by clinicians.

<u>Eating Disorders</u>

Beating your eating disorder: A Cognitive-Behavioural Self Help Guide for Adult Sufferers and their Carers
By Glenn Waller, Victoria Mountford, Rachel Lawson, Emma Gray, Helen Cordery & Hendrik Hinrichsen

Bulimia Nervosa and Binge Eating: **A Guide to Recovery**
By Peter Cooper

Getting better bit(e) by bit(e): Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders.
By Ulrike Schmidt and Janet Treasure

Overcoming Binge Eating
By Christopher G. Fairburn

The Compassionate Mind Approach to Beating Overeating
By Ken Goss

<u>Other disorders</u>

Mind over mood: Change the way you feel by Changing the Way You Think
By Christine Padesky and Dennis Greenberger

Overcoming Anxiety
By Helen Kennerley

Overcoming Depression: A Guide to Recovery with a Complete Self-Help Programme
By Professor Paul Gilbert

Overcoming Low Self-Esteem
By Dr Melanie Fennell

Overcoming Perfectionism
By Roz Shafran, Sarah Egan, and Tracey Wade

Resource List

The following is a list of organisations and information that you may find helpful:

BEAT: the leading national eating disorder charity in the UK. They offer various support services and a wider range of information for children, adolescents and adults with all types of eating disorders, as well as advice, support and training for carers. You can find their website here.

CENTRE FOR CLINICAL INTERVENTIONS (CCI): a specialist clinical psychology service in Perth, Western Australia. Their 'Overcoming Disordered Eating' series includes 18 downloadable workbooks based on cognitive behavioural therapy for eating disorders. The Centre has also developed a range of other evidence-based online self-help materials and resources for individuals with a wide range of problems. You can find the link to their website listing a number of self-help resources here.

FEAST: an organisation that focuses on supporting families and carers of loved ones with eating disorders- predominantly children and young people, but also adults. You can find their website here.

FIXERS: a charity for young people using their past to fix the future. On their site "Fixing Eating Disorders," they talk to Sam Thomas (founder of Men Get Eating Disorders Too) and several top international experts about eating disorders. You can access their webpage here.

FREED FOR ALL: a website for FREED, First Episode Rapid Early Intervention for Eating Disorders developed by South London and Maudsley NHS Foundation Trust. The website contains information on eating disorders, the importance of early intervention, how to seek help and stories from young people who have recovered from an eating disorder. You can also access a number of helpful guides, apps and resources, as well as a self-assessment quiz. You can access the webpage here.

HUB OF HOPE: The Hub of Hope is a UK-wide mental health support database, provided by the national mental health charity Chasing the Stigma. It collates a list of local, national, peer, community, charity, private and NHS mental health support and services for a range of problems and issues in your geographical area. You can access the website here.

JOURNAL OF EATING DISORDERS: free, open access for those interested in reviewing the current research and academic literature. You can access the website here.

KEEP YOUR HEAD: a website hosted by Cambridgeshire and Peterborough Adult Mental Health and maintained by The Sun Network. This webpage contains information and advice about eating disorders as well as a list of local resources and organisations available to those living in the area. You can find the webpage here.

MaleVoiceED: is a charity for men with eating and exercise-related difficulties. On their website, you can find resources and information ranging from self-help, accounts from men with lived experience, peer support groups and documentaries. Access their webpage here.

WARM WORDS AND SUPPORT FOR THOSE WITH EATING CHALLENGES: an information leaflet produced by The Sun Network and written by those who have lived experience of eating challenges and recovered, including myths and truths about eating disorders, as well as messages of support and encouragement. You can find the link to their leaflet here.

Acknowledgements

The Keeping Safe programme was written and developed by Dr Madeleine Tatham and colleagues at Cambridgeshire and Peterborough NHS Foundation Trust, in collaboration with clinicians, carers and service users within the East of England Adult Eating Disorders Provider Collaborative.

We would like to thank all those who gave permission to cite or refer to the materials contained in the Keeping Safe programme including the Centre for Clinical Interventions, the Sussex Eating Disorders Service (Sussex Partnership NHS Foundation Trust), South London and Maudsley NHS Foundation Trust, the All-Age Eating Disorder Service (Black Country Healthcare NHS Foundation) and Glenn Waller and co-authors, Helen Cordery, Emma Corstorphine, Hendrik Hinrichsen, Rachel Lawson, Victoria Mountford and Katie Russell.

We would also like to extend our thanks and huge gratitude to Alice, Antonia, Hope, Simon, Mary, Kelly, Sandra and Becky for agreeing to share their stories for the benefit of everyone listening to the Keeping Safe programme.

The narrators were Rebecca Bell, Anna-Lize Botha, Kira Brown, Ben Havercroft, Rodney Kelly, Anne Roux, Dr Jaco Serfontein, Rhianon Timmins, Erin Puttock, Naomi Wilcox and Sharon White, and recorded and edited by Terry Whyman. The illustration used in the Keeping Safe podcast and workbook was designed by Yulia Saraswati.

This workbook is protected by copyright: Cambridgeshire & Peterborough NHS Foundation Trust © 2022. All rights reserved.

Any redistribution or reproduction of part or all the contents and copyright in any form is prohibited other than printing or downloading for your personal and non-commercial use only.
You shall not, except with our express written permission, distribute, modify, or commercially exploit the content and its copyright.

For any query, please contact M.J.Tatham@sheffield.ac.uk