



Cambridgeshire and Peterborough NHS Foundation Trust

How to Keep Safe

Guided self-help workbook to be completed
prior to treatment



How to Keep Safe Programme

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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 help you begin to make sense of your difficulties and to encourage you to take steps to minimise any potentially harmful 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 and harm minimisation tips to help you keep yourself 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 programme so that you can select to listen to the information and exercises that are most relevant to you. If you are interested in learning more about your specific symptoms, please follow the prompts and links throughout the workbook which signpost you to additional information. Alternatively, you might find it helpful to listen to all the podcasts and learn about other eating disorder behaviours or issues that may also resonate with you.

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 this 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 that 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." Your responses 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 then 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 the workbook one podcast at a time, giving yourself time between each
- Complete each task in each section 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 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?

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.

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

Following your assessment, you have probably been told that your current symptoms meet the diagnostic criteria for an eating disorder.¹ 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 such as Anorexia Nervosa and Atypical Anorexia Nervosa, or the binge/purge disorder group such as Bulimia Nervosa or 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

¹Diagnostic 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.

- 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
- 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 attending 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.](#)

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

Historically, the BMI measurement was used as a key diagnostic criterion for eating disorders, particularly for Anorexia Nervosa. However, although still widely used, there is now less emphasis on using the BMI to make a diagnosis. In fact, some services – such as the South London and Maudsley NHS Foundation Trust - provide cautionary advice to health care professionals about its limitations as a risk marker for people presenting with Anorexia Nervosa.

The BMI calculation can be misleading for certain groups - including males, trans women, body builders, pregnant women - and does not take into account 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 to assess risk and should never be used solely to determine an individual's treatment and / or eligibility for services. There are many other factors that need to be considered when considering risk (e.g., rate of weight loss, medical stability, severity of other symptoms), which will be covered later in the workbook. 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). 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.

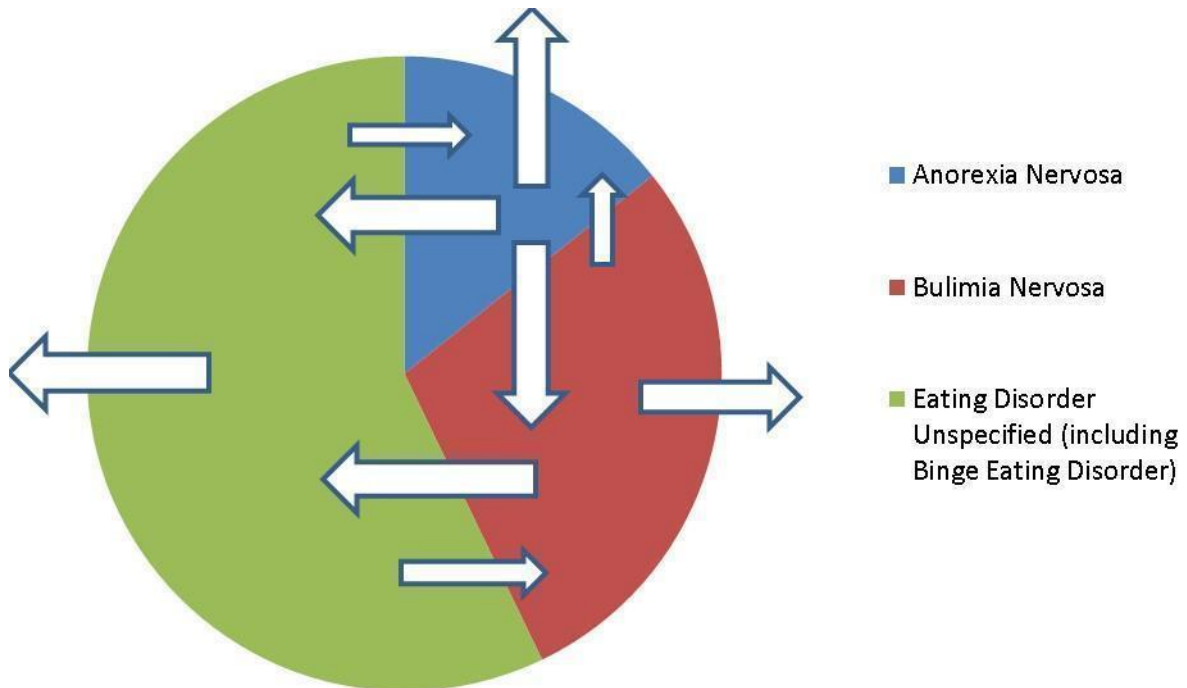
My eating disorder symptoms past and present

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.



Fairburn, C. & Harrison, P. (2003). *Eating Disorders*. The Lancet Vol 361, p. 407-416.

The graph above has been taken from literature published in the early 2000’s. 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(s), you have a choice. We have created 3 separate podcasts about the different sets of symptoms so that you can select those that are of most relevance or interest to you. They include a podcast on the effects of restricting your eating and/or having a low body weight, a podcast on the use of compensatory behaviours, such as inducing vomiting or excessively exercising, and a podcast on eating behaviours, including binge eating and chewing and spitting, and the factors that can trigger binge eating.

Based on the list of your symptoms that you noted down on page 10, please select the podcast(s) that are most relevant to you. Depending on your presentation, you may find it useful to listen to one, two or all three of the podcasts.

Podcast 2a – Section 2a, pages 1-11

This podcast is relevant to you if you limit or restrict your intake and / or have a 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 – Section 2b, pages 1-13

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 1-8

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

Please note: we recommend that everyone makes themselves familiar with the Minnesota study featured in Podcast 2a, regardless of eating disorder diagnosis.

Section 2a: The Effects of Underreating

The Minnesota Study

Read the following study: Effects of semi-starvation on behaviour and physical health: The Minnesota experiment².

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 of 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, hypersensitivity 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

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

If you are restricting your intake and / or have a low body weight and would like to know further about the symptoms associated with this, you might also find it useful to read [the CCI handout on “What is Starvation Syndrome” which you can find here.](#)

Short-term and long-term risks associated with having a low body weight

There are several short-term and long-term symptoms associated with restricting our food intake and maintaining a low body weight, which increase our risk of other problems.

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. **If you would like to learn more about the role of low blood sugar and an increased risk of binge eating, please listen to podcast 2c and turn to Section 2c in this workbook.**

A serious long-term risk of maintaining a low body weight is the effect on our hearts and cardiovascular functioning. As our bodies lose muscle and fat during weight loss, the size of our heart becomes smaller and weaker, and needs to work harder on less energy and nutrients. Heart problems may lead to feelings of tiredness and fatigue, light-headedness, feeling faint and increased sensitivity to the cold. It may also lead to an irregular heartbeat, chest pains or in very serious and extreme cases, may lead to sudden death.

Another long-term symptom of a restricted intake or low body weight is the risk of osteopenia or osteoporosis. Osteoporosis occurs when oestrogen levels are reduced due to low weight, and our bones become weak and brittle. Osteopenia is the stage before osteoporosis and can be reversed by eating regularly and regaining weight to a normal healthy weight range. However, there is no reversal or no cure for osteoporosis. Please turn to the next page to learn more about the causes and consequences of osteoporosis.

Losing weight and maintaining a low body weight has consequences for other areas of functioning such as our digestion and hormonal health. Please turn to page 7 in this section for a full summary of the health consequences associated with low weight and food restriction. If you would like to know more, you may also find [the CCI handout on “Eating Disorders: What are the risks?” helpful, which you can find here.](#)

Bone health and Osteoporosis

Osteoporosis is a condition where bones become very fragile and break easily. Since it is impossible to observe bones without a bone scan, many people are unaware that their bones are weak until it is too late. So, it is important to know that anorexia nervosa will strongly increase your long-term risk of osteoporosis. Bulimia nervosa also carries some risk, especially if weight is low.

Normal bone

Bone has a structure a bit like a honeycomb. Healthy bone is constantly being broken down and then reformed, so that the honeycomb structure stays stable. In eating disorders, the breakdown of bone occurs at a faster rate than the rebuilding occurs, leading to the structure becoming a lot weaker. The spine and hip bones are often the bones most affected by osteoporosis, leading to chronic pain, loss of height and curvature of the spine. Minor falls, knocks or just ordinary daily activities can result in fractures of the affected bone.

Whilst we know that bone health improves with treatment, bone may not completely return to optimum health, especially if many of the risk factors (see below) have been present for some time. Achieving and maintaining a healthy weight, - and for a woman, where menstruation occurs naturally - is the best way to prevent permanent damage to bone or minimise current bone damage.

What causes osteoporosis in eating disorders?

The main risk factors are:

- A lack of menstrual periods, which leads to oestrogen deficiency (there is some evidence that the oral contraceptive pill may be protective, but the oestrogen the body naturally makes at a healthy weight is the most effective form of oestrogen)
- A low weight - males are at higher risk of developing osteoporosis (and at a higher weight) due to the natural difference in body fat composition compared to women. For females, even if menstruating naturally a BMI below 18.5 will not be enough for the body to benefit from weight-bearing activity
- A history of being at a low weight during teenage years and early adulthood (up to late twenties), even if weight is now within the healthy range. This is because bones become strongest (known as peak bone mass) during this time. If bones do not reach their optimum strength, fractures become a risk at an earlier stage than normal
- A very low or a very high level of activity, especially weight bearing (like walking)
- A low calcium intake (dairy foods are the best sources, including low-fat versions)
- Poor vitamin D status (Vitamin D is mainly obtained by 15-20 minutes in the sun each day, with face and lower arms exposed, during the summer months)
- An unbalanced diet - all nutrients from all food groups are needed for healthy bones.
- Smoking cigarettes
- A very high caffeine intake (say, more than 4 mugs of coffee, or 8 mugs of tea a day)
- A high alcohol intake (more than 14 units in women, 21 units in men)

Important note

Unfortunately, there is currently no treatment for osteoporosis secondary to eating disorders other than to achieve a normal weight and to menstruate naturally. Sometimes a doctor may want to use a treatment more commonly used for osteoporosis seen in postmenopausal women.

However, some of these are not licensed for use in women who have yet to reach the menopause. One such treatment is a medication known as bisphosphonate (Fosamax, Fosamax once weekly, and Didronel PMO). It is important to be aware that these drugs may cause harm to unborn babies or increase the risk of cancer, even if they were taken some time ago. Therefore, the decision to prescribe these drugs should be taken on a case-by-case basis by a rheumatologist after careful discussion of the relative risks and benefits with you, the patient.

Complications and health consequences of food restriction and low weight

Anorexia Nervosa is a potentially life-threatening condition. As well as the relatively high risk of death, it is also associated with many other serious complications. These are basically all associated with the body's attempt to conserve energy, keep warm and find the food it needs.

Most of the effects are not permanent and are reversed once food intake and weight are normalised.

Area of the body/system affected	Common Symptoms	Why do they occur
Gastrointestinal (gut)	<ul style="list-style-type: none"> ● Reduced stomach size/ capacity, leading to feeling full on less food than normal ● Constipation ● Feeling bloated ● Abdominal pain 	<p>During periods of food restriction and weight loss the gut does not process food as quickly, meaning that food moves through it much more slowly. This may be because the gut muscle is too malnourished to work normally, also to ensure the body gets everything it can from the food.</p>
Fertility	<ul style="list-style-type: none"> ● Irregular/absent menstrual periods ● Reduced fertility or infertility ● If pregnancy does occur the foetus is also at risk in both the short and long term if the mother does not eat enough 	<p>When food is sparse, the body reduces all processes that need large amounts of energy, such as pregnancy. The body prevents this from happening by temporarily stopping menstruation. A lack of interest in sex is also common, also reducing the likelihood of pregnancy.</p>
Blood results	<ul style="list-style-type: none"> ● Low sugar levels, leading to increased risk of bingeing, and poor concentration ● Anaemia ● Increased risk of serious infections ● Cholesterol levels increase 	<ul style="list-style-type: none"> ● A low blood sugar caused by a lack of carbohydrate sends a powerful signal to the brain to encourage it to eat the food it needs ● Anaemia can be due to low iron intake ● White blood cell levels are the front line for protecting against infection. If food is sparse there is not enough energy or protein to make these cells ● The cause of high cholesterol is unclear, but it may be due to cholesterol excretion being affected.

Tolerance to cold	<ul style="list-style-type: none"> ● Reduced sensitivity to extremes of temperatures ● Numb/cold peripheries (toes, fingers, and nose) ● Hair growth on face and back (lanugo) 	<ul style="list-style-type: none"> • Low body fat levels reduce the ability to cope with extremes of temperature. • Blood flow to the organs (heart, kidneys, liver, etc.) is prioritised, causing low blood flow to peripheries. • Lanugo is one way the body has to keep warm.
Cardiovascular/ circulation	<ul style="list-style-type: none"> ● Low blood pressure leads to dizziness and feeling faint ● Slow pulse rate ● Irregular heartbeat (atrial fibrillation) ● Swollen feet and ankles (oedema) 	The slowing down of the heart is to conserve energy. Also, the heart is a muscle, so will be weakened in cases of extreme weight loss. Oedema is often an effect of suddenly stopping laxative abuse or vomiting, a sudden increase in food, or due to low body levels of protein in severe weight loss.
Bone health	<ul style="list-style-type: none"> ● Thin bones (osteoporosis) ● Not reaching optimum peak bone mass in adulthood (increasing the risk of osteoporosis in later life) 	The main cause is low levels of oestrogen in women (when menstrual periods stop) or testosterone in men. This causes bones to lose strength. Peak bone mass is reached as a young adult, exactly the time most people develop anorexia. Bone health is one area where effects of anorexia can be permanent, although it can always be improved.
Dental health	<ul style="list-style-type: none"> ● Gum problems - gum recession, bleeding, and weakness ● Permanent erosion of teeth 	<p>Weight loss and vitamin and mineral deficiency can cause gum disease.</p> <p>High intake of acidic foods (like fruit, fizzy drinks, condiments like vinegar) can cause dental problems.</p>
Emotional	<ul style="list-style-type: none"> ● Irritability ● Depression ● Poor concentration ● Feeling isolated ● Fatigue and exhaustion 	<p>These responses occur for two reasons:</p> <ol style="list-style-type: none"> 1. To conserve energy we tend to do less when depressed 2. Anxiety and thinking about food may increase the likelihood that we go out and find food to eat.

	<ul style="list-style-type: none"> ● Anxiety ● Thinking about food all the time 	
Bladder function	<ul style="list-style-type: none"> ● Kidney infections ● Poor bladder control 	The kidney can become less able to concentrate urine, leading to increased urine production. Problems with the nerve supply to the bladder, and muscle loss can lead to infections.
Muscle function	<ul style="list-style-type: none"> ● Muscle wasting and weakness 	If food is very sparse the body breaks down muscle to provide energy (especially carbohydrate).
Other	<ul style="list-style-type: none"> ● Poor sleep 	Light sleep patterns are a known effect of weight loss.

Additional complications occur if low weight is in combination with vomiting, laxative abuse, diuretic abuse and/or excessive exercise.

Monitoring my symptoms

In the box below, note down any symptoms you are experiencing and/or you are concerned about. Next, mark (with an x) when you notice them and / or they trouble you.

Symptoms of low weight and restricted eating	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total per week

Do you notice a pattern to the symptoms you experience (e.g., do they occur at the same time each day or day of the week?) What factors increase these symptoms? What factors reduce these symptoms?

Things that make my symptoms worse:

Things that make my symptoms better:

Please note: if you are concerned or notice a deterioration in your symptoms, please contact your local eating service or GP surgery.

STOP and Reflect...

What can we conclude?

- Low weight, restricted food intake and / or chaotic eating can significantly affect our thinking, behaviour, emotional functioning, and physical health
- Many of the changes that you and others have noticed are linked directly with weight loss / a low body weight and / or poor nutrition

Most of these are improved and can be reversed when weight is restored and/or we are better nourished. Take some time to note down your thoughts below, [or access the link to the exercise here.](#)

- Which of my symptoms would I most like to reverse?

Section 2b: Compensatory behaviours

Compensatory Behaviours

Compensatory behaviours are activities or behaviours people use in order to compensate for eating and are usually undertaken in the belief that they influence weight and shape. For example:

- Restricting food intake
- Self-induced vomiting (making yourself sick)
- Excessive laxative use
- Excessive diuretic use
- Excessive exercise
- Excessive fluid intake

The effect of self-induced vomiting on physical health³

You may make yourself sick after eating or bingeing in the hope that it will help you control your food intake and your weight. Whilst on the surface it seems a perfect way of eating freely without gaining weight (although it is important to be aware that this is far from true since around 1200 kcals are retained if vomiting occurs after a binge), there are many health risks involved with this behaviour.

Electrolyte (body salts) imbalance

When you vomit you will not only get rid of some of the food you have eaten, but also many essential salts (potassium, sodium, and chloride) that keep nerve and muscle function normal. This leads to:

- Irregular heartbeat/palpitations
- Fatigue
- Muscle weakness and spasms (made worse by over exercise)
- Irritability
- Convulsions
- Cardiac failure

Dehydration

Consistently making yourself sick will lead to dehydration. The effects of chronic dehydration are:

- Feeling thirsty all the time
- Light-headedness
- Feeling weak
- Fainting (especially on standing)
- Frequent urinary tract infections (e.g., cystitis)
- Kidney damage

Drinking excessive amounts of water will not reduce the dehydration and may make it worse. This is because the essential salts are needed to allow the body to absorb the fluid.

When you stop vomiting there will probably be a temporary weight gain due to rehydration. This can show itself as puffy fingers, but also slight swelling in the ankles and feet. This can cause much alarm, but in fact is only of medical concern if the swelling extends above the knee. At this point it is important to seek medical advice. Otherwise, rest and raise the feet whenever possible and it will resolve in a few days. Diuretics are not necessary, except in severe cases, when your doctor may prescribe them for a short time. Avoid self-medicating with diuretics.

(NB. Both dehydration and electrolyte imbalances are more likely and more dangerous in laxative and/or diuretic abuse.)

³Taken from pages 401-402 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.

Problems with teeth

Vomiting for more than a few months is likely to cause dental problems. The important thing to note is that, unlike ordinary dental decay, the damage is likely to affect all your teeth and can require very expensive dental treatment. In order to limit the problems, it is important to avoid brushing your teeth for at least an hour after vomiting. The main dental problems seen in chronic vomiting are:

- Erosion of tooth enamel
- Frequent cavities
- Sensitivity to hot and cold food and drinks
- An unsightly smile!

Stomach problems

Chronic vomiting can cause problems throughout the whole of your gut:

- Swollen salivary glands (leading to a swollen “chipmunk” face)
- Sore tongue, mouth, and throat, which can lead to a hoarse voice
- Inflamed / bleeding oesophagus (also known as the gullet)
- Distension of the stomach and oesophagus (ruptures can occur, which can be fatal)

Problems with eyes

Vomiting can cause eyes to become bloodshot, which, whilst harmless, is unsightly.

Other problems

It is possible for vomit to pass into the lungs, which may cause lung infections and pneumonia.

The effects of laxative abuse on physical health⁴

Laxatives are medications used on a short-term basis to relieve constipation. There are several different types, which have different roles depending on the cause of the constipation. Some are available over the counter from chemists, whilst others are only available on prescription. Many such laxatives are described as “natural” or “herbal,” which suggests they are safe, and carry no risk. However, this is not the case. The most common type of laxative abused in eating disorders is stimulant laxatives, such as Senokot or Dulcolax.

(NB. Laxatives prescribed under medical supervision are fine, especially since the doctor will usually prescribe a different type of laxative - usually one that is bulk-forming, such as Fybrogel or Lactulose.)

You may have started to take laxatives because of a belief that they will help you lose weight, or to compensate for eating more food than you feel comfortable with. Abuse of stimulant laxatives will leave you feeling empty, with a much-desired flat stomach, and convinced that you have not gained weight. However, any weight loss and change in body shape is the result of the dehydrating effect of watery diarrhoea and the complete emptying of the large bowel. It has nothing to do with changes in fat, muscle, or carbohydrate levels in the body. This is because laxatives work on the large intestine, whereas food is digested and absorbed in the small intestine.

Laxative abuse can have serious side effects on health, many related to low potassium levels (hypokalaemia) secondary to watery diarrhoea. This can be severe enough to trigger dangerous cardiac problems and other medical problems, whilst the long-term dehydration related to laxative abuse can lead to kidney failure or problems with kidney function. Other problems that can occur include rectal bleeding (probably related to chemical irritation from the laxatives), urinary tract infections, muscle weakness, confusion, or convulsions.

Laxative abuse may also cause you problems when you try to stop taking them. The large bowel gets tolerant to the levels of laxatives taken, so you may have found you needed to take more and more to get the same effect. Stopping them suddenly is then likely to cause water retention due to the fact the watery diarrhoea has a dehydrating effect. It is possible for weight to increase up to 5kg or more when laxatives are stopped abruptly, due to the fluid levels returning to normal. The rise in weight is detectable both from the weighing scales (which can reinforce the belief that laxatives lead to weight control) and from seeing differences in your body, such as feeling more bloated, plus possible temporary swelling of the feet and ankles. This swelling is called rebound oedema and usually lasts for 10-14 days after stopping laxative abuse, following which weight drops slightly due to normalisation of body water levels.

You may also experience constipation when you stop taking laxatives. However, there are healthy ways to help your body return to normal bowel function, such as making sure you eat a range of foods that contain dietary fibre (wholemeal or granary bread, high-fibre breakfast cereals, brown rice, lentils and beans (e.g. kidney beans), and fruit and vegetables), drinking enough fluids (around 2litres a day, or 6-8 glasses) and developing a routine for going to the toilet (even if you do not find it easy to pass a bowel motion to start with). Giving up laxatives can be really anxiety provoking so talk to your clinician/doctor/dietitian if you feel you need more support.

⁴ Taken from page 403 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.

The effect of diuretic abuse on physical health

People with eating disorders sometimes take diuretics (also known as water tablets) because they believe that the weight loss is due to loss of fat. In fact, diuretics have no effect whatsoever on calorie absorption, and the weight loss seen is due to water loss. As soon as the diuretics are stopped, rehydration occurs, and weight returns to normal.

Non-prescription (over the counter) diuretics

Whilst over the counter diuretics rarely cause medical problems, they can contain very high levels of caffeine. This can lead to headaches, trembling and a rapid heart rate. Caffeine can also greatly increase anxiety.

Prescription diuretics

Abuse of prescription diuretics tends to be more dangerous.

Dehydration

Consistent abuse of diuretics will lead to dehydration, the chronic effects of which are:

- Feeling thirsty all the time
- Light-headedness
- Feeling weak
- Fainting (especially on standing)
- Frequent urinary tract infections (e.g., cystitis)
- Kidney damage

Electrolyte (body salts) imbalance

When you abuse diuretics, you will get rid of many essential salts (potassium, sodium, and chloride) that keep nerve and muscle function normal. This leads to:

- Irregular heartbeat/palpitations
- Weakness
- Muscle weakness and spasms (made worse by over-exercise)
- Irritability
- Convulsions
- Cardiac failure

(NB. These effects are likely to be worse if you also abuse laxatives and/or regularly vomit.)

Low levels of magnesium in the blood

This is called hypomagnesaemia. It can make the symptoms of low potassium worse and can result in arrhythmias (abnormal heart rhythms) and even in sudden death.

Urine problems

Abuse of tablets that stimulate urine production will potentially cause problems with passing urine:

- Polyuria (producing large amounts of urine)
- Blood in urine (haematuria)
- Pyuria (pus in urine)

Kidney damage

Long-term abuse of diuretics can eventually lead to kidney problems due to the effects of chronic dehydration, and also due to the toxic effect of the diuretics on the kidneys.

Other problems

Diuretics can cause several other problems, such as:

- Nausea
- Abdominal pain
- Constipation

Exercise and Activity

We frequently hear about the need to be more active to improve our chances of remaining healthy. Most of the general population need to increase their activity in order to reduce their long-term health risks. However, many people with eating disorders go too far the other way and are too active, which can also have severe health consequences.

“Excessive” versus “compulsive” exercise

The diagnostic criteria for eating disorders often include the fact the person uses “excessive” levels of exercise for purposes of weight control. However, it is difficult to define this objectively, and it is now recognized that it is more relevant to consider whether the person feels a compulsion to exercise. Therefore, it is important to think both about how much activity you do, but also why you are active. Common difficulties with activity levels seen in people with an eating disorder include:

- Excessive activity. Although it is difficult to define this objectively, doing more than four hours of activity or exercise per week is probably an excessive level, unless you are a competitive athlete. Activity could be anything such as walking, running, exercise classes, extreme forms of yoga, very high levels of housework.
- Compulsive activity. The person has a belief that they must do an exact number of repetitions (e.g., exactly 300 sit-ups) of an exercise, or something bad will happen (e.g., uncontrollable weight gain).

Both excessive and compulsive levels of activity are unhealthy and possibly dangerous, so therefore need to be addressed in eating disorder treatment.

How much activity is healthy?

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, but 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. They 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](#). You might also find the following link to [the CCI handout on “Unhealthy Exercise”, helpful, which you can access here](#).

Risks of excessive exercise

Excessive exercise can:

- Increase the risk of injury and even permanent damage.
- Lead to dehydration / fluid balance fluctuations (especially if the person is also purging).
- Lead to exhaustion and impaired performance.
- Result in poor concentration.
- Lead to weight gain and a change in body shape, due to higher muscle levels.
- Lead to infrequent or absent menstrual periods, increasing the risk of osteoporosis.

Signs and symptoms that exercise may be excessive or compulsive⁵

Some people with an eating disorder find it difficult to accept that their activity level is a problem. If other people have expressed concern about how active you are but you do not share their concern, go through the list below and mark all those that apply to you. If you prefer, [you can access a link to the exercise here](#). Try to be as honest with yourself as possible. The more you recognise, the more likely it is that your exercise may be excessive or compulsive.

	Question	Mark X if applies to you
1.	I exercise more than once a day (unless a competitive athlete)	
2.	I have lost weight (when not following a weight reducing diet)	
3.	I feel distress if I am asked to take a day off	
4.	I am resistant to cutting back on exercise, even when medically advised that permanent damage could occur	
5.	I feel anxiety/irritable if I miss a session	
6.	I exercise even if I am ill/exhausted	
7.	I have an ongoing injury caused by overuse and there is no sign of improvement	
8.	There is little variation in my exercise programme	
9.	I refuse to change my activity when asked to do an alternative exercise	
10.	I neglect other aspects of my life (e.g., relationships, social and academic life) in favour of exercising	
11.	I have incurred debts from spending on exercise equipment, personal trainers, gym fees, etc.	
12.	I keep extensive records or logs of my workouts and activity	
13.	I hide my level of exercise and activity from others	
14.	I do not feel I have a problem with exercise despite physical injuries	

⁵ Reference: Exercise excess: treating patients addicted to fitness. *The Physician and SportsMedicine* (1992) 20, 193201.

Psychoeducational information taken from pages 405-408 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

Complications of excessive fluid intake

- Electrolyte imbalances
- Water intoxication
- Headaches / confused state
- Oedema
- Chemical irritation

How much fluid should I be drinking?

1.5 – 2 litres (around 3 – 4 pints) per day, spread throughout the day in order to be adequately hydrated. Remember to drink more if you are engaging in increased physical activity if it is a particularly hot day and / or have diarrhoea.

It's a good idea to try to vary your types of drinks. Caffeinated drinks do not have to be avoided but can exacerbate anxiety and there is some evidence that they damage bones. Carbonated drinks can lead to feelings of being bloated.

Do not wait until you are thirsty to drink this indicates that you are already dehydrated. Furthermore, your eating disorder may affect your ability to recognise thirst.

Complications and health consequences of compensatory behaviours

Bulimia Nervosa and purging disorders are potentially life-threatening conditions. As well as the relatively high risk of death, it is also associated with many other serious complications. These are mainly related to the effects of purging (e.g., inducing vomiting, excessive laxative use, or exercise).

Area of the body/system affected	Common Symptoms	Why do they occur
Imbalance of body salts (electrolytes - sodium, potassium, and chloride)	<ul style="list-style-type: none"> • Irregular heartbeat/palpitations • Irregular heartbeat (cardiac arrhythmia) or cardiac failure • Convulsions • Dehydration (leads to light-headedness and fainting) 	Both vomiting and laxative abuse lead to large losses of body salts and water. The salts are vital in maintaining normal electrical impulses in muscle, especially the heart.
Oedema (swelling) in ankles and legs	<ul style="list-style-type: none"> • Swollen ankles and legs 	<ul style="list-style-type: none"> • The sudden stopping of vomiting and/or laxatives causes the body to rehydrate (see above) • This usually resolves by day 10 • It is important to drink normally during this time.
Mouth/oral Problems	<ul style="list-style-type: none"> • Swollen salivary glands (making the face look "fat") • Erosion of tooth enamel and possible the tooth itself • Frequent and widespread dental decay • Increased sensitivity to hot and cold • Sore throat/difficulty Swallowing • Acid reflux • Chronic regurgitation 	<ul style="list-style-type: none"> • Stomach acid is vomited up into the mouth, inflaming sensitive tissues in the mouth, tongue and throat. • The acid also attacks all of the teeth, not just one or two that dental decay usually affects.
Gastrointestinal (gut) upper bowel (stomach and small intestine)	<ul style="list-style-type: none"> • Oesophagus and/or stomach rupture (which is usually fatal) • Bloating and abdominal pain • Distension • Bleeding in the oesophagus • Pancreatitis (inflammation of the pancreas) 	<ul style="list-style-type: none"> • Prolonged vomiting often leads to the flap of skin at the top of the stomach becoming weaker, meaning acid escapes very easily • Bleeding is caused by the physical trauma of vomiting and needs medical assessment.

Gastrointestinal (Gut - lower large intestine)	<ul style="list-style-type: none"> • Damaged large bowel • Chronic constipation/ impaction of faeces • Piles (including bleeding) • Bowel prolapse 	<ul style="list-style-type: none"> • Chronic use of stimulant laxatives may cause the loss of normal passage of material through the gut (peristalsis), leading to constipation, and possibly piles • Prolapse can occur due to weakness of the pelvic floor.
Eyes/face	<ul style="list-style-type: none"> • Eyes can be bloodshot • Small red spots can occur on the face 	The strain of vomiting causes bleeding in the eyes and facial skin, which resolves once vomiting stops.
Kidney and bladder infections	<ul style="list-style-type: none"> • Pain on passing urine • Pus/blood in urine 	<ul style="list-style-type: none"> • Dehydration increases the risk of infection • Faecal contamination of urinary tract (common with diarrhoea).
Lungs	<ul style="list-style-type: none"> • Lung infections/ pneumonia 	<ul style="list-style-type: none"> • Vomit can pass into the lungs • The acid will burn the lungs • Bacteria can cause an infection.⁶

NB. If you vomit, avoid brushing your teeth immediately after vomiting. This is because it brushes acid into the teeth throughout your mouth, increasing the risk of dental problems. Instead, rinse your mouth out (including under the tongue) with water or fluoridated mouthwash.

Additional complications commonly seen in anorexia nervosa can also be experienced, especially if the person is relatively low weight, has recently lost a lot of weight or is following a very restrictive diet.

You may also find [the CCI handout on “Eating Disorders: What are the risks?” helpful, which you can access here.](#)

⁶ Tables taken from pages 394-400 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.

My Compensatory Behaviours

In the box below, write down any compensatory behaviours you currently use and mark (x) how many times you used them each day.

- If you are inducing vomiting, count each episode as one incident
- If you are taking laxatives, note down how many (tablets or millimetres) you take each time
- If you are exercising, note down how long (minutes) each session lasts

Compensatory behaviour(s)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total per week

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

Factors that increase my use of (insert compensatory behaviour)

Factors that help me reduce my use of (insert compensatory behaviour)

Please note: if you are concerned or notice a deterioration in your symptoms, please contact your local eating service or GP surgery.

Section 2c: Binge eating

Types of Problematic Eating

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 overeat 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 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).

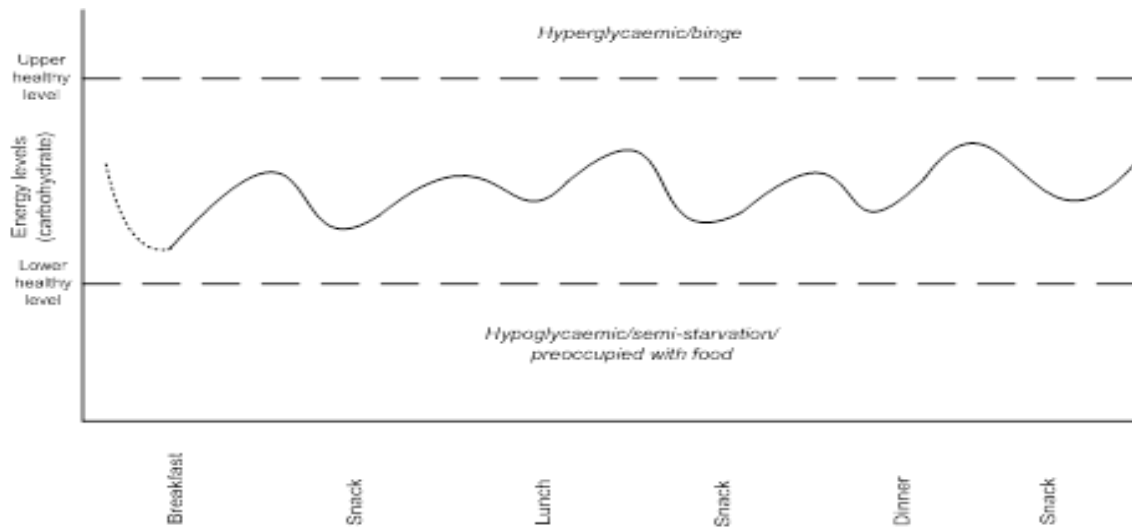
Thoughts and thinking style

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.

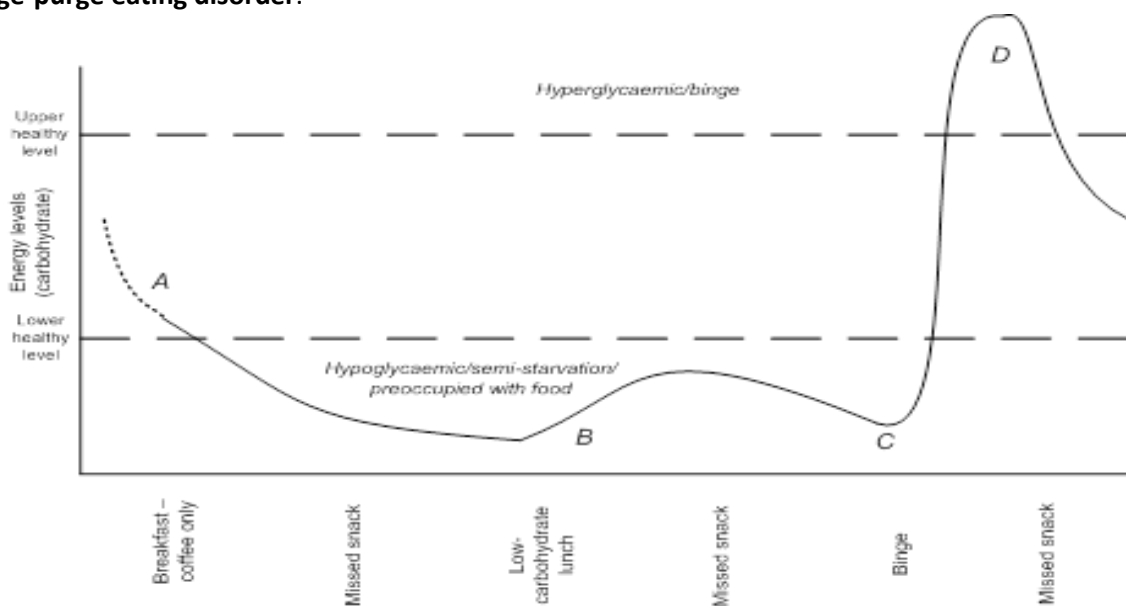
Energy Graphs⁷

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**.



⁷ 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.

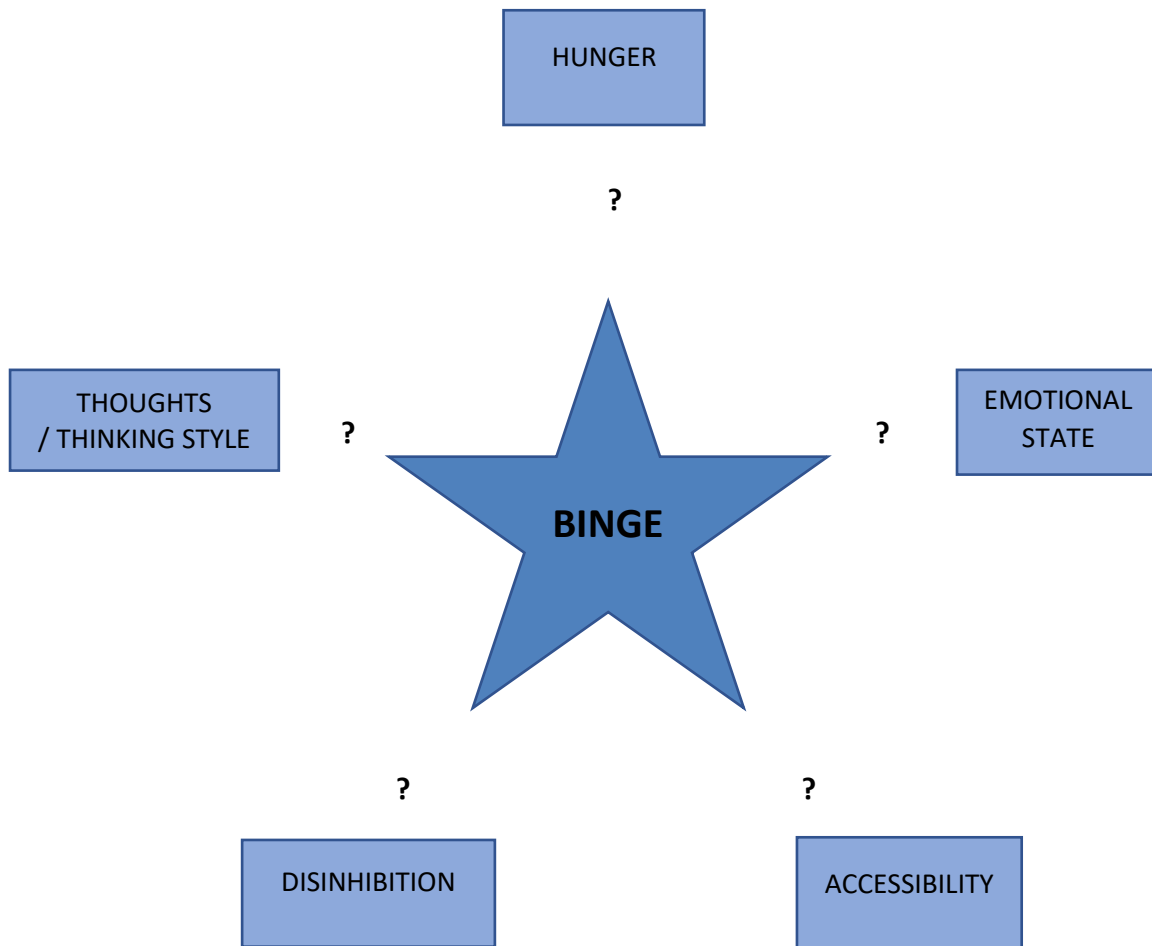
Safe and Feared Foods

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 the exercise 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?



(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 with 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.

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:

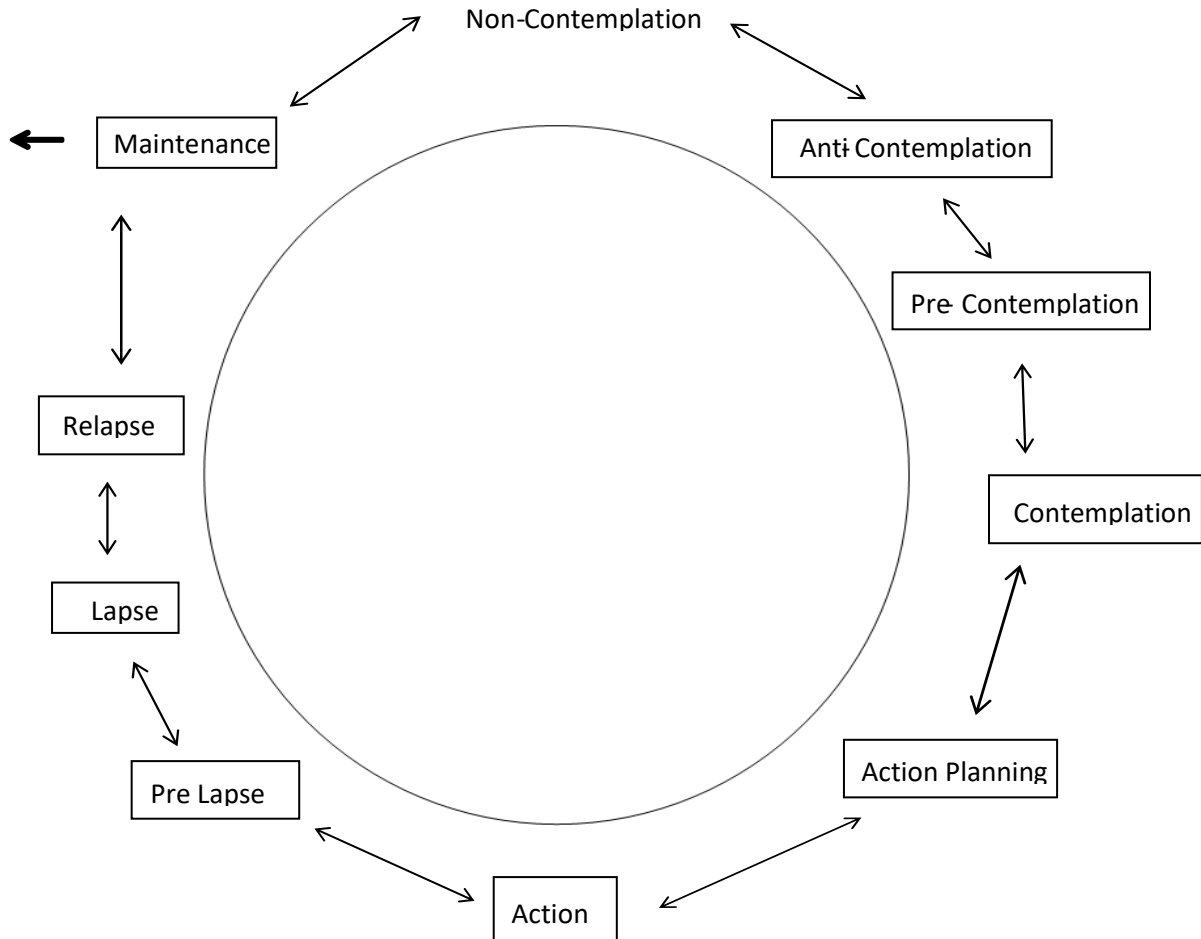
- Factors that help me reduce bingeing:

Section 3

Motivational States

The Stages of Change model was originally created by Prochaska and DiClemente⁸ in 1983 and later developed into the Motivational States model by Freeman and Dolan⁹ in 2001.

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



⁸ 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.

⁹ 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.

Weighing up the Pros and Cons of my Eating Disorder

Example

<p style="text-align: center;">Advantages</p> <p style="text-align: center;">List the positive aspects of your problem</p> <p style="text-align: center;"><i>What are the helpful aspects of your eating disorder? For example, does it help you manage painful feelings?</i></p>	<p style="text-align: center;">Disadvantages</p> <p style="text-align: center;">List the negative consequences of your problem</p> <p style="text-align: center;"><i>What difficulties do you currently experience because of your eating disorder</i></p>
<p>Now and near future</p> <ul style="list-style-type: none"> ● <i>I'm good at not giving into my appetite - it gives me a sense of achievement</i> ● <i>It helps me keep skinny</i> ● <i>It gives me a focus, so I don't have to think about what is upsetting me</i> ● <i>Because I'm not well, other people don't expect as much of me</i> ● <i>People are nice & care about me</i> ● <i>I don't have periods</i> <p>In the long-term</p> <ul style="list-style-type: none"> ● <i>I won't put on weight</i> 	<p>Now and near future</p> <ul style="list-style-type: none"> ● <i>I feel anxious about food & eating</i> ● <i>I have to spend lots of time thinking and planning what I will eat each day</i> ● <i>I can't eat out with my friends anymore</i> ● <i>I've lost interest in going out</i> ● <i>I feel cold / tired a lot of the time</i> ● <i>I'm developing osteopenia</i> ● <i>People are always on at me to eat, and I hate worrying my family</i> <p>In the long-term</p> <ul style="list-style-type: none"> ● <i>My friends might lose interest in me</i> ● <i>My health is going to deteriorate</i> ● <i>I may not be able to have kids</i>
<p style="text-align: center;">List the personal benefits you expect if you overcome your eating disorder</p> <p style="text-align: center;"><i>How would your life change in a positive way if you overcame your eating disorder? For example, perhaps you would feel less cold and tired, or be able to enjoy eating out with friends?</i></p>	<p style="text-align: center;">List the personal costs you expect if you change</p> <p style="text-align: center;"><i>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></p>
<ul style="list-style-type: none"> ● <i>I will feel much healthier (not cold, might be able to reverse the damage it has done to my bones)</i> ● <i>I will be able to socialise and enjoy my friends</i> ● <i>Other people won't always be on at me to eat / worry about me</i> ● <i>I may be more able to meet someone, move in with them and have a family myself</i> 	<ul style="list-style-type: none"> ● <i>I will have to eat more, and this really scares me</i> ● <i>I will have to gain weight, and this also really scares me</i> ● <i>I will need to face the things that upset me rather than avoid them - I will need to learn to recognise how I feel, and how to manage this differently</i> ● <i>If I am not ill, people will expect more of me - I will have to face my fear of disappointing them or not succeeding....</i>

Section 3a

Personal Recovery Stories

Please select to listen to the stories that seem most relevant to you. The details of personal stories 7 and 8 have been shaded out as they may not be as relevant to you (but you are welcome to listen to these if you wish).

Personal story 1 - page 1 (and on podcast at 1mins 7secs)

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

Personal story 2 - page 3 (and on podcast at 10mins 40secs)

Antonia is in her late 20's. Antonia describes how it took her time to recognise that she was suffering from Anorexia Nervosa, and the difficult process of considering whether to seek treatment. She writes about some of the things that helped her during treatment to recover.

Personal story 3 - page 5 (and on podcast at 17mins)

Hope is in her early 30's. 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. She talks about her admission to hospital for Anorexia Nervosa and the things that helped her on her journey to recovery.

Personal story 4 - page 7 (and on podcast at 23mins 33 secs)

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. He was also later diagnosed with Emotionally Unstable Personality Disorder. In his story, he talks about the things that have helped him on his journey to recovery, whilst also highlighting how events can re-trigger the eating disorder.

Personal story 5 – page 11 (and on podcast at 36mins21secs)

Mary is in her mid-20's. 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 – page 12 (and on podcast at 40mins 58secs)

Kelly is in her late 20's. 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. She also talks about some of the difficulties of engaging in treatment, as well as the process of recovery and what it has meant for her.

Recovery story 7 (on podcast at 49mins 23secs)

Sandra is in her mid-50's. Sandra talks about how she used to comfort eat from an early age and struggled with her weight. She highlights how long it took to seek help, and how she eventually accessed treatment for Binge Eating Disorder (BED) through a weight management service.

Recovery story 8 (on podcast at 59mins 25secs)

Becky is in her early 40's and recently completed treatment for BED. 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 - Alice

My name is Alice, and I'm 20 years old. I was diagnosed as anorexic at the age of 12, but in all honesty, I think I've always had a problem with food. I remember being in year 3 and my teacher asking who was hiding their chocolate spread rolls behind the toilet – it was me. Since my hospitalisation aged 12, I've had relapse after relapse, but most recently aged 19. This relapse, though, has been both the worst and the best.

I've always believed that everybody wanted me to be fat, and that I could only be happy when I was thin. I truly felt that people should leave me alone to be who I wanted to be, and I wanted to be thin because being thin was being Alice. I had an awful summer in 2014 after my first year at university had spiralled downhill. I didn't know how to look after myself and I hated being away from home, which was so unlike the confident, bubbly girl I used to be. The only way I could control this was through food, yet again. I didn't realise how much power it had over my life, and it isolated me from my friends, my family, from everyone I'd ever had a relationship with. I wouldn't leave the house, I'd cry hysterically on the floor, but still I refused to admit that I had a problem. I was so vile to my family, and I would scream and swear at them. Eventually, I was eating so little that I weighed as much as I did when I was 11 years old. I weighed 8 years younger than I should have weighed.

I started my second year of university worse than I had ever been. Within 2 weeks, I knew I couldn't do life anymore. I couldn't continue the way I was and not die. I went to my doctor who was very helpful, and she immediately referred me to the local eating disorder service. I remember when my psychiatric assessment date came through. These steps I'm discussing seem very logical and straightforward, but it took me months of sorting through the anorexic voice to find my own and to fight for myself. On the day of my assessment, the psychiatrist asked me what I was there for. I burst into tears and replied, "I'm here to get Alice back." I couldn't remember who I was anymore; all I was and would ever be anorexic. I didn't ever know if I could get better; I wanted people to do the work for me because I was so terrified of making the changes myself. I had to break my own self-imposed routine, but I just couldn't. I had the full support of my family, and they were with me every step of my journey through recovery, but I needed people who were distanced emotionally from me to help me.

I was told that there were group therapy sessions I could attend. I didn't want to go to them because what would any of the session leaders or other attendees know about me? Why would I talk about food with strangers? But I made myself because as my parents said, I should just try a session. This was honestly the first step of my recovery, and I cannot express enough importance in going to the sessions. Nothing was ever forced upon us, we could be as truthful and open as we wanted to be, and we were told that we would never be made to change. I knew that I had to be totally honest because I knew that this was a moment for me when I could begin to be totally transparent with myself and others. I felt so safe in that room speaking with other people and the session leaders who understood what I was going through. It was a real turning point because I knew that these session leaders wouldn't make me do anything I didn't want to do and were there to offer me the advice and support but that I wasn't forced to take it. It was enlightening and incredibly reassuring to be told that other people had sat where I had sat and were now fully recovered. It made me more determined than ever to be one of those survivors.

I was able to absorb all the information given to me and recognise that I was ready to begin making changes, I just didn't know how to. I still wasn't eating anything else other than my safe foods and I

was still losing weight. I mentioned earlier that this was my best relapse as well, and the reason I said that is because I know it's going to be my last relapse. For the first time ever, in these group therapy sessions, I was able to understand that my teenage years had been plagued by this illness which had destroyed not just me, but my family and their lives, too. I became more focussed on balancing getting better with getting my degree. I could feel within myself that the old Alice was fighting back.

After the group therapy sessions, I was allocated a personal counsellor who I would see weekly. The lady I saw, and still do see, has been the most supportive person. She's so kind, so gentle, and so understanding. Every week I could tell her if I'd had a great week or a bad week, and regardless of what I said, she would make me understand just how far I'd come. I was getting myself back, day by day. The more I cooperated with the service, the more they could give me. I am always kept up to date via letters, phone calls and am told I can ring the service at any time. One thing that will stay with me forever is a phrase my therapist is constantly reminding me of: I should strive for excellence and not perfection.

I could not have gotten better by myself, no way at all. I needed people to lay out the facts of my illness in front of me, so I could see that it was now or never. It's the hardest thing I've ever had to do, but I know that fighting this illness with the help of the service has been the most rewarding thing. I never imagined that I'd be where I am now, alive, and healthy and, most importantly, having a great relationship with food.

I look back at my life a year ago and don't remember much of it. My counsellor tells me that this is a mechanism to help me never ever go back to the way I was. I've just been discharged as a weekly patient and am now going to be a follow-up patient which means I'm seen less often because of how well I am doing. Every stage of the process through my recovery, I have been at the forefront of decisions: nothing is ever made without my cooperation and full understanding of why. I always imagined that other people would get better, but not me, because I was too far gone. The Eating Disorders Service made me realise that it's never too late to get help, and they have been truly invaluable in getting me where I am.

There are bad days and bad weeks, of course, but that's the process of recovery. There's no quick and easy fix to beating an eating disorder because there are so many variables which impact upon the disease and your recovery from it. The good times though definitely outweigh any bad times, and my therapist has taught me to see that any negative experiences are in fact good because they're learning curves to help prevent them from happening again. If anyone is reading this and thinking they don't deserve help, that they don't need help, I urge you to think again. I remember being you and it was the loneliest thing I've ever done. I remember taking my first step in eating something new, and having a toffee penny on Christmas Day, and it was the bravest and most delicious thing I've ever done.

You deserve to be happy, and to live your life to the fullest it can possibly be. I never thought I'd recover, and my own parents said they didn't know if I'd get better in the end because I was so poorly, but I did, and I did it with my local Eating Disorders Service. You can do it too, trust me. Last year at my 20th birthday I was unbelievably sad when I blew out the candles on my cake because I knew I couldn't have any. In just a few weeks I'll be turning 21, and I'm so excited to have a big old chunk of cake, and maybe I'll even have two slices to make up for last year. Please understand that my local Eating Disorders Service helped save my life and your local service will help you, too - you've just got to be brave and let them.

Personal story - Antonia

I was 22 years old and had just returned from living on my own in France when I was diagnosed with anorexia nervosa. The illness was manageable while I lived on my own; I thought I just had a different lifestyle, priorities, and future dreams to others of my age. On moving back in with my parents, I was scared by how abnormal my behaviour had become.

As the changes in my behaviour were gradual, I hadn't noticed them. Although I had consciously tried to slim down after gaining a bit of weight during my first term at university, this became less of a conscious decision over time. Initially, I rejected meals out with friends, or chose salad by default. I also started weighing what I ate, such as cereal, nuts, slices of bread.

On moving back in with my parents, the food I prepared was out of place (frozen peas at lunchtime) and I was obsessed with presentation, temperature, and routine. I hated feeling like I always had to be the last one to finish my meal, forever fiddling with food on my plate. I'd lost my independence and couldn't see a way forward. I was torn between wanting to obey my eating disorder's instructions and get my life back.

My eating disorder had started as a survival mechanism – blocking out emotions and preventing contact with people so that I felt in control. Slowly though, the eating disorder began to control me. On reflection, I can see that although my thinking processes appeared normal to me at that time, my thoughts were neurotic and exacerbated by a lack of energy and nutrients. My body was in starvation mode, and I wasn't making rational decisions.

You could think of an eating disorder as a third party – as a bully and a compulsive liar. For me, it pretended to be a loyal friend but was parasitic in its fascination with me and my life. It was competitive and spotted when other people missed meals or talked about losing weight. It was almost as if the eating disorder was trying to blind me and put me in denial. An eating disorder embeds your habits so that it can continue living at your expense. It ensures there is always a reason to reject food or treatment, but if you comply, it will only come up with another excuse.

The eating disorder got worse before it got better, and I felt conflicted. Initially it convinced me to keep it a secret. Once exposed, it tried to throw family and friends off the scent. When threatened, it kicked up a fuss and its voice became stronger, encouraging me to deny my shared secret. I felt angry, vulnerable, and nervous about eating; I felt like arching my back and hissing like a cat. For this reason, my weight continued to fall. Over a period of 3 years, I had gradually but consistently lost weight and my weight had dropped to around 44kg when I was eventually diagnosed.

The initial stages after receiving a diagnosis were scary. Before I received treatment, I was responsible for managing my physical symptoms and ensuring the eating disorder didn't create a critical situation. Everyone around me wanted to help, even though some thought it was self-induced. Eating disorders put a strain on everything and everyone around you, and it is helpful to allow people to come to terms with what an eating disorder involves.

Nothing is ever right for the eating disorder, so my advice would be don't try to make sense of it. It's not your fault. Remember it's an illness; you have to listen to your own voice, which tells you to speak up, and seek help.

However, I know it can be hard. My acceptance of treatment felt like a betrayal, and the days after diagnosis passed in a blur. Having finally accepted to see my GP, I had an emergency ECG and blood tests. Luckily, I was able to meet with a specialist team within a week or so and, although I felt intimidated by the team initially, I soon grew to trust them. I saw that they understood what I was going through and wanted to help.

As part of my recovery, I found it useful to tell myself that I enjoyed food, the taste of it and the social aspects of eating. I tried to be confident that food was going to taste good and nourish my body. You've got nothing to hide, nothing to be ashamed of. Be proud of small steps: eating one mouthful, handling food in public, leaving clues that you're eating, using food-related vocabulary... You might find it helpful to find an author through whose writing you can express your own thoughts; I read Janet Treasure's book 'Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers' and left post-it notes and comments on the pages that were relevant to me. I also found it helpful to write down my eating disorder thoughts and put them in a box.

I made a list of the things that I was missing because of the eating disorder and ticked them off as I reclaimed them. I also made a list of the things I couldn't wait to fill my time with when I was free of concern about food and eating.

My eating disorder meant that I missed having a lie-in, being able to concentrate when I read a book, drinking milky coffee, asking for snacks, helping my Mum cook, having seconds at dinner, eating in restaurants, finishing a meal without stalling. I wanted to play golf with my dad, go swimming, visit friends or family for a weekend, get a new job...

For me, recovery was so much more than being a healthy weight. There are so many other benefits – such as learning how to cope with life's ups and downs, relinquishing and maintaining self-control, learning how to deal and relate to others, or managing your feelings in a healthier way. It could also be about recognising when you don't feel yourself or speaking about how you feel and asking for help. It can also be tempting to work out why the eating disorder started in the first place - you may have some historic sadness or worries that you are desperate to resolve. When you're thinking clearly again, these worries can fall away or be addressed in treatment if need be. The eating disorder traps you in a time warp and by the time you're ready to move on, the old worries won't matter anymore; you'll be ready to start your new life. Don't push yourself; recovery is a journey.

On being discharged in 2016, I started a steady relationship with an old boyfriend who was supportive throughout the process. I returned to university to complete my degree and lived independently throughout. After graduating, I moved back to France and now work as a Paralegal in a local French Legal Services team. This year I will have been with my boyfriend for six years. We own our own house, have a cat called Milo and are getting married in May. We're always cooking different recipes, trying new restaurants, and making plans for the future together.

Personal story - Hope

Hi, my name is Hope Virgo, and I am an Author and Campaigner. I spend my life travelling all over talking about eating disorders and mental health. The reason I do this is because I have had my experience of an eating disorder, seeing first-hand the challenges, the destruction they cause and coming through it. I wanted to share my experience to help others and to change understanding about eating disorders.

So where do I start? I grew up in a family as the middle child. I struggled a bit growing up with my emotions, but just got on with things hoping that at some time, things would click.

When I got to secondary school, life began to feel slightly harder. I had some challenging relationships at home, and experienced 9 months of sexual abuse when I was 12 years old. After this, I was left sitting with the feeling that there was something wrong with me that I had to change. But you don't have to go through abuse to have these feelings. It could be anything that causes them - from not seeing images of people who look like you on social media, or something someone says to you. Any of these comparisons, judgements can make us feel like we are not good enough.

And for me it was a combination of these, in addition to not wanting to feel the way I did, that caused me to go on to develop anorexia. Anorexia acted as a coping mechanism to life. Serving a purpose, numbing emotions, distracting me and I loved how it made me feel. Loved those feelings that life would be okay, and everything would work out. But little did I know that what I was doing was destructive and causing more harm. The thing about eating disorders is we think they give us what we need, but in reality, when we look at it, they are stopping us from really living our lives. We stop having energy to do things, we think about food all the time, we are cold... tired... The list is endless.

I am sure, like me, some of you will be listening to this and not be able to accept that anything is the matter. Such as those patterns of behaviour that become so ingrained that we get stuck and can't accept that we need that support. Fast forward through the next four years and my school got in touch with my Mum, and I went to see my GP. After a few appointments, I was referred to CAMHs. I spent 6 months at CAMHs but wasn't able to actually accept that anything was the matter with me. After 6 months, I had no choice but to be admitted to an inpatient unit where I spent a year learning a lot about myself and pushing to get well. But the thing for me was, even as I stood there in the hospital doorway waiting for my admission to start, I still didn't think there was anything the matter with me. I was in complete denial. It took a few days in hospital before I could begin to accept that something was going on, although for a huge amount of time, I would tell myself to just eat so that I could get out of the hospital. Recovery is hard work, and there will be moments along the way when things feel harder and you aren't sure you can get well, but in those moments, we need to identify the fear and then focus on our motivations. We need to keep communicating if we feel guilty doing that and keep bringing behaviours out into the open.

When I was discharged, I turned 18 so didn't receive any help but I knew what I had to do to keep well. By sticking to my meal plan I managed to get through the next few years and then began to really challenge my recovery further.

It's really important to realise that everyone deserves prompt access to treatment regardless of their weight. I went into treatment 14 years ago, when there were fewer people needing services, and where there was space, so please don't compare your treatment experience to mine!

But I wanted to share just a few of things that have helped me get to the space I am now!

Firstly, learning to communicate about what is going on! Realising the issues are wider than about the eating disorder behaviours - there is something going on and if we can share on those days instead of numbing it, instead of communicating through food, it gets easier to navigate life.

Secondly, focusing on my reasons for wanting to get well. The eating disorder traps us in this fear. We need to look beyond that fear and focus on our motivations! For me, it was things like getting spontaneity back into my life, being able to go out with friends, travel... The eating disorder will try and seduce you in moments, pulling you in, but in those moments, remember the negatives of the eating disorder and the positives of recovery!

Thirdly, unpacking my belief systems. We need to keep challenging our behaviours and our beliefs around food, our bodies and exercise in order to get to a space where the eating disorder no longer has a grip over us! Make a list of these and start breaking them. It's hard, but so worth not settling.

Fourthly, pushing through the discomfort and uncertainty! This is one of the hardest things to do but it will always be worth it. Find a way to process your experiences - I find journaling really helps.

Fifth, not losing hope! I know how hard it is to recover. But every single person can make a full recovery. It's hard work, relentless but will be worth it!

Personal story - Simon

Hi there,

My name is Simon, and this is my story and I hope this podcast helps those who have an eating disorder, and anybody affected by this.

I guess I first struggled with having an eating disorder in my late teens and then into my twenties. I initially struggled mostly with anorexia and as I gained weight, my diagnosis changed, and I struggled with bulimia too. So, for a few years, I would have some stable periods of eating, but then have periods of anorexia & bulimia. Then through my thirties and up until late 2019, I have been mostly stable and healthy in terms of eating.

There was no single cause for my eating disorder - I guess it was down to several social triggers, loss of loved ones, media pressure to look thin, life stressors and for me, a general sense of not feeling in control of life. As a result of these negative thoughts and feelings, I started to eat less and less and increase my exercise, which in the beginning, made me happy and feel in control. Losing weight always seemed easy for me in those days, and it felt good to feel healthier. I also received lots of positive feedback from people and many - including myself - said I looked and felt healthier.

In the beginning, Anorexia felt like a warm blanket that comforted me and made me feel safe and in control of life. However, the thing that I thought I could control became a monster that then took control of me. With hindsight, and reflection, I would have to say that both anorexia & bulimia felt like being in control.

By my early 20s, I recognised I had an eating problem. My mental health was declining, and I was also having lots of physical issues too; tiredness yet not sleeping much, difficulty concentrating, lowered libido, cold, hungry, and irritable. Given this, I sought help and support from various sources, family, friends, the Mental Health Team, and a local eating disorder charity that offered both emotional and practical support. For the first time, I met other people struggling with eating disorders which for me was amazing as I realised I was not alone in the world with my struggles & realised too that men can have an eating disorder as well. Incidentally, it was from this experience that I met my best friend, who has been amazing at supporting me emotionally. Since then, during the most part in my thirties and forties, my eating has been relatively stable. Of course, my weight has fluctuated at times, but remained within a healthy range.

However, there have been some wobbles. In 2019, I was diagnosed with borderline personality disorder, which hit me hard, and I found it hard to process. This of course impacted on my mental health again and consequently my eating - in trying to feel in control and manage my distress. Also, when Covid hit in 2020, the lockdown restrictions made it hard to live a normal life - seeing people, family, travelling, and exercising were all my usual coping strategies for my own mental health and wellbeing. I wanted to focus on improving my health. I started to exercise and lost some weight, and just like in my early twenties, brought positive feedback from others. This enticed me back into wanting to lose further weight and unknowingly slip back into that anorexic thinking again. According to the scales, I was still a healthy weight, so BMI indicators would say there was no reason to worry. However, no one could see my inner thoughts or urges to eat less and exercise more, until I started to look unwell.

Luckily, I could recognise that I had a problem. My mental health was declining, and I was experiencing lots of the physical issues I had from earlier years, so I decided to contact a local Eating Disorder Service charity

for support to return to recovery. The anorexia had almost become like the old identity again and it seemed so easy that life experiences such as a new diagnosis and/or Covid could re-trigger me into old eating disorder thoughts and behaviours in order to help me cope. With hindsight, like earlier times, I would have to say that for me, the eating disorder was about control. I was very unhappy during this time, and events and experiences left me feeling like I had no control in my life. Just to reiterate, anorexia makes you believe that you have control and sadly this is what makes it hard to escape. That said, the support from my partner, family, friends and eating disorder organisations who have offered emotional support, support groups and self-help tools can really help.

I now consider myself recovered – my weight remains stable, and I enjoy eating a variety of food. However, I will admit that some days can be difficult in terms of my eating. I think it's important to say to perhaps expect to have a bad day or a set-back sometimes, and that's okay, because recovery is a journey. It is now the recovery process and ways to stay safe that I will turn to and from this, hopefully you can take away something that you might consider helpful/useful.

So, the things that helped me are as follows:

1. Healthy & Balanced Diet: - Recognising that we all need different foods to maintain a healthy body. For me, there has been a lot of pressure to lose weight and not eat certain foods, especially carbs or what is considered fatty/bad foods such as chocolate, pizza, fast food, etc. What has helped me is switching off from lots of the messages in the media about food, as this has been too triggering. Instead, what helped me was to change my thinking away from seeing foods as either “good or bad,” to allowing myself to have lots of different foods. You can't beat the old motto “everything in moderation” and I now eat pizza, chocolate, bread, carbs without the attached guilt I had with certain foods. Now I have let go of the guilt, if I overeat or have what is considered to be a “fatty” meal, I just eat a bit healthier the next day. Again, I now see this as part of a well-balanced meal, yet still enjoying the foods I like as well as making a meal plan.

2. Letting go of the scales: - I found it helpful to stop weighing myself. I realised that Recovery means putting on weight. It is very difficult to be healthy whilst maintaining a low weight and hardly eating anything. Although weighing myself was reassuring at the beginning, as I regained weight I could panic when I saw my weight had gone up a couple of pounds. I had to constantly remind myself that I will put on weight, and that's okay”. And as my weight went up, I felt healthier with each passing week. As time went on, I was able to reduce the number of times I weighed myself, whilst checking weight in the long term. The good news is that we will eventually reach our body's set point, whereby we are full and not hungry all the time. This leads me onto my next point.

3. Set Points: - Many people ask, “if we have a set point, why do people keep eating?” For me, it was important to learn about set points. I reached my set point at a certain weight and no longer craved food all the time. I know it is easy to worry or feel like you are eating yourself to death when on the road to recovery and regaining weight; it certainly felt like I would not ever stop eating, I mean like ever. This was scary but I was encouraged and reassured that my food intake would even out once I had reached my set point. I can honestly say this worked for me and once I began to eat more healthily – 3 meals a day with a snack or two – I felt full.

4. Find support from charities/disorder teams: - My local eating disorder charity has been inspirational to me in so many ways - from helping me to monitor my weight, providing emotional support and encouragement and giving me lots of self-help tools, which were also on their website. I was lucky enough to attend a weekly support group consisting of service users/people struggling with eating as well as facilitator's who had lived experiences of eating disorders but had recovered. This for me was important for 2 main reasons. One, I met and was able to listen to other people's experiences, which made me feel that I am not alone in the world. I felt more connected with others. The second reason is that having facilitators with lived experiences showed me that recovery is possible by what helped them. They empowered me to start and work on my own recovery and journey. They also ran groups for carers & family members whereby they helped our loved ones understand what an eating disorder is, and how they might be able to help us in our recovery too. This certainly was an amazing insight for my loved ones, who have been enabled to support me.

5. Support from friends & family: - I learned to be open and honest with family and friends about how I was feeling and if I was struggling. So, learning to trust and communicate with those closest to me was helpful in allowing them to help me. It has not been easy for me, and the eating disorder thoughts certainly told me to try to keep my eating a secret. Part of recovery was letting go of trying to hide and keep it a secret. So, if you can find people/family members you can trust then this might help.

6. Self Help Tools & Recovery toolbox: - My local eating disorder charity had some useful materials on their website, and it might be worth checking if your local services do too. If not, there are things we can do ourselves that are relatively simple to do, like writing down our triggers and things that make us unhappy. In terms of self-help tools, it might be writing down a list of coping strategies and ways to manage distress through healthier ways, rather than using food to control feelings of distress. For example, I found writing down my feelings, finding support from others, listening to music, watching tv, going for a bath, spending time with friends and my animals, reading & exercising but for enjoyment all helpful. We all have different things that help us.

A specific task that was particularly helpful for me was writing down the costs and benefits & negatives/positives of having an eating disorder. Likewise, writing down the personal costs and benefits of recovery or overcoming the eating disorder. I had never done this before and was surprised by what I discovered. I realised that I had a long list of negatives for not eating and only a couple of what I deemed were positive things. The benefits of being recovered vastly outweigh the costs. When I saw what I had written down in black and white, it made me realise for the first time in many years that having an eating disorder sucks. It takes away more than gives, in terms of trying to have a happy/healthy life. So, this exercise I would encourage anyone to do and in fact, you can find a worksheet on this exercise in the workbook that accompanies these podcasts`.

7. Books: Lastly, one of the things that has been inspirational to me is reading books and reading about people's personal stories and their journey of recovery and what has helped them over the years. This led me to thinking "Wow, if they can recover I can too".

I'd like to end with the message that recovery has been a long journey for me and there have definitely been setbacks too. However, the important part is despite setbacks - or if we have a bad day - we move towards recovery with each week/month that goes on.

So just to say I hope this podcast has offered a ray of hope that we can recover from or at least manage our eating disorders with the right support. Each of us will have our own journey and each person will recover in their own time, some longer than others. But it is possible. I can't say it's not been hard work but I'm happy to say I have got there in the end, and you can too.

So, to end, thank you for taking the time to listen to my podcast and I wish you all the best. :)

Simon

Personal story - Mary

I first started to become more aware of my body when I turned 18. I had started college and not made many friends. This was ok for me as I wanted to be alone to focus on losing weight. I was going on holiday with old school friends, my first trip without my parents! We had all agreed we needed to lose a little weight and wanted to feel happier with our own bodies (I was in the healthy weight range at this point). I started to make small changes, such as choosing pasta/rice or wraps instead of bread and adding salads and fruit to my meals. Quite quickly, my weight started to drop off. I started to walk instead of taking the college bus and would even sacrifice seeing my friends to do the 40 min walk to the centre of town from college. People started noticing my weight loss and at first congratulating me on it.

Not long after, my obsession with losing weight increased. I had already gotten to my 'goal weight' (which was in the underweight range) but wanted to lose more. Getting to my goal weight was not good enough for me. I became good – and even felt successful - at losing weight and started throwing away food. I almost felt a 'buzz' from throwing away the food my mum had started to give me, because she was worried about my food intake. I began to avoid socialising. I didn't want to meet with my friends in fear that they would want to eat out, or ask about my eating/exercise habits, or why I had lost weight so quickly. I felt I had to push away people who were close to me and wanted to be alone to 'do my thing' and let no one get in the way of it.

Things started to change as I lost more weight. My periods stopped and my emotions went all over the place. Around this time, I decided to go to the doctors. This was my first referral to my local eating disorders service. I went for an assessment, and also attended a not-so-successful session with a dietician. At this point, I did not feel I needed any help as I did not consider myself to have a problem in my eyes.

I continued to feel this way until I started university at 19/20 years old. I had now lost so much weight I was really skinny and super poorly. I was still using the gym but eating very little. Everything felt such an effort, like going shopping, seeing friends, even pulling up my trousers after going to the toilet. I felt exhausted. I was fed up, upset, and had no idea why.

By this stage, I was at an anorexic weight and petrified of eating a normal amount of food. However, I still didn't feel like I had a problem because 'at least I was eating.' But I felt everyone was against me if and when they approached me about anything to do with my weight or eating. I was then referred and assessed by the local eating disorders service again. It was only then that I started debating whether I did need a bit of help or not. I started questioning my own thoughts because of the information they gave me. I had thought treatment would be about making me eat but to start with, it was about giving me information about eating disorders. As treatment progressed, I became more aware of my feelings and how I could deal with them. I had to deal with putting on the weight I needed to in order to become healthy and well again and found it helpful to refer to food as my 'medicine'. Another activity that was very helpful was writing a letter to my future self. I found this very effective - through envisaging my life without my eating disorder, my 'dream' life became my new goal not throwing food away or chewing food and spitting it out, or even losing weight. My goal was to be content, to be me again.

To this day, I still work on how to deal with my feelings and continue to have up and down days, especially when I feel I need to control a situation around me. But I have been through these feelings before and have developed the skills and tools to become my own support and love myself again!

Personal story - Kelly

Having bulimia was something I lived with for a long time. It was something I knew as part of my day-to-day life, but it wasn't until being in treatment that I really began to understand it.

Looking back, I find it hard to specify the starting point, or where it all began. Someone once said to me that it was like watching something with your fingers in front of my eyes and that is exactly what it felt like. Although I have more of an idea of where and why my bulimia developed, and more of an idea of what it is and what it looks like for me, it still isn't easy for me to see a clear succinct timeline.

For me, my worries about my body and my weight began when I was about 9 years old. This was the first time I have a memory of being worried about it. It was at this time that PE changed from being something I loved to something I hated. Although I had always enjoyed sport, I began to worry about getting changed in front of other people, and this took away all the enjoyment that PE had ever held. Although my eating disorder didn't begin then, this was when the thoughts and beliefs which ultimately led me down that path became more entrenched in my mind.

As I grew older, my concerns about my weight continued, reinforced by what I watched, read, and heard. I was constantly finding evidence to reinforce my thoughts as though they were fact and validating that I wasn't worthy because of how I looked. As I got older, I dieted continually and found ways to try and control my weight. However, I also began to turn to food when I was upset, stressed or when things were hard. The more I turned to food, the more guilty I felt. The more guilty I felt, the more I tried to find other ways round it, other ways to punish myself for what I was doing. I don't remember the first time I made myself sick. I don't remember how or why it seemed like a plausible thing to do, but it happened, and things started to change from there.

When I went to university it was the first time it began to get worse. I was going out, meeting new people, and enjoying the freedom of being away from home. When I think back to this time, these are the things and memories which first come to mind. But I also remember the other side, the side other people didn't see, the side which made me so ashamed. Ashamed of the amount I ate, how I compensated, that I just didn't have enough willpower to not have to binge and purge.

Going to university seemed to increase the pressure - the need to rely on something familiar when everything else was new. Worrying about my grades and constantly trying to achieve higher and higher, while also trying to be confident enough to meet new people and make new friends. I berated myself whenever I wasn't the best I could be, and all the while, worrying that if only I was thinner, perhaps I would be more likeable and confident and that all the other things I felt I lacked might come that bit easier. The eating disorder was something I relied on throughout the whole of my degree to different extents, but there was one point which always stands out as being significant for me. It was in the January of my second year, and I had taken on yet another 'New Year diet'. It had started so well, as diets always did, until my will power wasn't enough, and my weight loss slowed. I felt like I just wasn't doing enough. But while the pressure to eat less increased, the desire to eat more did too and I ate something 'not on plan'. The guilt I felt overeating that one thing was almost unbearable, and then I ate another and another. Before I knew it, the guilt was overpowering, and I saw no other way but to purge. I figured that if that helped me to lose weight, perhaps I could rely on it for now, and then once I was happier, I would stop. I continued to convince myself this would be the case. But the time came when I knew it was happening too often. This was the first time I told myself that it had to stop, and that it had gone far enough. It's a time I remember

so vividly and can still recall now...because I couldn't. I just couldn't stop. I wanted to, I knew I needed to, and I tried. But I wasn't in control. That realisation hit me hard - how could this thing which made me feel so in control, be completely and utterly out of my control?

I would like to say that at this point that I got help and things got better. But I didn't. I still felt like I wasn't sick enough, and that my problems weren't severe enough. I was constantly telling myself that other people had it harder than me. So, things continued like this for a few more years. There were times when I would go days, weeks, and months at a time without bingeing and purging. But there were also times when it ruled my days, my thoughts, and was too much to handle. All I could do was try to push it down and block it out.

There are a few different reasons why I didn't end up seeking therapy earlier. There were times when logistically it didn't seem possible – such as when I was living abroad, or in locations for just a short amount of time. There were also times when I got to the point of receiving help and then I ended the sessions. This was often when there were other things going on for me, and I didn't have the head space to devote to therapy. In reality, looking back, it was also probably because I had a lot of stressful things going on, and giving up one of my coping mechanisms just felt too scary.

Starting therapy was a scary thought, however much I knew I needed it. I wanted it more than anything and knew that this was the point I had to part from my eating disorder. But I just didn't know who I was without it. I felt like the eating disorder and I were one person. What I can see now is that my eating disorder had taken over so much that I could no longer see who I was.

From where I am now, I can look back and see that starting therapy was without doubt the best, scariest and most life changing thing that I have done. It isn't easy when the person sitting in front of you sometimes feels like the enemy, asking you to give up something so familiar. Asking you to abandon your eating disorder feels like asking you to abandon your support network, your coping mechanism, your friend. How can it be that I need to leave all these things in the past, they are me, they are who I am? That's how it felt. But through the process, I began to unpick what was me and what was my ED. It became clearer that deep down, trapped and suppressed by the voice of my ED was me, the real me. I was a separate entity, who had thoughts, dreams, wishes. Who would once again, have a life, free from the ED.

There were many times during treatment when I wanted to turn and run, when the calls from my ED became louder, and the pull of familiarity almost outweighed the draw of a life of freedom. At those times, the ED voice would grow stronger, shouting louder, convincing me that I was a failure, and trying to convince me that IT was the only way to be happy. But I can see more clearly now and see that those choices – making the choice to choose recovery again, again and again - was the bravest and hardest thing I could have done, and the one which has got me to where I am today.

The life I have, free from my eating disorder, was most definitely worth every difficult minute, every scary moment of facing my eating disorder thoughts. I can enjoy things that I didn't realise had been taken away. I can go out for a meal and enjoy it without keeping track of what others are eating or worrying about how I will compensate. A simple invite out for coffee, or lunch becomes just that again – a simple chance to enjoy life. When things are hard, or stressful - although it can feel difficult, and I may need to find ways to cope – they aren't as difficult as my eating disorder thoughts. These may creep in from time to time, but I can see now that they are not me. I had moments in therapy where I would hear these thoughts and think 'how can I be so mean to anyone, let alone myself?' The realisation that I had been talking to myself like

this for years was hard to think about, but easier than continuing in this way for many more years to come. I truly feel I've got my life back. I have heard people talking about recovery and being recovered, and how great their life is when rid of their eating disorder. I used to think that although I knew this had been possible for them, maybe it wasn't for me. But that was my eating disorder talking. Now I am there I can see that it is possible, and it was so worth it.

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 Alice's / Antonia's / Hope's / Simon's / Mary's / Kelly's / 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

You may or may not want to change any of your eating disorder symptoms at the moment, but there are some things you can do to minimise the shorter- and longer-term consequences of choosing to stay the same. These include:

1. Attend physical monitoring at your GP surgery or local eating disorder service (if recommended to do so)
2. Harm minimisation techniques
3. Improve your general wellbeing via seeking help and support from others, being engaged in meaningful activity, or increasing knowledge and skills

1. Physical health monitoring

If you have been recommended to attend physical monitoring, it is really important that you attend. Physical monitoring should include:

- Blood tests
- Blood pressure
- Weight monitoring
- Other investigations might be required such as ECG or DEXA Bone Density Scan

Why is this important?

Whilst you may not **feel** physically unwell, the effects of under-eating and / or engaging in compensatory behaviours will be putting your body under strain.

2. Harm minimisation of physical effects of eating disorder behaviours

If you feel unable to work on making any change in the immediate future, there are things you can do to reduce the harm caused by some of your current symptoms now. These include:

- Ensuring you receive adequate nutrients and minerals
- Reducing the risk of developing / or worsening osteoporosis
- Looking after your teeth
- Taking adequate precautions regarding contraception and pregnancy
- Taking precautions regarding pain control

You can find more information about harm minimisation techniques on the next page

3. 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
- 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.)

General physical well-being recommendations for patients with eating disorders

Below you can find some general physical well-being recommendations for people with eating disorders. The information provided below is adapted from King's College London's general physical well-being recommendations for patients with eating disorders leaflet.

Multivitamin and mineral supplementation

- Expert consensus suggests that people at low weight (BMI below 17.5) may benefit from multivitamin and mineral supplementation.
- Supplementation should be with a compound containing multivitamins and multi-minerals such as Sanatogen Gold or Forceval.
- Vegetarians and vegans may need to remain on these supplements longer after weight restoration as their diets may not be sufficient.
- If you are taking other supplements, please tell your doctor: there may be a risk of taking excessive amounts.
- If you use alcohol excessively, we recommend you discuss this with your GP as people who have eating disorders and use alcohol excessively may develop more severe and potentially dangerous vitamin deficiencies.
- Supplementation should continue while you are low weight (a guide may be to stop supplementation once periods have been restored, i.e., two normal cycles).

Osteopenia and osteoporosis

- Malnutrition, low body mass, lack of oestrogen and over activity may lead to the development of reduced bone mineral density, making patients vulnerable to bone fractures in the future.
- The best prevention and treatment of a loss of bone mineral density (sometimes referred to as osteopenia) and osteoporosis (more severe) is maintenance of adequate nutrition and weight.
- Treatment with hormones and drugs are not normally advised in people with eating disorders.
- There are no clear evidence-based guidelines on when you should be investigated. We recommend that you should consider having a bone density scan if you have had anorexia nervosa for a year or more with a BMI of below 17.5, or if your menstrual periods have stopped for a year or more.
- You should discuss with your doctor the need for a bone density scan.
- If you have been diagnosed with osteopenia or osteoporosis, you may be advised to take calcium and vitamin D supplementation, and to avoid high impact physical activities or physical activities that may increase your likelihood of a fall like horse-riding or skiing (because of your increased risk of bone fracture). We recommend you consider repeating the bone density scan every two years or so if you have osteopenia or osteoporosis, or if you remain underweight, or continue to have menstrual disturbance.

Dental hygiene and vomiting

Vomiting results in exposing the tooth enamel to gastric acid leading to erosion and caries. Regular monitoring by dental practitioners is recommended.

- To reduce damage after vomiting:
 - Avoid brushing teeth after vomiting
 - Rinse mouth with a water and sodium bicarbonate mixture (or non-acidic mouthwash) to neutralise the acid environment
- Limit the intake of acidic foods (e.g., fruits, pickled products) and drinks (carbonated drinks) to mealtimes.
- Finish meals with alkaline foods (e.g., milk or cheese).
- Things to avoid:
 - Acidic foods and drinks before bedtime
 - Prolonged sipping or holding of acidic beverages in mouth
 - Brushing your teeth after acidic substances

Contraception

It is possible to conceive even if due to your eating disorder you are not menstruating. Discuss contraception with your GP.

Pregnancy

- Pregnancy can be a very difficult time for people with eating disorders. To have a healthy baby, you would have to gain 10 to 13 kilograms. It is an emotionally difficult time and the normal consequences of pregnancy like weight gain, vomiting, bloating and breast enlargement can be very challenging.
- 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"](#).

Paracetamol and low weight

When you are very underweight an adult's dose of Paracetamol can be dangerous. You may need to consider taking a child's dose.

Typical Questions

- 1. *I am a vegetarian and am concerned about how to regain weight and the risks of 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'm worried about the risk of osteoporosis. What can I do?***

For more information about the effects of eating disorders on calcium and bone health, please follow [the CCI handout on Calcium and Bone Health, which can be accessed here.](#)

- 3. *I can't stop making myself sick at the moment, but I'm really worried about my teeth. What can I do?***

If you would like more information about the effects of inducing vomiting on your health, please follow a link to [the CCI handout on Vomiting and Your Health which you can access here.](#)

- 4. *I suffer from abdominal pain and bloating when I eat, which puts me off trying to eat more. 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.](#)

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

If you would like to find out more information about the effects of eating disorders on hormones and pregnancy, please follow the link to [the CCI handout on “Eating Disorders and Hormones” which can be accessed here](#) and [“Eating Disorders and Pregnancy”, which can be accessed here.](#)

- 6. *Is it safe for me to drive?***

If you would like more information on driving and eating disorders, please follow the link to the [Black Country Healthcare NHS Foundation leaflet entitled “Eating Disorders and Driving” which can be accessed here.](#) Further information about the [UK law, driving and eating disorders can be found here.](#)

- 7. *I've booked my summer holiday abroad. I'm really excited, but my doctor says if things don't change, I can't go. Is that really true?***

For more information on flying and eating disorders, please follow the link to the South London and Maudsley NHS Trust's leaflet entitled “Thinking of Going on Holiday?” [which can be accessed here.](#) Please contact your insurance broker / check your medical insurance before you travel to ensure you are adequately covered for your journey.

Improving my wellbeing

In addition to ensuring that we are eating adequately, 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 – through 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?

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 well-being

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			
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 and note down your thoughts below. Alternatively, you can [complete the exercise by accessing the link here](#) which you will find after the previous questionnaire under Section 2.

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

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 1-4 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 you should seek medical attention
- Identify some of the signs others might notice in you which suggest you should seek medical attention
- 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.

**Keeping Safe Plan
SAMPLE**

Name: Joe Bloggs

DoB: 19.8.1991

Address: Cathedral Street, Norfolk

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

- Get a GP appointment to discuss the frequency of my medical monitoring. Once agreed, I will make a commitment to attend all medical monitoring appointments regardless of whether I feel ill.
- I will also make a GP appointment if I begin to feel unwell.
- I will arrange to meet up with Jack (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 parents 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 exercise, 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 Jack 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 I feel unwell or black out
- If my GP contacts me about abnormal blood tests I will follow his advice
- If my symptoms get worse, I will tell my doctor
- If my weight drops 1 pound per week it is important to tell my doctor

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 means I am exercising more
- If my friends comment that I am unsteady on my feet

If I feel unwell I will:

Telephone my GP, if it is out of hours, I will call a taxi and go to A&E. I will also contact my mum if I have to go to the hospital.

I would contact: mum (Sheila Bloggs) **Tel Number:** 00000000000

My GP's Details are:

Dr. Smith
The Surgery,
Norwich

My local A & E is:

Norfolk and Norwich University Hospital

My Care Coordinator is:

CEDS Team member / I do not have a care Coordinator but the person who assessed me is... and I will contact them if I need to get in touch with the service.

Tel Number:

0300 300 0142

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:

My GP's Details are:

Tel Number:

My local A & E is:

My Care Coordinator/Keyworker 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 or below, or [complete the exercise by accessing the link 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: BRAVE

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 you are underweight, you will need to gain approximately 3 stone by the end of your pregnancy. If you are a 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 of 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.

People who are significantly underweight and / or have lost a lot of weight quickly often struggle to get enough sleep during the night.

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. **However, it should be noted that people needing to weight restore may be required to include a higher than recommended ratio of these types of foods as part of their weight restoration programme, following which their intake should resemble the ratios above.**

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?

Basic nutritional facts and principles¹⁰

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, 1oz/25g hard cheese, average portion of milk sauce (e.g., custard, cheese sauce)).

¹⁰ 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 of 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 250-300g 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 of 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.
- Foliates - 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 of small, dried fruit (e.g., raisins) One small glass (100-150ml) 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 information which you can find 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.

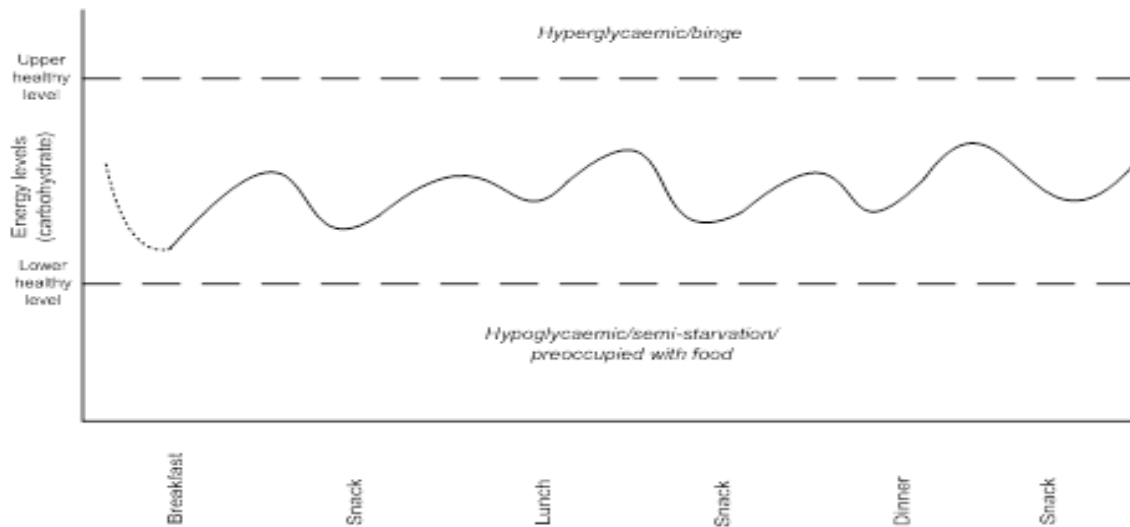
The effect of alcohol on weight

- 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 (with or without vomiting).

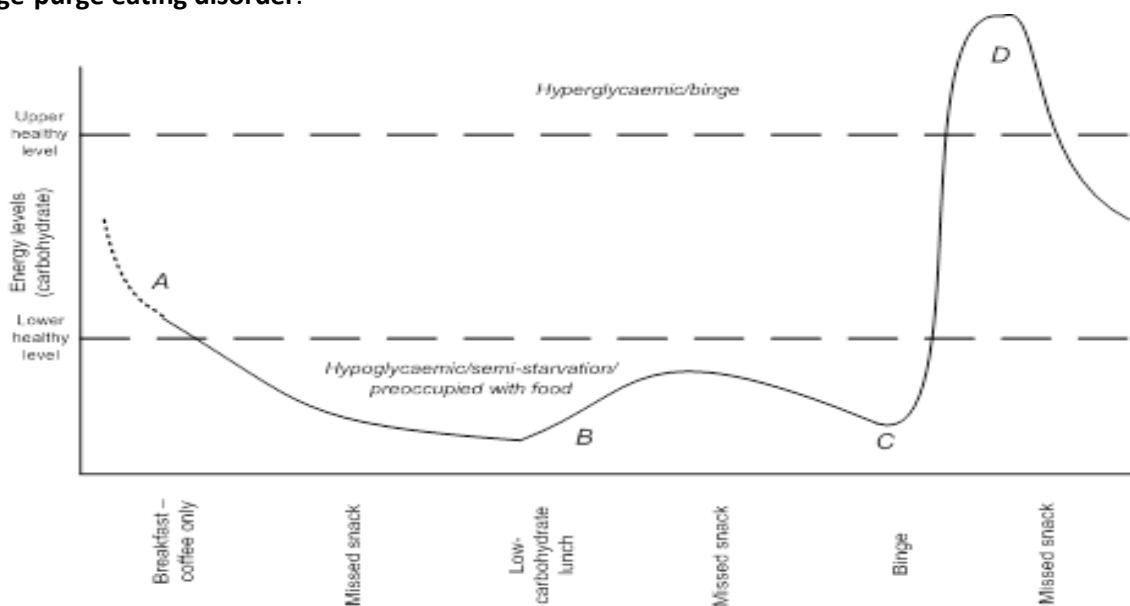
Energy Graphs¹¹

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**.



¹¹ 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 (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	Vomit (V) Laxatives (L) Diuretics (D) Exercise (E)	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		V	Didn't want to eat anything this morning, so I got rid of it.
10.50am	Diet coke	Work			Feeling hungry and a bit stressed, but having a coke to tide me over
1.30pm	1 tuna sandwich, salad, 1 apple, 1 low-fat yoghurt	Work			Packed lunch - I made it myself. Had a thin rather than 2 pieces of bread. Ate it on my own at work and took my time.
4.55pm	2 bags of crisps and 1 Kitkat	Work	Yes	V x 2	On my way home, I went to the shop. Didn't mean to buy these. Ate them quickly on the way home and made myself sick as soon as I got in.
7.15pm	½ chicken breast, salad, green beans, 1 jelly with berries	Home			Didn't really want my dinner as feeling bad about earlier. Only had ½ chicken breast

Food and drink diary¹² (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	Vomit (V) Laxatives (L) Diuretics (D) Exercise (E)	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)?

¹² Taken from Centre for Research on Eating Disorders Website (http://credo-oxford.com/pdfs/F5.3_Blank_monitoring_record.pdf). Accessed 19.02.2016

R: 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 and / 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 or 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?

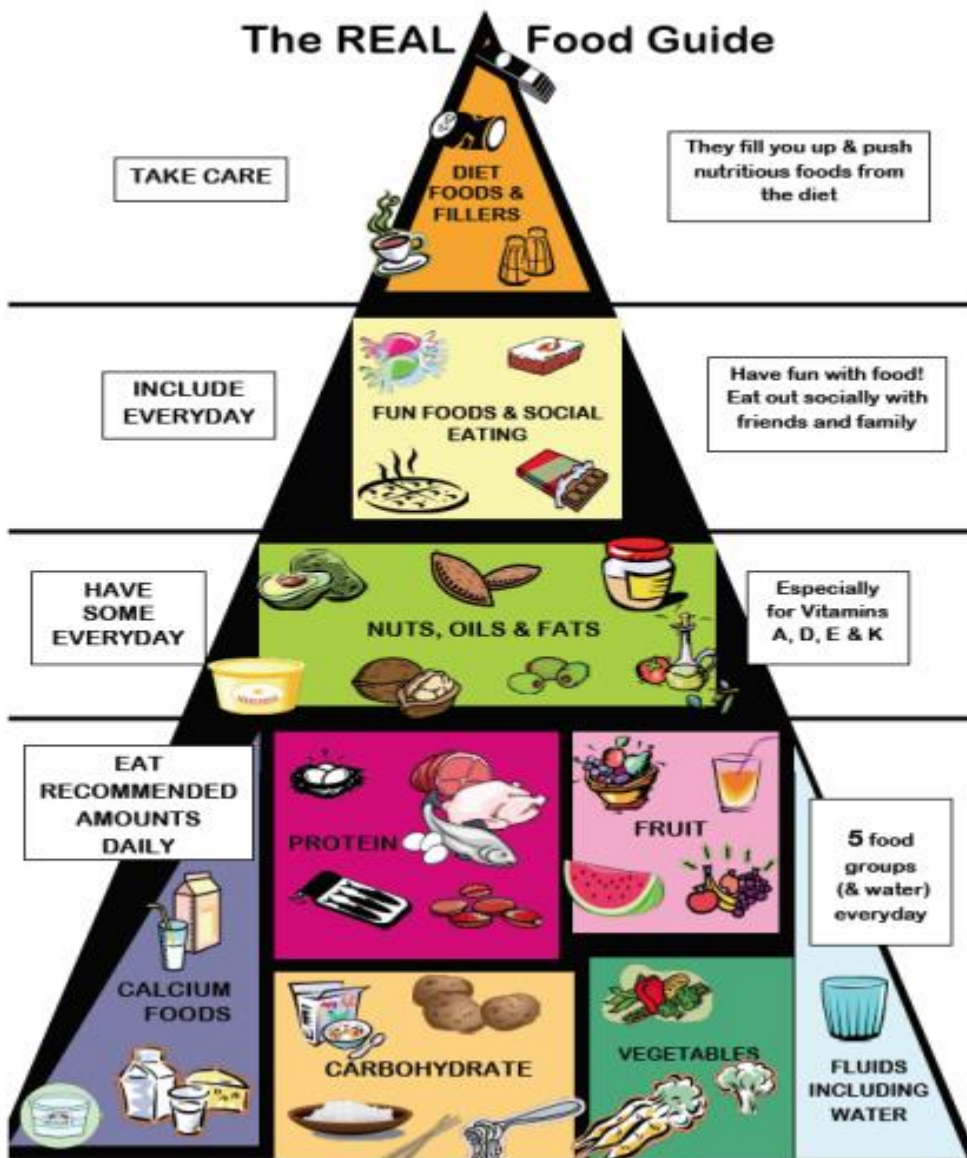
- Hollow tummy
- Feelings of edginess and irritability
- Thinking about food and / or eating
- Salivation
- Feeling light-headed
- Searching for food
- Unable to concentrate
- Feeling physically shaky
- Any, none, or all of these things

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	What do I need to do to make this change?	When will I make the change?	How did it go?
<i>e.g., Adding in a new food or meal? Eating out or at a different venue?</i>	<i>e.g., Go shopping, arrange to eat with others?</i>	<i>e.g., What time of day? What day of the week?</i>	<i>e.g., What was tricky? What are the benefits?</i>

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 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 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 (see for more information about the role of [exercise](#))
- Premenstrual syndrome
- Compensatory behaviours
- The Set Point Theory

Dieting vs Disordered Eating

Diets:

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.

Why is dieting unhelpful? ¹³

- 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 required calorie intake for a male or a female will tip the body into a starvation state, increasing the risk of binge eating / overeating at a later time. 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

¹³ 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.

- 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 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 day¹⁴. 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 since 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 1-1.5kg (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)

¹⁴ Wurtman, 1989 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 standard 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

Myths about purging

“Making myself sick gets rid of the food I have eaten and prevents weight gain”

“Taking laxatives gets rid of the food I have eaten, leaves me feeling empty and prevents weight gain”

Facts about purging - the effect of purging on calorie absorption

Many people with eating disorders eat more than they feel comfortable with, either regularly or occasionally. This can lead to many emotions like panic, anger, guilt and shame, and often results in methods to try and rid the body of the excess calories eaten, thus regaining control but how effective are these behaviours?

Self-induced vomiting

How many calories are lost?

- Researchers have found that on average around 1200 kcals are retained after self-induced vomiting, whether the binge was relatively small (around 1500 kcals) or relatively large (around 3500 kcals; Kaye et al., 1993)
- “Markers” used to judge when all the food has been purged (e.g., eating carrots first so that the orange colour in vomit indicates complete gastric emptying) are ineffective because of the fact the stomach mixes food up during and after the eating process
- Many people who binge and purge report that they gain weight over time, which suggests that the body learns how to retain calories, despite vomiting

But vomiting helps me gain control, doesn't it?

- After eating, the body produces insulin to mop up the sugar it expects to absorb from the food. Purging gets rid of some of this food, but the insulin levels remain as high, and therefore results in a low blood sugar around an hour or two later. A low blood sugar level sends a strong signal to the brain saying “I AM HUNGRY, FEED ME!” resulting in a strong urge to binge again
- Therefore, instead of purging because you have binged, you are possibly bingeing because you have purged
- Many people say that once they have decided to purge, they eat more as they expect to get rid of all the food through purging. Since around the equivalent of two normal sized meals are retained regardless of the size of the binge, it could be argued that you are more in control if you eat a normal meal and avoid vomiting afterwards

Laxative abuse

How many calories are lost?

- Laxatives work on the large bowel, whereas calories are absorbed in the upper, small bowel. So, it is no surprise that Bo-Linn and colleagues (1983) found that laxatives decrease calorie absorption by at most 12% each time they are used, despite 4-6 litres of diarrhoea

But laxatives help me gain control, don't they?

- After laxatives, the empty feeling and flat stomach probably feel very good. However, as soon as you start eating again the effects are lost, and many people feel fuller and more bloated than if they avoided the laxatives in the first place
- Long-term abuse of laxatives can result in constipation and bloating when you stop taking them because the bowel has become “lazy” since it has relied on the laxatives for so long

Diuretics/water tablets

How many calories are lost?

- Diuretics have no effect on calorie absorption. Weight loss after taking water tablets results from fluid losses only and will be regained once the effects of the water tablets have worn off, and fluids are drunk. All behaviours used to get rid of food have physical side effects - some very dangerous.

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 battling 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, concentration, 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](#).

Section 7

Factors that Influence 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 find 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 (see page 5 in this Section).

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.](#)

Use of social media monitoring form

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	6	Instagram	35 mins	Looking at Jilly’s, Emma’s, and Becky’s latest photos	They all look really great in their photos - much better than me. Worried about how I will feel when we go out tonight. Jilly’s got really long, slim legs. I can’t wear a short skirt. Emma’s really toned as well, whereas my arms look flabby	3
8.45am	5	Tik Tok / Instagram	20mins	Looking at a group of girls doing a dance routine. They are all slim and really fit. Their clothes really show off their body shape. Looking at what Becky posted for b’fast - she hardly eats anything, no wonder she’s so thin.....	I wish I could get away with wearing those clothes but my fat stomach and hips would just look hideous. I’m feeling fat after comparing what I ate for bfast with Becky	3
9.30am	7	Pinterest / YouTube	15mins	Checking out some hairstyles, followed by a fitness routine that I am going to do later when I get home	I need to tone up my arms and this fitness routine looks like it might help. The model has a good body anyway, so hope so. Thinking if I get my hair cut, it may make me look more cute.	6

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 a 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 a 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 a link to the exercise here](#) which you will find after the previous exercise 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 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.

Eating Disorders

Almost Anorexic: Is My (or My Loved One's) Relationship with Food a Problem?

By Jennifer Thomas

Anorexia Nervosa: A Survival Guide for families, friends, and sufferers

By Janet Treasure

Overcoming Anorexia

By Christopher Freeman and Peter Cooper

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 Complete Guide to Overcoming Eating Disorders, Perfectionism and Low Self-Esteem (ebook bundle)

By Christopher Freeman

Other disorders

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 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 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: The 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.](#)

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