

EATING DISORDERS

NEWSLETTER

Is There A Gene For
Anorexia?

Binge Eating Disorder
& Compulsive Eating

Body Dysmorphia

Anorexia &
Pregnancy

*Mother's with Eating
Disorders*

The Adonis Complex

Childhood *Obesity* &
TV

Recovery

Welcome To Our Eating Disorders Newsletter!

Editorial

We are very proud to present our first electronic newsletter as part of our joint effort in founding the 'World Eating Disorders Federation'. We are professionals that have come together from different countries with a common mission - to prevent eating disorders; to treat and support sufferers and their families, and to equip professionals with the information and up-to-date skills to confront the complex and misunderstood intricacies that are eating disorders.

We reach out to a global community and not just our local areas. We share common reference experiences for working with eating disorders and must also take different cultures and beliefs into account when working in our individual countries. This is our exciting challenge - to become an interactive forum for people and professionals around the world to share their views, experiences, even write friendly, personal and evidenced – based articles which will help you to stay up to date with all the latest news on eating disorders, with a view to working together towards a unified and evidence based approach.

- www.eating-disorders.org.uk
- www.choiceslebanon.com
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If you wish to participate in sharing your personal experiences with eating disorders and have us publish it in our newsletter please email us at info@choiceslebanon.com

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P Think of the environment; please do not print this newsletter unless you really need to.

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Bulimia by Default

by S. H.

Bulimia is an illness characterised by episodic binge eating and harmful behaviours to prevent weight gain such as purging or taking laxatives. In some people, the features of the illness are so severe that it is easy to assume that something really bad must have happened for bulimia to have developed. But bulimia can happen by accident.

Lisa was only 16 when she had her first bulimic episode. She had picked up a stomach bug the previous week and ended up vomiting and unable to eat for 3 days. Afterwards she spoke of feeling 'lighter', 'empty', and she got a buzz from this. Her friends began to comment approvingly about her weight loss and she enjoyed their attention. It is normal for teenagers to enjoy receiving compliments, and Lisa was in all respects an average teenager, sometimes feeling bigger than she wished to be, but never really doing anything about it. Now after this bug she found herself focusing on how much lighter and more attractive she was feeling and she became afraid of losing this feeling when she started to eat normally again.

She tried to preserve this feeling by restricting her food, but was unable to do this successfully. Eventually, she ended up restricting for most of the day and then would binge eat at night. She was so annoyed with herself for overeating that she began to purge. She felt too heavy unless she could 'get rid' of this food intake.

Over a period of time these habits became the norm for Lisa and while she didn't like indulging, she felt compelled to do so, possibly because it meant she could purge after-

wards and get the light feelings back.

This is an example of how bulimia can develop through 'bad luck'. Most people with bulimia do not intend to vomit or take laxatives after eating their food. It is a condition which develops over time. What begins as being a way of controlling food gradually becomes the **only** way that someone is able to feel light in the body and free of anxiety and guilt. Purging also releases endorphins in the brain, giving someone a "lift" whenever they vomit or take laxatives. Many sufferers describe this buzz, which keeps them attached to their illness, they also describe the way in which purging helps them feel "instantly thin" and how it gives them an emotional release.

The DSM-IV Diagnostic Criteria for Bulimia Nervosa is as follows:

1. Recurrent episodes of binge eating characterized by a large amount of food in a short space of time and a sense of lack of control over eating during the episode.
2. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or medications; fasting; or excessive exercise .
3. The Binge Eating and other inappropriate compensatory behaviours both occur, on average at least twice a week for 3 months.
4. Self Evaluation is unduly influenced by body shape and weight.

Bulimia presents itself in a variety of ways and 30 to 50%

of people who develop anorexia go onto develop bulimia or binge eating disorder. Many people with bulimia however have not been anorexic.

Treatment involves addressing why the behaviour developed, what purpose the behaviour is serving, what the payoffs are , and developing skills necessary to deal help tolerate, regulate and deal with unhelpful, painful or negative emotions.

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“30 to 50% of people who develop anorexia go onto develop bulimia or binge eating disorder.”





Is there a gene for Anorexia?

by J. A.

Many people ask whether there may be a gene for anorexia. Is it hereditary?

A recent Swedish study suggests there is a link. Cynthia M. Bulik, Ph.D., of the University of North Carolina at Chapel Hill, and colleagues studied individuals in the Swedish Twin Registry to examine the prevalence, heritability and risk factors for anorexia. Results showed that out of the 31,406 twins that participated in a 4 years screening for a range of disorders, including anorexia, the researchers estimated that anorexia was 56% heritable, with the remaining differences caused by environmental factors. Their works also suggests

that anxiety or depression early in life could be a trigger factor for the disorder to occur. The overall belief is that certain people are at greater risk and environmental pressures like those from the media play a contributing role.

Anorexia nervosa affects more than 1 out of every 100 women. As many as 10 million women and 1 million men in the U.S. alone are struggling with an eating disorder; and millions more with a binge eating disorder. The overall prevalence of anorexia in 2002 was 1.2% in women and .29% in men. Teenagers and young adults are most vulnerable. There is a strong psychological component asso-

ciated with the condition. The major problem associated with anorexia is a distorted body image. A person with anorexia often believes they are overweight despite being thin, sometimes dramatically underweight.

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Can too much exercise be bad for you?

by H.S.

"You should exercise on a regular basis".

Whether we read it in magazines, watch it on TV or hear it from our doctor, exercise doesn't only keep you in shape but it also improves your endurance, your mood and lowers the risk for certain diseases. If exercise is that good, then one would think that doing more of it would be even better.....isn't that so?

While some people starve themselves in order to stay thin, others binge then purge to get rid of these "Extra calories" or even choose to work out as a means to "purge" what they have eaten: a condition called "Exercise Bulimia".

Eating disorders are complex situations in which a person gets extreme emotions, behaviors and attitudes surrounding weight and food issues. So extreme to the point where a person can damage her body through exercise, resulting in panic attacks, heart failures and other severe problems.

Symptoms include:

- Working out when injured or sick
- Not getting any recovery days and being depressed if unable to exercise
- Avoiding social events or missing out work or school in order to exercise
- Refusing to eat if unable to exercise
- Defining self-worth in terms of performance

So when do you know when to stop? How can doing too much of a good thing be of a negative impact on your health?

At times where obesity seems to have taken over a good part of the population around the world, and huge efforts are being made to fight through diet and exercise, it is somehow ironic to notice that one of the means to remedy that problem (exercise) can also play against it. We will never preach enough balance and equilibrium in managing eating disorders: Therapy and counseling, are therefore important for people diagnosed of exercise bulimia to rebuild their self-esteem, improve their self-image and ensure at all times that a balance is maintained and extreme behaviors are avoided.

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Binge Eating Disorder & Compulsive Eating: A Personal Perspective

by D. J.



In 1959, Albert Stunkard, an American psychologist, first identified “the binge eating syndrome” by observing the weight loss struggles of one of his clients. Binge eating did not attract further attention until the late 1970s, when people who binge eat but who do not purge were described as “bulimics”. Many people overeaters did not, understandably, like this description, thus in 1992, the term “Binge Eating Disorder” was coined to describe people who binge eat but who do not use extreme weight control behaviour. B.E.D. is now considered to be a form of EDNOS, (eating disorders not otherwise specified) a category which includes milder forms of anorexia and bulimia. The recent NICE guidelines are somewhat coy about how to treat B.E.D., recommending variants of therapy that are deemed suitable for bulimia nervosa, even suggesting that binge eaters can be treated by putting them on a diet.

Binge Eating Disorder?

The reason for this coyness is that it is hard to describe what Binge Eating Disorder really is about, and sufferer accounts of the disorder differ from that of professionals. The clinical literature describes B.E.D. broadly as a condition where: ‘People regularly eat larger amounts that a normal eater would consume in the same period of time, this food tends to be “forbidden” (that is, fattening) the behaviour is consistent (i.e. not infrequent), they feel guilty and upset about their behaviour, which they sense is abnormal, they feel “taken over”, out of control, and may not even be conscious of what they are eating, and they may try to compensate for overeating by starving, weigh-

ing themselves and going on diets or taking slimming pills.’

People with B.E.D. might promise to be good, end up having a biscuit, and then the rest of the packet, and typically say, “I’ve blown it...” Chaotic eating might follow, such as a fry-up, several bowls of cereal, and then all the leftovers to boot, promising all the while to “start again tomorrow”.

The trouble is, that when real people are asked “do you ever binge?” or “do you often binge?” far more people say yes than those who would be diagnosed with B.E.D. For some people, a single bar of chocolate feels like a binge, especially if there was a craving beforehand, or if they feel that the food was “forbidden”. Some people just go backwards and forwards to the fridge all night, nibbling, hating themselves for their lack of willpower, looking for something that never seems to satisfy.

There is therefore a subjective experience that we can describe as “compulsive eating” among people who don’t satisfy the full criteria for B.E.D.. But does this difference really matter? When we try to put a label on something as complex and as variable as the eating disorders, we stand in danger of becoming removed from people’s real and authentic experience. This was described eloquently by one of my clients who said:

“I cannot control myself. I’ll open the fridge and eat. No matter what time of day, even if I’ve just finished breakfast or dinner. I’ll still search for food. I’m not necessarily hungry, I’m just addicted

- it’s like a drug. The more I have the more I want. I eat it so quick, like there’s no tomorrow. And it’s always in secret. I even bring food to bed., and in the morning I put the wrappers in an outside dustbin so no one knows what I’ve eaten. If I know that my family and husband are going out, I’ll make up an excuse to stay home, that way I can eat and eat and eat. I’m so disgusted and ashamed of myself. I hate myself for doing it. I know it’s wrong while I am doing it but I will carry on. That is what I can’t understand, while I’m bingeing. I know what I’m doing but I don’t stop. Food is ruling my life. I just wish I could take it or leave it. But it’s never enough”

The Typical Binge Eater

Not unlike people with anorexia and bulimia, binge eaters are extremely sensitive about their shape and weight, and view control over food as perhaps the most important goal of their life. They tend however to have less stringent standards for how they need to look in order to accept themselves. As with the other eating disorders, there is no “typical binge eater” although many describe themselves as “comfort eaters” whose eating bears little relationship to “hunger”. They believe that they lack willpower. The foods that they eat, the number of calories they define as a binge, the triggers that lead to overeating and how they cope after overeating, all vary from one person to another. Compulsive eaters may use metaphor to describe their situation. One person describes her eating as trying to fill a black void, the other speaks of a hole in her heart, one describes food as her treacherous friend, the other says “I just have to have it”.

“People who binge eat and do not purge usually struggle with excess weight, they are shamed by this and by their feelings about their behaviour”.

A Silent Epidemic

People who binge eat and do not purge usually struggle with excess weight, they are shamed by this and by their feelings about their behaviour. Hence it is not surprising that they are acutely unhappy, although it would be wrong to describe B.E.D. as a symptom of depression. Studies show that binge eating is common among the overweight, with over 50% of all overweight people, male and female, claiming that binge eating is a serious problem for them. This represents a huge silent epidemic of sufferers, for whom binge eating is a stealthy destroyer of health and an ultimate cause of early death through complications of excess weight. Binge eaters however, sense a lack of the sympathy given to people with anorexia or bulimia, and may be afraid to confess their problems to a GP. If they do, they are likely to be handed a diet sheet although their condition will render most obesity interventions ineffective.

Treating Compulsive eating

In trying to understand binge eating, and therefore to treat it effectively, we look more to the future than to the past, moving people forward by changing their behaviour, and teaching people the skills to respond to the feelings and situations which trigger over-eating events in a more helpful way. Many people can trace their binge eating behaviour back to the time when they

started dieting, and since the connection between dieting and binge eating is well known, part of the treatment involves helping people to forgo dieting, eat regularly, develop a whole new set of skills to manage the food environment, their feelings, and other people. In other words, people learn to take care of themselves in a totally different way.

There are other people who claim that their binge eating began before they ever started dieting, perhaps during stressful times, or following a personal trauma such as bullying at school, or the break up of



their parent's marriage. We suspect a core problem here is difficulty managing emotions. People who cannot tolerate painful feelings tend to use food as a way of hiding from feelings, and calming themselves down. When they develop skills to manage their feelings and their relationships with other people, they are far less likely to turn to food as an emotional band-aid. Eating behaviour does calm down when people stop running unhelpful thinking patterns such as beating oneself up for lapses, or being too much of a perfectionist around food.

I am often asked whether I consider B.E.D. / compulsive eating an "addiction". I don't. It resembles addiction, insofar that the need for the "fix" of food takes over your life, costs a lot of money, and changes your behaviour around other people. However, binge eaters need to be moderate with food, they cannot be abstinent, which is the goal of treatment for alcohol or drugs. There are many features of the 12-Step programme such as gaining spiritual contentment, which is arguably useful alongside Cognitive Behaviour Therapy.

"Cognitive" aspects of therapy

-ive eating respond generally well to treatment in the hands of a properly trained therapist who understands the "secret language of eating disorders". Such a therapist will not simply provide "insights." He or she will also have the knowledge base to empower the sufferer with helpful information and guidance. By fostering control in other areas of life which are "out of control" we can reclaim our natural appetite and make eating a source of pleasure once again. Such a therapist will not simply provide "insights." He or she will also have the knowledge base to empower the sufferer with helpful information and guidance. By fostering control in other areas of life which are "out of control" we can reclaim our natural appetite and make eating a source of pleasure once again.

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“With some children watching over five hours a day of television, it is no great surprise that obesity levels, especially among children, are reaching epidemic proportions”.

Childhood Obesity & TV by H. S.

The modern lifestyle of computer screens or television is pushing us more and more to an unhealthy lifestyle resulting in a decrease in physical activity and an increase in food intake. As a matter of fact, the number of children, teenagers and adults that are overweight and obese is quite alarming.

So what are the effects of TV on your health and in particular on your child's health?

To begin with, the whole “process” of watching television is NOT an active one: Television involves sitting on a sofa and NOT moving. It is literally the laziest thing you can do. The majority of us appreciate a companion during our TV marathons, the most popular of which is junk food which contains high levels of dangerous fat, sugar and salt. We choose this companion because we are sure there will be no interruptions during our favorite show and we won't be

judged as we open that second pack of monster chips!

If television is concerned with promoting a healthy lifestyle, then where are the TV commercials promoting healthy good groups such as fruit and vegetables?

Instead, the opposite occurs and we are bombarded with advertisements promoting high calorie foods such as cakes, soft drinks, chips and pastries. With some children watching over five hours a day of television, it is no great surprise that obesity levels, especially among children, are reaching epidemic proportions.

This is not a problem that concerns simply children. Adults are perhaps more aware of the power and influence of advertising but they are just as prone to eating junk while watching TV as children. How many of us are guilty of snacking the wrong foods in front of the TV?

We can keep looking for excuses when we pile on a few extra kilos but if our concern is to protect our child's health then we should consider more closely the power of television.

Overall, whether we are guilty of snacking in front of the TV or not, we should focus on recreational activities that promote exercise and reduce time spent in front of the TV or computer.

Making positive lifestyle

changes for you and your family will dramatically improve your health and reduce the possibility of serious, life-threatening diseases:

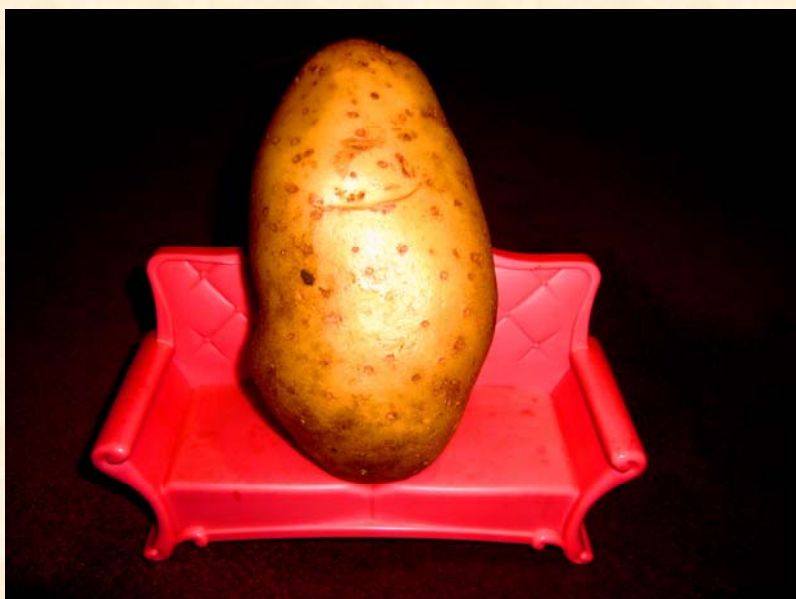
- Keep TV's out of children's bedroom
- Limit the number of hours spent watching TV
- Teach your children to be savvy consumers and let them understand that what they want is not necessarily what they need
- Make mealtimes TV-free
- Encourage alternative entertainment:

play a board game with your child, read, or listen & dance to music!

- Use an exercise or a treadmill while watching TV
- Put a fruit bowl next to you rather than sitting with a big bowl of popcorn on your lap!
- Set a good example by limiting your own television viewing!

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REALITY DOESN'T ALWAYS STARE YOU IN THE FACE

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“Mothers with EDs are very uncertain about their parenting skills, but they are good mothers who believe that parenting is hard.”

This records from the presentation delivered by Rachel BW at the Division of Clinical Psychology Special Interest Group for Eating Disorders in the U.K.

Mothers with eating disorders are a neglected group who need help for their own issues and to prevent eating disorders in their children. It is also a sizeable group, 1/3 of attendees at an eating disorder service in Hampshire were mothers or mothers to be.

Literature Review

The size of the literature points to several issues. Mothers with EDs are very uncertain about their parenting skills, but they are good mothers who believe that parenting is hard. The post-partum period is vulnerable in respect of onset of an eating disorder or exacerbation of an eating disorder. They may have unrealistic expectations of weight gain during pregnancy, weight loss after birth, routine disruptions to their normal life and attending to the needs of a child. Infants of ED mothers vomit more often, cry more and laugh less. Mothers with EDs are less organised, more likely to use food to calm a child down and are more anxious about their children's weight. Studies of infants of 1 years old indicate the following compared to non-ED mothers; more conflict more negative comments toward the children, less positive comments and more reported difficulties with breast feeding and weaning.

Mother's with Eating Disorders

by D. J.

Studies of children at 4 years of age show the following; less organised in play, more secret eating.

Overall ED mothers show the following; less likely to eat in front of the children, under-feeding children, making certain foods forbidden, verbally intrusive and controlling and less facilitating during play.

On the one hand we could see factors pre-disposing a child to develop an eating disorder. Perfectionist attitudes are invariably present. But these are women trying very hard to be good mothers who care for their children and don't want to pass on their issues to their children. Thus they will benefit from specific support.

What are the issues

The issues that challenge us invite us to go back to basics with respect to assisting mothers with eating disorders for the benefit of both them and their children. We need to address dependency issues, to consider the importance of early feeding experiences, the emotional associations that children forge with food and the development of a child's food preferences and autonomy. From these first ideas we have identified certain areas of concern which could be useful targets for intervention, transcending both parenting and eating disorder issues.

1. Reflections on the past
2. Modelling eating behaviour
3. Education
4. Developing flexibility
5. Gender
6. Who does the feeding

7. Responsiveness to emotional cues

8. How to take care of themselves

Preliminary Research

In order to test out these thoughts a pilot group was set up in Hampshire, a thematic analysis was done to pick out the issues that mothers themselves felt were important to them. These are the main concerns that mothers came up with:

1. Passing on eating disorder traits to their children

2. Fears about child development

3. Lacking confidence especially in food preparation, handling food and setting eating routines

4. Social and emotional interactions during mealtimes and how to handle children who play up

5. Their own food intake predisposed from birth, fears about weight gain and body image

6. Dealing with their own needs and meeting their expectations of mothering

7. A loss or change of identity – woven up with feeling unattractive or different

8. Lots of relationship issues, for example: The impact of their own psychological distress on the child, boundaries, the impact of the eating disorder on their ability to cope

Control issues, for example: Handling mess, who pulls the strings

Group experience

They acknowledged a need for

support but there would be practical issues such as should their children come too. They felt caught in a paradox, people were saying 'be yourself don't follow rules', but follow our rules.

A Mothers Workshop & the Results

From these initial concern themes a workshop program was developed to address certain areas. It was a closed workshop with formal rules for attendance, stated aims and a need to flat up protection issues. The format of the workshop would be to introduce certain topics and be very upfront about what the literature said about each topic without being judgemental. It would be useful to say "it is thought" or "some say". Following introduction there would be open discussion about how this affected each of them, problem solving, practical suggestions and task setting agreed by the facilitator.

To make it simple the workshops were divided into 8 subject areas [Issues and fears of passing on eating disorders traits will pervade each workshop]

Workshop 1: Interactions around food and mealtimes.

Mothers tended not to realise that anxiety around child eating issues are normal for mothers but harder for them because of their problems. They needed help with every aspect of eating behaviour and children such as the ability to tolerate mess, encouraging the child to eat lumps, the amounts of food to give, helping children take food from others, fostering healthy interest in food, eating at the same time as the child for modelling of happiness around eating and how to vary

routines. Some mothers had difficulty being in the same room as the child whilst they were eating and had a tendency to distract the child from eating, or whilst eating such as eating in front of the TV (this is not a good idea since it impedes the development of speech).

The homework was putting plastic sheets under the child's chair, and to experiment with varying routines, and eating finger foods together.

Workshop 2: The preparation and provision of food.

Mothers were predictably concerned about fats and sugars, the type of food that is part of a health diet, the ability to cook for their children and getting the amounts right.

The facilitator's impressions were that the mothers lacked knowledge, had a heavy reliance on prepared meals, high levels of anxiety and poor confidence. They needed more confidence generally in their mothering ability, too experiment and take risks.

The homework was the provision of recipes, experimenting with new foods, too give solids and then milk and too allow their child not too finish the meal.

Workshop 3: The mother's food

Many complained of having lack of time due to the demands of their children and they were unable to get support from other mums due to their own social anxiety and perfectionist attitudes and irrational belief that they would be judged as poor mums.

The researcher's impressions were that they can't take care of themselves generally; they were confused about their responsibilities and that having both an eating disorder and raising a child together was exhausting.

Homework was to get Dad to take the child to the park and ask for help from others in their lives.

Workshop 5: Self identify and Expectations

What came up in this workshop were feelings that a Mum is not a person and they have very high expectations of themselves but a poor sense of self efficacy leading to very low self confidence and feelings of hopelessness.

The facilitator's impressions

were that in becoming a parent they had relinquished their sense of self and had no interest in self care.

Their homework was to repeat the assertions that they are doing the best they can and to reality check all their negative self beliefs.

Workshop 6: The need for control

The women found it difficult to handle messy clay, and tended to adhere strictly to mealtimes. They complained of lack of time to play with their children due to the need to clean and tidy up. They

expressed worries about potty training and teeth cleaning and control of the child's diet both at home and with others.

The facilitators impressions were that the Mum's are aware of their own regidity and that they do try to balance their anxiety and respond to the child's needs yet fail.

The homework was to play with children after mealtimes and use a mirror to teach the child how to clean their teeth

Workshop 7: The overall relation-

ship between self and children, general parenting issues

In this workshop the facilitator felt that the Mum's had an overwhelming sense of being totally responsible for all aspects of the child's ultimate development, happiness and wellbeing. Further that they were therefore enmeshed with their children. They like all Mum's had the wish to do what is best for their child but this was backed by anxiety and possibly these ideas were intrusive.

No advice has been given about the homework suggested.

Workshop 8: Group debrief

The Mother's have found these sessions to be useful and they really valued the support and assistance of other group members.

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The Adonis Complex

by J. A.

Even though statistics show that about 10% of men suffer from eating disorders, a growing body of evidence suggests that men may be especially vulnerable to **Muscle Dysmorphia or the Adonis Complex**, a condition in which one obsesses about lacking muscle definition and mass, even with a muscular body.

Although a relatively new area of medical research, many experts believe this disorder is underreported. According to Katharine Phillips, MD, Director of the Body Image Program at Brown University's Butler Hospital, men who constantly seek instant results from workouts and frequently check their progress in mirrors or on scales are most at risk. Though her findings are geared to athletes, or those who want to be, others say that less-

athletic men are not immune to muscle dysmorphia and related body image problems.

This condition often leads men to use or even abuse anabolic steroids, which are potentially dangerous and can make men become much more muscular than nature ever intended. **More than a million men including teenagers abuse steroids as a way to build the 'ideal' body.**

The warning signs to look out for are:

- **Distortion of body image** (Viewing yourself as being fat, although others around you say that you are muscular)
- **Exercise interferes with other areas of life** (Relationships, job, or school suffer because of

your exercise routines)

- **You harm yourself in pursuit of fitness** (Taking steroids, tearing joints or ligaments because of over-training, or fainting because of not drinking enough)
- **Your self-esteem is based solely on your appearance** (The perfect body is the only way you can feel good about yourself)

References:

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Body Dysmorphia

by J. A.

Body Dysmorphic Disorder (BDD) is a preoccupation with an imagined physical defect in appearance or a vastly exaggerated concern about a minimal defect. The preoccupation must cause significant impairment in the individual's life. The individual thinks about his or her defect for at least an hour per day.

BDD affects as many men as women. Men with body dysmorphic disorder are most commonly preoccupied with their skin (for example, with acne or scarring), hair (thinning), nose (size or shape), or genitals. The preoccupations

are difficult to resist or control.

The person may fear ridicule in social situations, and may consult many dermatologists or plastic surgeons and undergo painful or risky procedures to try to change the perceived defect. The medical procedures rarely produce relief. Indeed they often lead to a worsening of symptoms. BDD may limit friendships. Obsessive ruminations about appearance may make it difficult to concentrate on schoolwork.

People with eating disorders may suffer from BDD. However the prevalence is unknown.

Seeking professional help to support you and help you find ways to encourage the person to seek help is a constructive way forward.

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“More than a million men including teenagers abuse steroids as a way to build the ‘ideal’ body“

Anorexia & Pregnancy by J. A.

In order to have a healthy child, the average pregnant woman should gain between 11 and 15 kg. Telling this to a person with anorexia is like telling a normal person to gain 45 kg. If you are anorexic, you may have trouble conceiving a baby and carrying it to term. Irregular menstrual cycles and weak bones make it more difficult to conceive. If you are underweight and do not eat the proper variety of foods, you and your baby could be in danger.

According to an article in the American Journal of Obstetrics and Gynecology, compared to women without a history of an eating disorder, the risk of having a preterm delivery or low birth-weight baby was 70 and 80% higher, respectively, in those with an eating disorder.

The following complications may result such as:

- Premature labor
- Low birth weight
- Stillbirth or fetal death
- Intrauterine growth retardation
- Likelihood of Caesarean birth
- Low APGAR scores
- Delayed fetal growth
- Respiratory problems
- Gestational diabetes
- Complications during labor
- Low amniotic fluid
- Miscarriage
- Preeclampsia

In addition, the use of laxatives, diuretics or other are harmful to developing babies as they take away important

nutrients essential for nourishing a baby which may lead to fetal abnormalities.

All pregnant women should receive proper prenatal care. Those recovering from anorexia or bulimia need special care. You should always take your prenatal vitamins and have regular prenatal visits. You should not exercise unless your doctor says it is okay and it is a good idea to enroll in a prenatal exercise class to be sure you are not overexerting yourself.

References:

Manzato, E. et al. (2008). Pregnancy in severe anorexia: case report. Inc, Wiley Periodicals, International Journal of Eating Disorders.

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Recovery by J. A.

Eating disorders are treatable, and lots of people recover from them. Recovery, however is not an easy process for all. For some it can take many years. Some people do better than others and make faster progress. Those who have a better prognostic work with a team of specialists in the field who help them resolve both the medical and psychological issues that contribute to, or result from, disordered eating.

About 80 percent of people with eating disorders who seek treatment either recover completely or make significant progress. Others, remain chronic sufferers or die.

Recovery is not only about the cessation of starving and bingeing behavior. It is more importantly about developing: a consistent maintenance of normal or near-normal weight, regular menstrual periods (for women) a varied diet of normal foods (not just low-cal, non-fat, non-sugar items), elimination or major reduction of irrational food fears, age appropriate relationships with family members, understanding of the process of choices and consequences and also a sense of self, plus goals and a realistic plan for achieving them, in addition to developing the capacity to move towards

building a meaningful, fulfilling, and satisfying life.

References:

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“The risk of preterm delivery or low birth-weight baby is 70 and 80% higher in those with an eating disorder.”

Personal Testimonies

“There are many invisible chains in my life; I am in bondage of obsessive thinking, material desires, confused priorities, perfectionism and food”



The following is a testimony of a Lebanese girl in her 20's who has been suffering from ED for over 5 years. She highlights the struggles she faces and how she continues to fight towards a healthy recovery:

“There are many invisible chains in my life; I am in bondage of obsessive thinking, material desires, confused priorities, perfectionism and food.

When I begin my day overwhelmed by the fear of bingeing, I become a slave, held in prison by food. Perfectionism limits my ability to relate to people; I am in bondage of high expectations for others. No one could possibly live up to my standards. Obsessive and intrusive thoughts hold me captive in my dark cell. I want to be free from slavery of unhealthy things, I want to be overcome by

the power in me. I was so used to abusing my body; it almost felt comfortable. Eating disorders had been a part of my life for so long that I had come to accept it as normal. I resigned myself to the fact that I would live the rest of my life obsessed with food and my body. I thought I would continually worry about what others thought of me. There are lots of ways for people to deal with the pain in their lives. Many choose to use drugs to numb their feelings; others obsess about sex. Alcohol is a socially acceptable way to escape pain; its even a way to gain acceptance in some crowds. Some people cling to a strict standard of religious ethics in order to find approval. Some shop compulsively thinking it's a healthy way of filling the emp-

ness. So what it boils down to is that people do all sorts of things to find acceptance and love. As for me I want to be healthy; I do not want to use or abuse or busy myself in order to void my feelings. It's tough, but I am convinced ill be happier in the end!

Lord, give me the courage to do life without a fix.”



This is a testimony of another girl in the U.K.: “I'm 15 years old. I have an older sister; she is smart and good at everything and it's hard to live up to her. I am close to my mother, she's a housewife, and my father is a businessman. They get along okay I think, they're not very demonstrative.

I've always done well at school; I suppose the teachers would call me an ideal pupil - not much trouble. I'm aiming for A's in my GCSEs, because I'm expected to go to University. Everyone says it should be a doddle for me but I don't have their confidence in myself. God, it would be terrible if I somehow failed!

It all started when I was 13 and started putting on a bit of weight and it didn't feel right. When the gym teacher remarked that I was looking a little podgy I thought right! that's it! and decided to diet there and then. I cut down on the sweets and stopped eating breakfast. It was a great feeling when those first few pounds came off and soon I was throwing away my lunch as well, I wasn't really hungry.

I guess I was always rather shy and not as popular as I wanted to be, so it was nice when people began to notice that I had lost weight - "you look really good" they'd say and "when are you going to stop?". I suppose you could say that I en-


joyed the attention, and later their concern. Fighting my hunger pangs at first was not too easy but when I started doing aerobics it took the edge off my appetite. Now, if I don't exercise I feel anxious and fat.

I don't honestly remember the point at which I started to be afraid of food. Everything I eat bloats me out and I'm terrified of gaining weight. So long as I am losing I know I'm safe. Of course people are starting to nag me now and I have become quite clever at pushing food around on my plate or hiding it in a napkin on my lap. Most of the time I pretend that I have eaten somewhere else.

I'm 40 kg now, but strange, when I look in the mirror I just see an enormous blob and my stomach feels huge. My Mum cries a lot now and I am sorry about that, she's threatening to take me to the doctor but I am certainly not going to let them make me fat again. They can't make me eat.

I am afraid to admit to myself that I am starving all the time and I'd love to let go and sink my teeth into some bread and butter. But when I manage to resist and I have won, I feel totally in control. Believe me, I'm happy just the way I am and I wish that people would just leave me alone.

Personal Testimonies


 The following is a testimony of a lady in her 30's from the U.K.:

“The year after our marriage I began calorie counting, cutting out some foods missing out meals and began speed walking. My weight then dropped to 7 stones, I felt utterly miserable with life but boosted by my weight loss and the control I had over refusing food. I worked as a Doctor’s receptionist at the time and a colleague, an older lady noticed what was happening and nurtured me out of the cycle I was in. To my delight I became pregnant.....”

But then:

“My husband spent a lot of time away from home and began working 7 days a week as well. I began eating less and less, was extremely physically active during the day, going to the gym 3 evenings a week and then discovered laxatives. I felt fantastic; I could go all day with just eating an apple or a grapefruit and drinking lots of coffee. A customer asked me if I was competing in the thinnest woman in the world competition. My weight down to 5 stones 9 lbs (Approx 35 kilos)...”

“I have become quite clever at pushing food around on my plate or hiding it in a napkin on my lap”

 The following is a testimony of how a teenage girl pretends to have eaten:


“This is what I do...I sprinkle some cereal in a bowl, and put a bit of milk in, and toss the spoon in and stir it around. Then I leave it on the side and my mum will think I have had my breakfast.”

The Anorexic Voice

“A hidden but universal experience in anorexia is the emergence of an “Anorexic Voice”

A hidden but universal experience in anorexia is the emergence of an “Anorexic Voice”. It might be a something that is heard inside a person’s head or even something that is heard from outside. At first the Voice suggests that the person will feel better if they just lose a little more weight. Then the Voice becomes louder and more critical. It may tell the person that he or she is weak for eating or for failing to lose weight. It may even threaten the person with consequences if they try to fight the illness.

Anorexics will not disclose to other people that the Voice is there; it has crept up on them very gradually and just feels like a normal part of their life. Many sufferers are surprised and relieved to know that other people with anorexia have this Voice and are controlled by it as well. Here are recurring testimonies expressed by sufferers:

 **“Yes this voice is with me all the time, it’s inside my head screaming in my ear”**

“I can hear it outside me. it is like another person is in the room with me. I thought I was going mad”

“I believed everything it told me”

“Even now years after I got better, I still hear it from time to time”

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