

For children, young people, adults, parents and other relatives

Information about

EATING DISORDERS IN CHILDREN, YOUNG PEOPLE AND ADULTS

The disorders, their treatment and prevention



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Preoccupation with diet, body shape and weight is an unproblematic part of life for most people. There is nothing inherently unhealthy about focusing on your body and weight or on food and eating as long as this focus does not push other normal, everyday things aside. It is important to be able to see when a harmless focus on the body and food becomes unhealthy.

This brochure describes eating disorders as well as prevention options and treatment by Region Midtjylland. It is not to be regarded as teaching material. It addresses children, young people and adults who suffer from an eating disorder, and their relatives.

In Region Midtjylland, treatment for eating disorders is offered at the Eating Disorders Centre, which is based in Risskov but also has a department in Herning. The centre was established in 1996 and offers specialist diagnosis and treatment options for children, young people and adults with eating disorders. From the very beginning, the Centre has also been actively involved in research, and has continually adapted its treatment in line with existing knowledge.

We hope this brochure will help you and your relatives to learn more about eating disorders, and to get treatment if necessary. We encourage you to discuss the contents with appropriate relatives, friends and therapists.

Kind regards
The psychiatric service in Region Midtjylland
Tingvej 15, 8800 Viborg
Tel. 7841 0000

WHAT IS AN EATING DISORDER?

An eating disorder is a psychiatric disorder characterised by an unhealthy relationship with food, body shape and weight.

A person with an eating disorder usually aims to be thin or attain a particular weight. To achieve this goal, the person with an eating disorder eats too infrequently and/or too little. This can lead to hunger pangs and binge eating.

People with eating disorders are also affected mentally and socially. The eating disorder leads to lack of energy, tiredness, sadness and difficulty concentrating. Most people suffering from an eating disorder retreat from friends and family – both to avoid eating situations and because they simply do not have the energy to be around other people.

The disorder can affect anyone – children, young people and adults, but girls/young women aged between 12 and 24 are particularly vulnerable to it.

Distinctions are made between three main categories of eating disorders:

- ❑ **Anorexia nervosa**
(nervous refusal to eat)
- ❑ **Bulimia nervosa**
(hunger pangs of nervous origin)
- ❑ **Other eating disorders:**
Atypical anorexia, atypical bulimia and binge eating disorder
(compulsive eating that often results in obesity).

People who suffer from anorexia are underweight because they eat too little, exercise compulsively or induce vomiting. People suffering from bulimia, on the other hand, cannot control their eating, and over-eat. In other words, during limited periods, they eat large amounts

I am so full of hateful thoughts about my weight and body shape that all I can think about is that I am disgusting, fat and ugly and that I need to lose weight.

KRISTINE, AGE 16, 9TH FORM. BMI 16.3

Apart from changes in normal eating habits, many start to force themselves to exercise and induce vomiting. This can happen after ordinary meals or after binge eating. Many also consume large quantities of laxatives and/or slimming products.

When the body does not get enough food, is exposed to compulsive exercise and is further burdened with vomiting and/or laxatives, the whole body is affected in a potentially life-threatening way.

of food. To avoid putting on weight, they often vomit afterwards.

Although anorexia and bulimia appear very different based on these descriptions, both disorders are characterised by anxiety about getting fat and an intense desire to slim.

ABOUT EATING DISORDERS

- 50% recover fully and return to a normal weight.
- 30% improve considerably, but never recover fully.
- 20% become chronically sick.

WHY DO SOME PEOPLE ACQUIRE AN EATING DISORDER?

There is no single reason why some people acquire an eating disorder. There can be many different reasons or factors which, singly or combined, lay the foundations of eating disorders. A distinction is made between predisposing factors, trigger factors and maintenance factors.

Predisposing factors

A predisposing factor is a fundamental vulnerability in the individual; this can be due to biological, social or psychological factors.

Biological factors can, for example, come to the fore in that there is a greater risk of acquiring an eating disorder if other family members have already had an eating disorder or other psychiatric disorder.

Social factors could, for example, include less favourable family conditions with lots of break-ups and stressful events, such as parents divorcing, a death, serious illness in the family, etc.

Psychological factors could, for example, be extreme perfectionism, low self-esteem and a rigid or compulsive personality.

Trigger factors

Trigger factors can be stressful events, such as:

- Long-term stress
- Breakdown of important relationships (family, friends, partner, etc.)
- Major weight loss.

Maintenance factors

Maintenance factors are of major significance in the progression of the disorder. Physical, psychological and behavioural factors can interact in different ways when someone is suffering from an eating disorder, and they can all contribute to maintaining the person's eating disorder.

When someone is suffering from an eating disorder, the trigger factors will still be present. Often, however, the

triggering issue becomes overshadowed by thoughts of food, weight and body shape. It is not only the body but also the brain that is affected by weight loss, over-exercising, binge eating, etc. In most sufferers, this effect on the brain distorts how they see and perceive their body. In other words, someone with very low weight will typically see himself/herself as chubby – perhaps even fat. This distortion is part of the disorder. Seeing yourself as fat makes most sufferers want to keep on losing weight. In most people with an eating disorder, it is evident that the very fact of losing weight activates anorexic thoughts, feelings and behaviour.

Another example of a maintenance factor is that eating too little over an extended period results in the stomach working more slowly, and the person may feel bloated. Constipation will result after an extended period of insufficient eating. If, after a period of very meagre eating, someone starts to eat normally, this frequently results in stomach aches. Because of the stomach aches, the person eats very little in order to avoid further stomach aches. Minimal eating then keeps the person in the actual eating disorder.

If a person with an eating disorder feels he/she has eaten too much, the tendency afterwards will be to eat too little or to induce vomiting. This makes the person hungry, which can in turn lead to bingeing. The result is a downward spiral which can be very difficult to break. Vomiting can affect the balance of potassium in the bloodstream. This can have a serious adverse impact on cardiac function.

A great many people with eating disorders lay down strict rules for their eating. These may be general rules or very specific rules, e.g.: “Eat less today than yesterday”, “Eat fewer calories than yesterday”, “Only eat food that looks really delicious”, “Never eat cake”. Rules like these are difficult to keep, and in the face of failure, the person is dissatisfied with himself/herself and comes up with even stricter rules. Now keeping the rules means working even harder, and even if the rules are kept, the person imposes ever-greater demands for the amount of food to be reduced, or for the food to be of a very special kind, in order to accept his/her eating behaviour.

Societal and cultural factors

Societal and cultural factors are significant, too, in the development of an eating disorder. In our culture, there is an extreme focus on the body and on looking “right” and projecting an image. The media and magazines are full of exercise programmes and diet regimes to help us slim down a little.

Over the past 50 years, bodies presented in the media as “right and beautiful” have become thinner, while our physical bodies have become larger. Thus, the media gives the impression that there is something wrong with us – that we are too chubby.

Depending on our current living circumstances, background, physical build, mental make-up and network, we may be at greater or lesser risk of developing an eating disorder. Girls and young women especially aged between 12 and 24 are at greatest risk of developing eating disorders.

Boys, too, can acquire eating disorders, but for every 10–12 girls with an eating disorder, there is generally only one boy.

” Although I **get angry and shout** at my parents **when they demand that I eat**, it is good that they do it. **I cannot give myself permission to eat**, even if I want to, because **the thoughts whirling around in my head are telling me how chubby and disgusting** I will become if I eat, or **that I haven’t earned it**, or that I **will never be able to stop putting on weight**, and that everyone will think I **am disgusting and greedy**.

JACOB, AGE 17; UPPER SECONDARY SCHOOL STUDENT. BMI 15.9

TYPES OF EATING DISORDERS

At some point in their lives, most girls/women and some boys/men feel that they are too chubby – even if perhaps they are not. Many also undergo periods of trying to lose weight by following a diet, trying to eat less or starting to exercise. And some are also familiar with losing control of their eating, and start to binge.

An eating disorder is indicated when restrictive eating (eating less than the body needs), bingeing, compulsive exercising, etc., start to interfere with the way the person functions in everyday life (in relation to studies, work, leisure and other people).

As mentioned in the introduction, there are three types of eating disorders:

❑ **Anorexia** is characterised by being underweight, usually as a result of restrictive eating. Weight loss can

also occur as a result of compulsive exercising, vomiting, abuse of laxatives, slimming pills, etc. An extreme preoccupation with food, weight and body shape is also observed. Anorexia has the highest mortality rate of any psychiatric disorder in the Western world.

❑ **Bulimia** is characterised by loss of control of eating, leading to episodes of binge eating. To avoid gaining weight, the person compensates for binge eating by means of vomiting, restrictive eating, abuse of laxatives, etc. As with anorexia, the person is usually extremely preoccupied with food, weight and body shape.

❑ **Other eating disorders** are characterised as different variations of anorexia and bulimia.

DIAGNOSTIC CRITERIA FOR THE VARIOUS EATING DISORDERS

$$\text{BMI} = \frac{\text{X KG}}{\text{X m}^2}$$

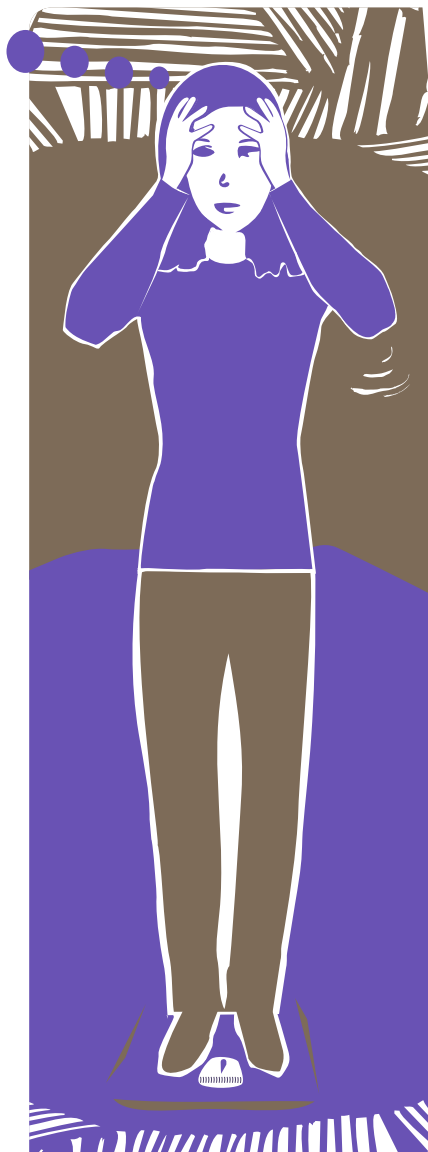
Specific criteria must be met for the doctor to make a diagnosis:

Criteria for anorexia

- ❑ **Weight loss** that leads to being underweight, corresponding to a body weight below 85% of the person's normal weight. For women, that corresponds to a BMI of under 17.5. BMI stands for Body Mass Index. To obtain the BMI, divide the weight in kilograms by the height in metres squared. For children, young people and men, the BMI boundaries are different, and the individual weight history is taken into consideration to a greater extent.

For children: Lack of physical development in the form of lack of growth or insufficient weight gain. You become underweight if you eat too little, vomit, over-exercise/exercise compulsively, abuse slimming pills, etc.

- ❑ **Distorted body image** with a resultant feeling of being too fat, and fearing obesity. Alternatively: Failure to recognise the disorder.
- ❑ **Preoccupation with weight and/or body shape.**
- ❑ **Hormonal disturbances** can lead to menstruation stopping, and loss of libido and sexual performance.



Criteria for bulimia

- Recurring episodes of binge eating. Binge eating is characterised by:
 - eating large quantities of food within a limited period of time. More than most people would eat under “normal” conditions
 - feeling that you are losing control in connection with binge eating. Inability to stop eating or inability to resist eating
- Persistent attempts to prevent weight gain by:

- Restrictive eating
- Vomiting
- Over-exercising/compulsive exercising
- Abuse of slimming pills, laxatives, etc.

- The person’s self-image is excessively dominated by thoughts about weight and body shape.

Criteria for other eating disorders

It is possible to have a mixed or atypical eating disorder if several but not all of the above criteria for anorexia or bulimia are present at the same time that the person’s relationship with food, weight and body shape dominates everyday life.

SYMPTOMS AND SIGNS OF EATING DISORDERS

The physical symptoms of being underweight include:

- Delayed puberty and absence of menstruation in girls/women
- Hormonal imbalances, with lack of production of sex hormones; this can lead to loss of libido and sexual performance
- Declining metabolism with resultant low body temperature, slow pulse, dry skin and constipation
- Generalised muscle weakness and inhibited growth
- Osteoporosis, cardiomyopathy and brain atrophy if underweight for a prolonged period

- Oedema and swelling

- Increased hair growth on the body and face.

The physical symptoms of compensatory behaviour (actions taken by the person with the eating disorder in order to lose weight) include:

- Tooth damage, inflamed parotid glands and sores at the corner of the mouth due to corrosion from stomach acid as a result of vomiting
- Sores on fingers and the back of the hand can be seen after induced vomiting
- Major fluctuations in weight of between 5 and 20 kg within short periods

- Stomach aches and catarrh in the oesophagus
- Disrupted intestinal function with sluggish stomach/bloating. Long-term use of laxatives or slimming agents can affect the functioning of the intestine
- Water retention in the body as a result of malnutrition and vomiting
- Excessive strain to the locomotor system as a result of excessive exercise
- Disruption to or possibly absence of menstruation
- Delay in or absence of sexual development
- Disturbed balance of salts, which can result in muscle cramps, disrupted heart rhythm and heart failure.
- Stubborn resistance to acceptance of being ill and needing treatment
- Difficulty in concentrating, learning difficulties, irritability and despondency. There may also be a risk of developing depression
- Changes in normal behaviour Thinking about food, eating, weight and body shape takes up so much of the person's time that everything else pales into insignificance
- Social isolation due to difficulties in eating with others or letting others see them eat
- Low self-esteem and poor self-image.

The accompanying psychological symptoms of eating disorders include:

- Increased need to be in control of everything: calorie intake, school work and exercise, and even relatives, etc.

Risk behaviour

Risk behaviour is very common and is seen in approximately 20% of young women. Examples of risk behaviour can be when a person is extremely preoccupied with thoughts of weight and body shape, or starts experimenting with diets without being overweight. For most people, this behaviour does not lead to eating disorders, but it is important to be vigilant in case this behaviour overwhelms the person.

DEGREES OF EATING DISORDERS

Eating disorders are typically divided into three degrees of severity: mild, moderate and severe. The physical and behavioural symptoms in particular are crucial in determining the degree of severity.

Degrees of anorexia

Mild anorexia is characterised by the physical symptoms being present

(low weight and hormonal imbalances), but not to any serious extent.

Moderate anorexia is characterised by stable but low weight (BMI 16–17) without serious abnormality of blood samples and no or limited purgative action (vomiting, abuse of diet products, etc.). The person's everyday life is significantly impacted.

Severe anorexia is characterised by pronounced low weight (BMI under 15), major or rapid weight loss, or extreme compensatory behaviour, e.g. stopping eating, or purgative behaviour (vomiting and abuse of laxatives, etc.) several times a day. There are usually serious physical effects, e.g. low blood pressure, irregular heart rate, potassium deficiency in the bloodstream (hypokalaemia), etc.

Degrees of bulimia

Mild bulimia is characterised by less frequent bulimic episodes and compensatory actions (1–8 times per month).

Moderate bulimia is characterised by the presence of bulimic episodes and

compensatory behaviour several times a week, but not several times a day. The person's everyday life is significantly impacted.

Severe bulimia is characterised by the presence of bulimic episodes and compensatory behaviour several times a day. There can be serious physical effects, with heart arrhythmias, potassium deficiency in the bloodstream (hypokalaemia), etc.

The more symptoms there are and the more serious they are, the greater the threat to the person's health. The presence of other mental disorders alongside an eating disorder, e.g. severe depression or personality disorders, can aggravate the person's condition.

HOW ARE EATING DISORDERS DIAGNOSED?

Normally, a GP or a psychiatrist will diagnose an eating disorder. A diagnosis is made on the basis of one or more diagnostic consultations, a physical examination, blood sample screening and an electrocardiograph (ECG). During the diagnostic consultations, the therapist focuses on the following:

- The start and development of the eating disorder
- Height and weight, in order to calculate BMI
- Restrictions and rules in relation to food and eating
- Compensation in the form of:
 - Vomiting

- Over-exercising/compulsive exercising
- Abuse of laxatives, diuretics or slimming products

- Binge eating
- Mental symptoms in the form of:
 - Anxiety about weight
 - The feeling of being fat
 - Difficulty concentrating because of thoughts about food and eating or weight and body shape.

In addition, attention is also paid to:

- The individual's upbringing, including the person's general physical and mental development

- Any previous difficulties, relationships with family, friends, schooling, etc.
- Current social circumstances, including education, work, family relationships, etc.

Finally, a broad-based physical examination is undertaken, including:

- Blood test with a view to assessing the degree to which the organs of the body have been affected by the eating disorder
- Electrocardiograph (ECG) to assess whether the heart has been affected.

DIAGNOSIS AND TREATMENT

THE EATING DISORDERS CENTRE IN REGION MIDTJYLLAND HAS FOUR SUBDIVISIONS:

- Risskov Child and Youth Outpatient Centre, offering multi-family therapy
- Risskov Adult Outpatient Centre with day hospital provision
- Risskov 14-bed ward
- Herring Outpatient Centre with day hospital provision

Region Midtjylland offers diagnosis and treatment at the Eating Disorders Centre.

In the case of children and young people under 18, relatives are involved during diagnosis of the eating disorder. In the case of adults, attempts are made to involve relatives during diagnosis.

Parents or other relatives are often able to contextualise information about the progression of the disorder to give the doctor or other therapists a more realistic impression of the person's eating disorder and how it affects the person's everyday life.

Many people suffering from an eating disorder have difficulty describing their symptoms because they find it difficult to notice and verbalise feelings and phenomena. For example, many may tend to:

- **underplay symptoms.** Perhaps they will say they exercise like anyone else, even though they do something like 500 abdominal crunches a day.
- **say they eat all their meals.** Therefore, they say they are eating normally, but they omit to mention that they avoid all food that contains fat, that they do not eat carbs, etc.
- **be ashamed that their eating is out of control.** So they cannot bring themselves to say that they regularly binge and vomit.

THE PATH TO TREATMENT

The path to starting treatment can be complicated and difficult, both for the person with the eating disorder and for his/her relatives.

Relatives can start to doubt what is “normal” and what is unhealthy, whether the person is eating a healthy and sufficient diet, or whether his/her diet lacks variety and is unhealthy. They may feel guilty about not having spotted the symptoms earlier and may also believe the person is able to get better without help, as he/she is very responsible in other areas.

Someone who is in the process of developing an anorexic eating disorder will often have difficulty recognising the disorder. Accordingly, the person will usually insist that his/her life is under control and will oppose the idea of getting treatment.

Someone who is in the process of developing a bulimic eating disorder will often feel very ashamed. Although the person wants to get well, talking about the symptoms seems so embarrassing that it is easier to avoid seeking help.

It is important for parents or other relatives to realise that someone suffering from an eating disorder could be ill for many years without personally seeking help. This is why it is very important for relatives to take responsibility for getting treatment for the person.

For example, relatives could approach:

- ❑ The person’s GP:
- ❑ The professional, anonymous advice line linked with **Aarhus University Hospital, Eating Disorders Centre Telephone 7847 3349.** The website is linked to Aarhus University Hospital, Eating Disorders Centre, and offers extensive informative material: www.spiseforstyrrelser.net
- ❑ Patient and relatives’ associations:
 - “PS Landsforening”. For relatives of people with eating disorders www.landsforening.dk
 - Relatives’ association against eating disorders and self-harm www.lmsspiseforstyrrelser.dk
- ❑ Some municipalities offer an advisory service for children, young people and adults with eating disorders – as well as for relatives.

It is important to emphasise that people with serious weight loss or compensatory behaviour in the form of vomiting and abuse of laxatives must always be examined by a doctor – either by their own GP or at a hospital.

” I had been **hiding my bingeing and vomiting for over 15 years. But when my youngest daughter asked me about the noises coming out of my mouth when I went to the toilet, I decided I had to do something about getting help.**

RECENTLY REFERRED WOMAN (MOTHER OF THREE CHILDREN)

TREATMENT

The purpose of treating people with eating disorders is to enable them to gradually develop a normal relationship with food, eating, the body and weight, and simultaneously to develop the ability to deal with any emotions, challenges, social and professional difficulties that have been significant in developing and maintaining the disorder.

In recent years, based on research results and treatment responses, extensive options have been developed for treating patients with anorexic or bulimic eating disorders.

The impact of the eating disorder on the individual's relationship with food, eating, his/her body and weight means that the basics of eating, accepting the body as a natural part of oneself and being in the company of other people have become seriously distorted.

Therefore, these basic skills have to be re-learnt. This involves extensive training to master normal eating, and long-term work on accepting oneself, one's body, and normal weight. Accordingly, treatment comprises:

- Refeeding
- Psychotherapeutic treatment
- Medication.

Refeeding is about meeting the person's need for nutrition and, if necessary, increasing weight. This is accomplished by means of dietary guidance, including preparation of a dietary plan as well as specific support with regard to eating – individually, with the person's family or in a group.

Psychological treatment can consist of various combinations of psychotherapy such as individual psychotherapy, family counselling, multi-family therapy, group therapy with different focus areas as well as teaching about the disorder – also known as psychoeducation. The purpose of psychological treatment is to provide support and guidance with a view to combating the symptoms of the eating disorder, identifying more fundamental psychological problems and promoting the development of new strategies for dealing with difficult emotions, stress and challenging mental problems.

Medication is given for severe bulimia and, in some cases, may reduce binge eating and vomiting. Medication is also used for complex physical symptoms and to treat other, simultaneous mental disorders such as depression.

Outpatient treatment

Outpatient treatment generally means the person is not hospitalised for treatment. Outpatient treatment is divided into phases. The phases are adapted to the differing needs and resources the person has at different points during treatment.

A lot of attention is paid to involving relatives throughout all phases because they are so vitally important in order for the treatment to be a success.

If the person is living at home, the parents are brought into the treatment process. For someone living away from home or for an adult, other people such as friends, a partner, spouse or other people close to the individual will usually be involved.

The therapy seeks to enable relatives and patients to regain the resources that existed before the disorder took over, to make everyday life work for everyone.

Weight loss and the often long-term, insufficient nutrition result in a number of mental, physical and behavioural complications that maintain the behaviour involved in the eating disorder. This is why it is important, early in the treatment, to give priority to the support that focuses on the patient regaining his/her physical condition with normal eating habits and weight. Concurrently with reinstating physical condition, many of the mental and behavioural symptoms associated with low weight or irregular eating patterns with compensatory behavioural forms disappear. Events for relatives/patients are offered throughout the treatment process, irrespective of the type and degree of the individual's eating disorders. These consist of presentations by various experts on eating disorders, former patients and their relatives, as well as group discussions.

Treating people with anorexia

Phase 1 – The refeeding phase

1. Dietary guidance with a view to normalising eating and weight gain.
2. Encouraging eating
 - In a group
 - During home visits.
3. Psychoeducation with a focus on:
 - What the body needs and how it works
 - The positive and negative aspects of exercise
 - The risks of being underweight and of compensatory behaviour.

4. Psychotherapy

- Individual, family based and in a group with a view to:
- Motivating and supporting the person to eat normally, to increase weight and to avoid weight-reducing methods such as vomiting, compulsive exercise, etc.
- Encouraging the person to work with underlying mental factors that maintain the disorder
- Advising and supporting relatives in the difficult process of being understanding and patient and at the same time making demands and insisting on keeping agreements that have been made.

Phase 2 – The stabilisation phase

Treatment during Phase 2 consists of the same sub-elements as in Phase 1:

- Encouraging the person to stabilise his/her weight within the normal weight range
- Encouraging the person to eat regularly and sufficiently in accordance with the dietary plan
- Encouraging the person to avoid compensatory behaviour
- Encouraging the person to eat more flexibly in relevant situations
- Working with underlying mental factors.

Phase 3 – Emerging from the eating disorder

The treatment during this phase consists of group therapy and physical therapy with a view to:

- Preventing any relapse
- Maintaining normal eating behaviour and normal exercise
- Becoming more familiar with bodily reactions

- Developing the ability to understand bodily signals
- Developing healthier and more flexible response patterns
- Modifying any inappropriate perfectionism, black-and-white thinking, etc.
- Increasing the ability to accommodate and deal with difficult emotions
- Boosting self-esteem.

Treating bulimia patients

Phase 1 – The motivation phase

1. Dietary guidance with a view to normalising of:
 - Eating
 - Weight gain.

2. Psychoeducation with a focus on:
 - The body's need for regular feeding
 - How the body works
 - Consequences of being underweight
 - Consequences of irregular and inappropriate eating (fasting, bingeing)
 - Consequences of vomiting, over-exercising and other weight-reducing methods.

3. Psychotherapy
 Individual or family-based, with a view to motivating and encouraging the person to:
 - Normalise eating
 - Avoid compensatory behaviour
 - Work with underlying mental factors that serve to maintain the disorder
 - Advising and encouraging relatives to accommodate the person's unease, anxiety, anger and powerlessness and to be able to maintain the frameworks that are vital for the patient to get well again.

Phase 2 – Group treatment for children and young people under 18

Phase 2 treatment for children and young people consists of the same sub-elements as Phase 1, but in this phase, it takes place in groups.

Group with a special focus on:

- Eating in accordance with the dietary plan
- Eating with other young people
- Eating with relatives.

Body group with a focus on:

- How a healthy body works
- Body signals
- Body exercises to get to know your own body better.

Counselling group with a focus on:

- Re-establishing and maintaining normal eating habits
- Avoiding compensatory behaviour
- Stabilising weight so that it is within the normal range
- Working on expressing thoughts and feelings verbally and not through the symptoms of an eating disorder.

Phase 2 – Group treatment for adults

- Re-establishing and maintaining normal eating habits
- Avoiding compensatory behaviour
- Stabilising weight so that it is within the normal range
- Working on expressing thoughts and feelings verbally and not through the symptoms of an eating disorder.

Body group with a focus on:

- Workings of a healthy body
- Body signals
- Body exercises to get to know your own body better.

SPECIFIC TREATMENT OPTIONS

People with an eating disorder have different individual needs just like everybody else, so there are treatment options tailored to special patient groups.

” All I think about is getting out and exercising. For a long time now, I have been going out running for about 1½ hours every day, attending a fitness centre in the evenings and doing about 500 abdominal crunches every day. **But I still feel fat and disgusting.**

JOSEPHINE, AGE 15. BMI 14.3.
HOSPITALISED

Hospitalisation on a ward at the Eating Disorders Centre

Children, young people and adult patients with severe anorexia may need to be hospitalised for their treatment.

The treatment includes three important elements:

- Support to normalise eating and weight
- Treatment with a focus on encouraging the patient to deal with ideas, emotions and behaviour underlying and maintaining the eating disorder
- Support to (re-)discover the resources and substance of life necessary for successful everyday living.

The treatment is divided into phases. The person proceeds to the next phase depending on how things go with increasing/normalising weight and reducing the anorexia symptoms.

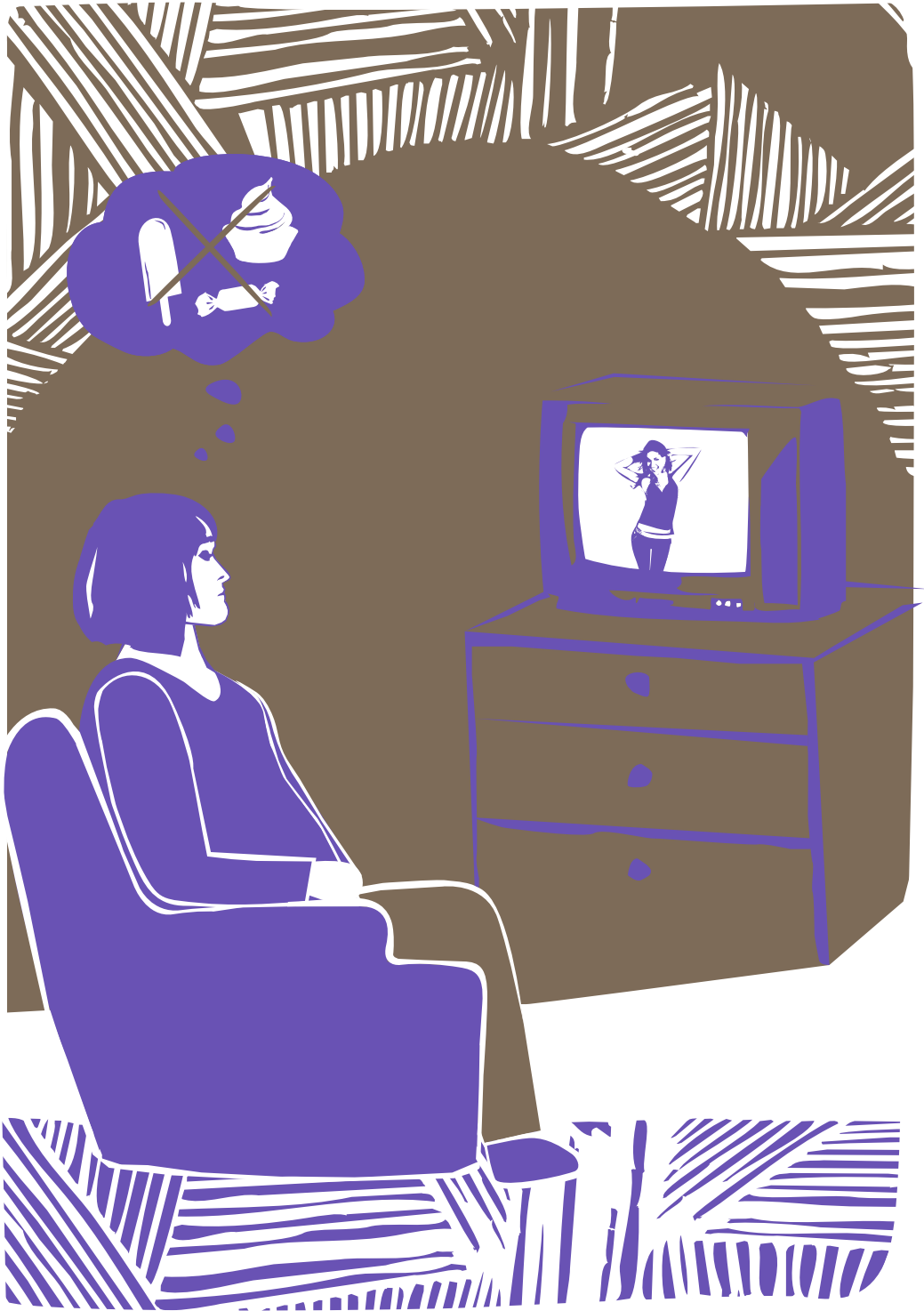
In the initial phases, the person is given help to normalise eating and reduce compulsive exercising, vomiting and other inappropriate weight-reducing behaviour. The better the person feels, the more responsibility he/she will be given, and the more the person will become involved in different activities on the ward and in planning home visits, etc.

The person will be actively involved in planning and preparing food, and will practise eating with other people, alone, together with the family and with other people outside the ward.

Everyday life on the ward is based on a fixed weekly programme, and many of the activities take place in groups. By participating in groups, the individual can re-learn functions lost because of the eating disorder – in relation to eating, body image and functioning with others.

The group activities on the ward are to support the treatment. Examples of group activities are:

- Group therapy in a counselling group
- Image therapy group
- Mastering group
- Physical therapy
- Body and movement
- Teaching group
- Eating journal group.



Relatives are involved throughout the period of hospitalisation so that, in cooperation with the person who has the eating disorder, they are able to take joint responsibility for continuing to combat the anorexic thoughts and actions in connection with home visits, subsequent discharge and ongoing outpatient treatment.

For adults:

Day hospital

For adults (age 18+) who are not responding sufficiently to outpatient treatment, more comprehensive and intensive day-hospital treatment is available in the form of three days of treatment per week for approximately 16 weeks. Afterwards, further treatment can be offered in the form of treatment one day per week for approximately 12 weeks.

Expectant and new mothers

Being pregnant and becoming a mother is a special challenge for women who have, or have had, an eating disorder. This is why special treatment provision is offered to this group in the form of home visits and group treatment. Like any other treatment for eating disorders, the focus is on normalising eating, etc., but there is an additional focus on the mother-child relationship as well as on the specific challenges associated with becoming a mother and having to take care of not only yourself but also a little child.

“ I thought the therapists were **brainwashing me with all their talk** about me being thin and this being dangerous. Now I know **I was quite far gone.**

SOFIE, AGE 29, MOTHER OF AN INFANT.
BMI 23.5

Special treatment provision for children and young people under 18

Multi-family therapy

Outpatient treatment for children/young people can, if necessary, be replaced by multi-family therapy. Here, the whole family meets other families so they can work together to:

- Create positive development in the form of weight gain for the young person
- Encourage one another to help children/young people emerge from the eating disorder
- Become aware of and work with their own difficulties
- Reduce the families' isolation, loneliness and hopelessness
- Promote hope
- Promote a secure emotional bond between family members
- Promote communication within the families
- Support the families' ability to deal with conflict.

WHAT CAN BE DONE TO PREVENT EATING DISORDERS?

It is not possible to prevent eating disorders entirely. But something can be achieved by boosting young people's mental robustness and creating social environments that recognise one another's differences.

In order to get well and avoid developing an eating disorder, it is important to have a good self-image, good social relationships, maintain normal, flexible dietary habits and a healthy relationship with the body in all its diversity.

Focusing and commenting on the young person's body, and what he/she eats and does not eat, can reinforce early symptoms. In their interaction with children, it is important for adults to model a healthy relationship with food and their body. For example, over-exercising is discouraged, as is persistently focusing on slimming and weight loss. The reason is that these activities can lead to unhealthy percep-

tions of "the right body" and incorrect knowledge of what it means to eat in a healthy manner, with appropriate quantities of food and sufficient variety. This advice is relevant to families as well as to schools and sports clubs.

If you, as an adult, suspect that someone (a young person or an adult) is in the process of developing an eating disorder, it is important to find out about his/her well-being and life circumstances.

- ❑ Is the person unhappy?
- ❑ Does something seem to be particularly difficult at the moment?

It may also be relevant to express your concerns and views on the person's relationship with food, weight and/or body shape. If you are in doubt, you could contact your GP or a professional advice line, for example (see page 12).

WHAT CAN YOU DO YOURSELF IF YOU ARE SUFFERING FROM AN EATING DISORDER?

- ❑ Get information from specialist literature (see page 12).
- ❑ Follow your dietary plan if one has been prepared for you, or find one at www.spiseforstyrelser.net.
- ❑ Be sure to eat regularly, with a good variety of foods and sufficient quantities.
- ❑ Remember: daily meals are your medicine.
- ❑ Tell your parents/relatives what you are struggling with.
- ❑ Tell your parents/relatives what support you need.

- Enlist the help of other people, even if they do not really understand what it means to have an eating disorder.
- Be aware that getting well takes time and can be very challenging – but it is possible.
- Be open about your illness when appropriate. Being open does not mean you have to tell people everything.
- Accept that, for a period of your life, you will have to make it a priority to follow a dietary plan – even if you do not feel like it.
- Accept that, for a period of time, because of being underweight/having inappropriate eating behaviour, you will not be able to cope with as many activities as before.
- Accept the fact that, underlying your disorder, there is stress that you have previously had difficulty dealing with.
- Try setting yourself small, realistic goals to work towards normal eating and restricting the behaviour that characterises the eating disorder.
- Acknowledge that changes may cause agitation and anxiety.
- Have confidence that you will be able to overcome the anxiety and recover.
- Be prepared for it to take a long time for you to recover fully.

” At some point or other, **I realised that no one else could make me well. I had to do it myself.** It was quite terrifying, but **I resolved that I wanted more out of life than being a patient.**

METTE, AGE 27; MEDICAL STUDENT

WHAT CAN RELATIVES DO?

It is important for relatives to gain as much knowledge as possible about eating disorders so they are equipped to relate to the many stressful challenges in the progression of the disorder. At the same time, it is very important for relatives to recognise that they need to take care of their own needs, too, so that they will have the necessary resources to cope with the strain.

There are special tasks that relatives – especially parents – need to undertake for a while because, without support, the person with an eating disorder will struggle to recover alone.

These tasks are a matter of encouraging the person to:

- Follow the dietary plan
- Eat regularly
- Avoid bingeing
- Avoid compensatory behaviour, such as compulsive exercise, vomiting and abuse of laxatives.

It is very valuable for the person, and for the progression of the disorder, for relatives to make an active effort to support

the treatment and to have the courage to set boundaries and be consistent.

Advice for relatives

- Do not be afraid to show your concern.
- Be patient.
- Say no when necessary.
- Get involved, but leave room for normal life too.
- Acknowledge the difficulty encountered by someone suffering from an eating disorder.
- Talk to the sufferer about symptoms, emotions, thoughts, and about life with and without an eating disorder.
- If possible, take an active part in the treatment process.
- Abide by the agreements that may help to encourage the person to get well.
- Make clear agreements, e.g:
 - Eat meals together
 - Eat meals at specific times
 - The meal must be tailored to the dietary plan
 - A meal must not last more than 30 minutes
 - Spend time together on an activity after the meal in order to:
 - avoid compulsive exercise
 - avoid vomiting
 - redirect the many thoughts that often occur after a meal about food, weight and body shape.

The background to this advice is that the person with an eating disorder may become intensely affected by anxiety and uncertainty if there are no fixed boundaries related to eating times, the amount of food, the amount of exercise, etc. Without clear boundaries, the person will often struggle mentally, eat too little, or have difficulty daring to eat in accordance with the dietary plan, etc.

Most people who have had treatment for an eating disorder want their parents/ close relatives to say a clear Yes or No with regard to diet, exercise, etc.

It is easier to relate to an external boundary than to the many ambivalent thoughts that trouble most people who have an eating disorder. One moment, the person wants to be healthy, to eat, and to put on weight; the next moment, a strong desire to be the thinnest person fills all his/her thoughts. These contradictory thoughts – which are extremely stressful for people with eating disorders – make it very difficult to act appropriately without the support of relatives. If a person with an eating disorder responds violently to requirements imposed by relatives, this must not lead to the misconception that relatives are not supposed to maintain requirements and boundaries. This support is absolutely key to the recuperation process and to re-establishing a normal relationship with food, weight and body shape.

HELP FOR RELATIVES

Most relatives need to talk to other relatives, and they need to be together in contexts where other people understand the difficulties they face on a daily basis.

Some parents are able to obtain sufficient support within the family; others find this with relatives of other sufferers, while others need special support, perhaps in the form of consultations with a psychologist. Some parents need

to be released from their work for a while in order to be able to support their child. In such cases, it is necessary to get in touch with social services.

A GP will be able to refer the parents of a child under 18 for consultations with a psychologist. It is also possible to seek help on websites, contact the advice line or relatives' associations (see page 12).



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➤ lms.dk

➤ ps-spiseforstyrrelse.dk

➤ psykiatrifonden.dk

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