Episode 051: An Inside Look At Eating Disorders: Anorexia, Bulimia, & Orthorexia

Sarah Bradley and David Puder, MD

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There are no conflicts of interest for this episode.

On this week's episode of the podcast, I interviewed Sarah Bradley, a competitive runner who has worked her way through a personal struggle with anorexia, bulimia and orthorexia.

What is an eating disorder?

One of the most important things about anorexia and bulimia is understanding that they are caused by a complex interplay of genetics, epigenetics, early development, and current stressors. They can lead to dangerous outcomes because of how the eating disorder changes both the body and the brain. Many therapists and nutritionists, as you'll hear in my conversation with Sarah Bradley, don't treat from multiple angles, and often lack empathy into this condition.

There are three main types of eating disorders we will cover here:

- Anorexia is the practice of cutting calories to an extreme deficit or refusing to eat.
- Bulimia involves purging, or vomiting, the food that has been eaten.
- Orthorexia is a fixation and obsession on eating healthy food (like only eating green vegetables with lemon juice).

Statistics:

- Anorexia traditionally lasts for an average of eight years.
- Bulimia traditionally lasts for an average of five years.
- Approximately 46% of anorexia patients fully recover, 33% improve, and 20% remain chronically ill.
- Approximately 45% of those with bulimia make a full recovery, 27% improve, and 23% continue to suffer.

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Symptoms:

In a future episode, I will go into details like the DSM V diagnosis of anorexia or bulimia. For this episode, we wanted to keep it more practical.

A patient with anorexia will desire food but choose not to eat it (unlike depression, in which the patient does not desire food). A patient with bulimia vomits their food after consumption, which can cause significant electrolyte abnormalities, seizures, and potential death.

Treating patients with eating disorders

Having empathy towards someone with eating disorders can be difficult if you are approaching it from your own experience (or lack of experience). If you are not careful, as a psychiatrist or therapist, you can actually make things worse. And if you suggest a certain diet to aid in recovery, you can push a patient into orthorexia.

The mortality of anorexia and bulimia is considerable, which is why my practice often gets patients into an eating disorder day treatment program.

In this episode we talked about what not to say. In particular, we talked about not saying things like “you have a great body, why do you want to lose weight?” Or a dietitian who told Bradley, “We will only talk about food, not emotions,” which assumes that eating disorders are a physical, and not emotional, problem.

When we looked at online chat forums to see how patients experienced their doctors when they discussed their eating disorders, these are some comments we found:

“Went to a dr to try to get referred to an Ed therapist I think last year? My bmi was 15, and I was told by the dr "you obviously don't need help. It's not like you need inpatient. You aren't at a weight that I feel it would be appropriate for me to refer you to someone. If you want to, you can go to the er for a voluntary psych hold." I was so humiliated that I just nodded and left.”

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“When my bulimia was at its worst, on the very first appointment, and right in front of my dad, the guy said, "I'm going to put you on Wellbutrin. You don't binge and purge right? Like eat and make yourself throw up." I said no because I was right in front of my dad. So the therapist said, "oh, yeah I didn't think so. You aren't overweight like people with bulimia, because it doesn't cause weight loss. I just have to ask. Also at the very beginning of my ED, my school counsellor dismissed me when I said I was trying to stop eating, because I wasn't a girl, extremely underweight, or actually not eating. I'm still pissed about it.”

“I told my therapist about my starving and then b/p-ing cycle a couple of sessions back, and then she told me after a while "do you still do your vomiting thing?" and I told her, "yeah, but maybe just 2 or 3 times a week now" and she's like "oh okay, at least that's better" and then proceeded to change the topic into something other than my "bad eating habits". Needless to say, I've never been diagnosed and I feel like my disorder isn't real.”

“An actual medical doctor said, after I told her how much weight I had lost by eating almost nothing, "At least you had the weight to lose. Let's get you on some antidepressants..." Um... ok, yeah, NO. I also told her I thought 88 lbs was a nice weight, I'm 5'2, she said that was much too low. She then added that when she immigrated to America, she weighed 88 lbs, but she is shorter. Like, WTF??”

Overall, mental health professionals need to do research into understanding the disorder and be empathic when responding to their patients.

Creating mental separation from the disorder

Although behaviors associated with the eating disorder are carried out by the patient, the confusion that the disorder is an aspect of their self (rather than a disorder or illness) can make it difficult for them to detach sufficiently from the disorder. Being able to detach from the disorder means that they can **evaluate the role of the eating disorder in their life**: both the positive and negative aspects.

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Here are some good examples from an online eating disorder toolkit to help you, as a therapist, be able to help your patients differentiate between their eating disorder and themselves:

"We've spoken about the ways anorexia can seem like a best friend to you. I wonder if you can see any ways in which the anorexia is making life harder for you?"

"Our job is to give you back some control over the Eating Disorder and keep you healthy no matter what."

"You are here because the Eating Disorder has gone too far and made staying healthy impossible for you."

Eating Disorder Patients' Interpretations of Therapists' Bodies

Clients evaluate their therapists' body size and speculate on their relationship with food. This can determine what impact this might have on the therapeutic process.

According to this article, three main themes emerged during analysis of how patients feel about their therapists' bodies:

1. They automatically look at the therapist's body.

2. They believe thinner therapists can help them more than overweight therapists. Still, "healthy looking" was as perceived better able to help than thin or overweight therapists.

3. The patients were less likely to take advice or help from therapists they viewed as overweight or too thin.

Delusional thinking with eating disorders:

In patients suffering from anorexia nervosa, disturbances of thought content may vary in severity depending on how much insight is preserved, ranging from obsessions to full-blown delusions. They often can believe food is "poisoned, contaminated, still alive or ready to attack; food may be animalized or described as a poison."

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They can even believe that their body is "under the influence of external forces, dissolving or being under attack; some patients fear that the contents of their body might spill outside or have a sense of all the body fat going down to their stomach. Delusions of sinfulness may emerge...There are patients who complain about hearing the 'voice of anorexia' or a voice that forbids them to eat."

Sarah Bradley recounts some of her experiences:

- *"I have major anxiety when being in close proximity to people with obesity while eating: I honestly worry in some nearly magical way, their eating will make me eat and potentially overeat. Often if I am exposed to someone with obesity eating, I cannot eat the rest of the day."*
- *"Not letting myself sit, sleep, or rest for too long out of fear that the lack of energy expenditure will cause automatic weight gain."*
- *"Being incredibly paranoid about the risk of weight gain from psychiatric medications, even if little to no risk exists for a certain drug. Before adhering to my current medications of zoloft, lamictal, and trazodone, I had to have several long conversations with my psychiatrist to get reassurance even though I knew those particular drugs held no serious risk for weight gain. Historically, my paranoia had been so bad, I would lie about taking medication or stop seeing my doctor altogether."*
- *"Thinking about food all day and thinking about my body all day. Literally, having these constant ruminations about what I could or could not eat and how large I must look to the point that I was falling behind in school and couldn't hold a social conversation for too long."*

Severe clinical cases of eating disorders

Often, in severe/chronic cases of eating disorders, clinicians do not even use psychotherapy until there has been a substantial improvement in nutritional standing and the patient has reached a healthier weight. One's cognitive functioning is also very low after having entered starvation, and they are often very focused on food beyond a

point of interest that comes with an eating disorder, but because the body is crying out for energy.

In these severe cases, sometimes the patient is not willing to make progress and is defiant towards weight gain or diet change, so they may need to be hospitalized.

Even though this isn't specific to psychotherapy, it is vital to recovery to reach a healthier diet and body weight (even if someone is overweight who is malnourished and has been starving themselves for rapid weight loss). And so, another big part of how to stop obsessing about food is the ability to achieve a better diet and healthier weight. For some, this means gaining weight. For some, this means maintaining weight. For some, this may mean ceasing binging and/or purging that can result in weight maintenance/weight loss.

What works to help patients with eating disorders?

In Sarah's experience, here's how she stopped thinking about food, and therefore is "90% better" after her long-standing eating disorder.:

- *Gaining weight, helped her stop thinking about food.*
- *Finding other passions in life helped her focus future goals and aspirations.*
- *Finding a good therapist that understood her and was open to learn about her perspective rather than putting on their own perspective (empathy).*
- *Taking and sticking with a medication to treat comorbid depression.*
- *Creating a stronger network of friends.*

As therapists, we can help our patients accomplish all of these things through empathic listening and encouraging to move towards healthy connections.