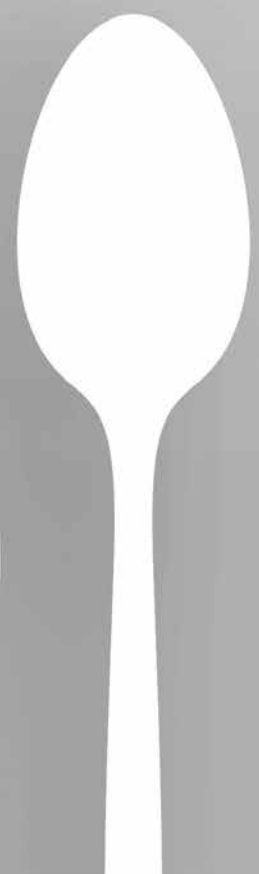




# TREATING EATING DISORDERS

The SGH Experience



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## **Dedication**

This book is dedicated to all our patients, their families and caregivers,  
without whom this book would not be possible.

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# Foreword

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Eating disorders is a unique class of psychiatric conditions, given the degree of psychological impact it can have on its patient and caregivers, the potential psycho-social dysfunctions which can result and the medical complications it can possibly bring. Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorders are the more commonly known conditions whereas diagnoses such as Avoidant/Restrictive Food Intake Disorder is a new diagnostic criteria described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), alongside Other Specified Feeding and Eating Disorders and Unspecified Feeding and Eating Disorders, which have generally replaced the previous all-encompassing Eating Disorders – Not Otherwise Specified.

Anorexia Nervosa can be broadly categorised into the restrictive and binge/purge types. Individuals generally adopt an extreme restricted intake of food which is insufficient relative to requirements, leading to significant weight loss. There is a preoccupation of one's body size and shape and its excessive influence on how one is evaluated, accompanied by an extreme fear of weight gain. Individuals with the restrictive subtype can experience behaviours such as cutting out entire food groups, obsessions with certain eating patterns, calorie-counting preoccupations and excessive exercise. Binge/purge behaviours involve regular binge-eating episodes accompanied by compensatory behaviours such as self-induced vomiting and use of laxatives, diuretics or enemas. Essentially, individuals with Bulimia Nervosa are very similar to individuals with Anorexia Nervosa, except that they must have regular binge eating episodes in the background of compensatory behaviours and their body weight is still within normal range. Individuals with Binge Eating Disorder will experience regular binge-eating episodes, but without compensatory patterns.

Why are eating disorders so uniquely dangerous? Studies have found that eating disorders have one of the highest mortality rates amongst all mental illnesses. Specifically, Anorexia Nervosa is the most deadly. And what sets this group of psychiatric conditions apart from others is the fact

that it strikes at such a young age, shockingly even in the pre-pubertal population. What used to be thought as a culture-bound syndrome or a Western-world problem is now found to be a growing feature in most Asian countries. Local studies have reported that patient demographics and psychopathology are not very different from their counterparts in the West. Given the propensity of medical complications, potential growth retardation, psycho-social dysfunctions and their lethality, early detection and treatment cannot be further emphasised. Preventive measures will definitely benefit, as with other psychiatric conditions.

This book brings together the experiences of various multi-disciplinary team members involved in the care of an eating disorder patient. We aim to provide some hard facts about the condition and what treatment entails. But most importantly, our team hopes to bring hope to the patients and caregivers in their journey towards recovery.

*Drs Ng Kah Wee and Lee Huei Yen*



# Preface

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This book is a labour of love and hard work from all members of the Eating Disorder (ED) team in Singapore General Hospital (SGH). Since 2003 when the ED services started in SGH, many patients have passed through our doors and many members of staff have participated in their treatment and recovery journey. The intention is to consolidate the shared knowledge and experience that we had accumulated through the years of treating ED in this hospital. It also began with the thought of preserving some of this knowledge and experiences in the form of a permanent record. We also felt it was important that this information be made available to the general public, practitioners, people with connection to an ED or mental health issues, in the hope that it will be helpful and useful in some way, no matter how small.

This book echoes our multi-disciplinary approach to the treatment of ED in SGH and in Singapore, from local to international patients. Chapters have been contributed by SGH practitioners in our field of specialisations – psychiatrists, psychologists, dietitians, physiotherapists, art therapists, occupational therapists, medical social workers and nurse clinicians. While individual names are attached to the chapters, it is worth acknowledging the unwritten contributions that have been made by many staff members past and present whose knowledge, wisdom and passion have all played a part in this book.

On a personal note, I must thank my colleagues and everyone in the ED programme and team for their contribution and patience in this project. I must also especially thank Dr Lee Ee Lian and Dr Evelyn Boon for offering me the opportunity to work in the ED team; Dr Lee Huei Yen and Dr Ng Kah Wee for their unstinting support for this project; Ms Dian Handayani for her help with the design of this book; Ms Erdyanna Binte Norman for all her help through my early years; Mr Goh Eck Kheng for his early advice; Mr Ian Koh and staff from

Armour Publishing; Ms Teo Shu Phay for help in editing; Ms Jacqueline Khoo; and JC Trust Ltd for their generosity in sponsoring this book.

*Vivien L H Yap*  
*Senior Psychologist*  
*Project Coordinator*

## **In Gratitude**

This book has been made possible with the kind sponsorship of  
JC Trust Ltd.

# **The Emergence of Eating Disorders and the History of Eating Disorder Services in Singapore**

*Dr LEE Ee Lian, Visiting Consultant Psychiatrist*

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## **A Brief History**

The first clinical case reports of Anorexia Nervosa date back to Richard Morton (Morton, 1694), Sir William Gull (1873) and Dr Charles Lasegue (1873). Bulimia Nervosa, as a recognised disease entity, is a relative latecomer, with Prof Gerald Russell describing it in 1979 (Russell, 1979). Binge Eating Disorder first merited a mention in the Diagnostic Statistical Manual in 1987 (American Psychiatric Association, 1987).

Western reports in both scientific journals and popular media emerged in greater numbers from the 1970s onwards. Celebrities such as singers and actresses helped to bring about greater awareness of the illnesses.

Eating Disorders (ED) as diagnostic entities emerged in Singapore in the 1980s, lagging a decade after they came to prominence in the West. Ong, Tsoi and Cheah described, for the first time, seven cases of Anorexia Nervosa (Ong, Tsoi & Cheah, 1982). Whether the late emergence and then-relatively few numbers was due to a lack of cases or a lack of awareness remains unknown and untestable.

A nascent flow of ED cases started showing up in the 1990s at the Institute of Mental Health. Other cases appeared at other hospitals, presenting themselves to the specialties, masquerading as medical or surgical problems.

Interestingly, it was in the 1990s that Singapore's GDP caught up with that of the Western world, e.g., the United Kingdom.

Certainly in the 1980s and 1990s, there were no specialised expertise or dedicated ED services. Psychiatrists had to self-educate themselves (pre-Google era) in the challenging treatment of these complex cases while the patients bravely fought to recover. In 1997, Prof Teo Seng Hock, then Medical Director of Woodbridge Hospital, had the foresight to approve the first Clinical Fellowship in Eating Disorders under the Health Manpower Development Programme of the Ministry of Health. This enabled the first Psychiatrist to be trained in ED, at the University of Toronto/Toronto General Hospital from 1998 to 1999. Since then, more Psychiatrists, Paediatricians, Allied Health Professionals and Nurses have received ED training, both in specialised centres abroad as well as in Singapore. Professional input has also been gleaned from prominent ED centres around the world, such as Maudsley Hospital, Stanford University, Toronto General Hospital/University of Toronto and University of Los Angeles.

An Eating Disorders Clinic was set up at the Institute of Mental Health in the period 1999–2000 to treat ED patients, a milestone in the early beginnings of an ED treatment service in Singapore.

In 2000, a support group for patients and caregivers was founded under the umbrella of the Singapore Association for Mental Health (SAMH). This group was started by a Psychiatrist and four intrepid recovered patients, who named it “Support for Eating Disorders Singapore” (with a tongue-in-cheek homonymous acronym, “SEDS”). The early meetings were held at the now-defunct Alexandra Psychiatric Clinic, in a scrubbed-up room which had to be on the second level because of the flooding everytime the *longkang* (monsoon drain) next to the clinic overflowed!

In 2003, after the SARS crisis had settled, the Eating Disorders Clinic was right-sited to Singapore General Hospital, in recognition of the clinical need for the integration with mainstream medicine in order to better manage physical complications and reduce mortality rates. Inpatient care and inpatient/outpatient groups were located in the midst of a medical ward at Ward 64 and thus the Eating Disorders Programme was founded, which included outpatient clinics. Referrals of ED cases were received from primary care physicians, other

psychiatrists and specialists — a secondary and tertiary referral centre for eating disorders. When the psychiatric ward was opened in 2004, the eating disorders treatment shifted there too.

With the providential support of the SingHealth and SGH leadership (Prof Tan Ser Kiat, Mrs Karen Koh, Prof Tay Boon Keng, Prof Woo Keng Thye, Prof Ng Han Seong and Prof Leslie Lim), funding support was approved for the renovation and setting up of a dedicated centre for EDs and other lifestyle-related diseases, i.e., LIFE Centre (Lifestyle Improvement & Fitness Enhancement Centre).

The Eating Disorders Programme finally found its home at LIFE Centre and was able to expand its capacity to manage more cases. SEDS was located there too. LIFE Centre's official opening was in 2008.



Since then, the treatment of ED has grown from strength to strength not only within SGH but within our nation; expanding to expert centres in other restructured hospitals (KK Women's and Children's Hospital and National University Hospital) and the private sector.

Singapore now leads the way in ED treatment and research for South East Asia, and Asia.

After due attention to the ordinary requests of physical health in respect of food, air, exercise and sleep, nothing more essentially contributes to physical development and good health than the education of the senses and the mental faculties. (*Sir William Gull, 1816–1890*)

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# Medical Complications Associated with Eating Disorders

*Dr NG Kah Wee, Director of Eating Disorders Programme;  
Consultant Psychiatrist*

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## Learning Points

- Medical complications are commonly found in individuals with eating disorders.
- Eating disorders are associated with one of the highest mortality rates among psychiatric conditions.
- Investigations are often required in the initial sessions of doctor's consults and hospitalisation may be advised under certain circumstances.
- Indicators for hospitalisation.

## Overview

Eating disorders are associated with a myriad of medical complications. The higher risk of premature death in individuals with an eating disorder cannot be overlooked. The topic of medical complications will inadvertently surface during the first consultation with the doctor and definitely in the subsequent reviews. It is one of those psychiatric conditions which requires the coordinated care between the psychiatrists and their medical colleagues. This chapter will discuss the medical complications resultant from the two main forms of eating disorders, namely Anorexia Nervosa and Bulimia Nervosa.

Medical complications which surface in individuals with Anorexia Nervosa are usually from malnutrition while those with Bulimia Nervosa tend to result from the purging behaviours and use of laxatives.



This chapter will discuss the various complications according to organ systems and the corresponding investigations the doctor may order for patients with eating disorders. In the conclusion, we include a brief section on when the doctor may recommend hospitalisation.

## **Cardiovascular System**

### ***Heart rate***

Electrocardiograms will usually be ordered by the doctor, especially in the first few visits in the clinic or the initial period of hospitalisation. An electrocardiogram is a non-invasive test which allows the doctor to look into the heart rhythm, conduction of the impulses and electrical activity of the heart.

Individuals with Anorexia Nervosa often present with bradycardia — defined as the slowing of the heart rate to less than 60 beats per minute. Severe bradycardia, usually rates of less than 40 for adults and less than 50 for children, can be an indication for hospitalisation (Hay, 2014) in view of risks of arrhythmias and cardiovascular collapses. With refeeding and weight restoration, bradycardia will usually resolve over time. Tachycardia, on the other hand, is an abnormally high heart rate. It can also be a harbinger of a much more serious underlying condition such as an infection (Krantz, M.J., 2004).

Subtle arrhythmias may also develop into serious complications in individuals with Anorexia Nervosa. Abnormal heart rhythms may even predispose one to suffer sudden cardiac death (Rotondi, 2010). Such abnormal heart rhythms can usually be reversed with weight restoration.

### ***Blood pressure and structural changes***

Low blood pressure is commonly found in individuals with Anorexia Nervosa. It may be a sign of dehydration secondary to restriction of fluid intake or due to purging practices. Individuals with Anorexia Nervosa may also suffer from decreased heart muscle mass and cardiac output, pericardial effusion (fluid accumulation around the heart) and structural valve abnormalities. The heart structure may be altered due to the starvation, resulting in thinning of the heart walls. With

the heart affected structurally and electro-physiologically, individuals with Anorexia Nervosa may not tolerate changes in their postures well. Normally, when we change our position from a sitting to a standing position, the heart will be able to detect the change and compensate automatically to maintain the blood pressure. However, this may not be the case for an individual who is severely malnourished from an eating disorder. Postural drop in blood pressure may give rise to complaints of feeling giddy or faint when they change from a sitting to a standing position. The doctor may want to measure the postural changes in blood pressure and heart rate during the clinic visits as well as during hospitalisation. The person may also be referred to the cardiologist for further monitoring and evaluation.

## **Gastrointestinal System**

### ***Gastric and intestinal motility***

Gastric dilatation or distension can be a complication in individuals with Anorexia Nervosa resulting from severe binge eating. Gastric bezoars (a mass of indigestible material) can result following ingestion of a large amount of fibre in a situation of slowing gastric and intestinal movements. This can lead to medical emergencies, i.e., obstruction and gastric perforation. Superior Mesenteric Artery syndrome (SMA) is a complication in individuals with Anorexia Nervosa who have experienced sudden weight loss. Part of the small intestine becomes entrapped between the major arteries in the body resulting in obstruction and this syndrome is characterised by bilious vomiting (vomiting of bile), abdominal pain after meals and weight loss.

Severe chronic starvation may lead to dysregulated hunger and satiety cues. Slowing of intestinal movements can also contribute to symptoms of bloatedness and constipation (Chial, 2002). Abuse of laxatives may also lead to intestinal obstruction and dilatation while self-induced vomiting predisposes the person to gastritis, oesophagitis and in some severe cases, oesophageal rupture. Dysphagia and heartburn are also common manifestations in people with repeated self-induced vomiting. An upright abdominal X-ray may be necessary to rule out possible abnormal bowel distension and perforation. Gastrointestinal

symptoms in people with eating disorders can be difficult to treat and may even interfere with the treatment recommendations of the team, as they can sometimes be regarded as justification for refusing an increase in oral intake.

### ***Others***

Other gastrointestinal related complications include non-inflammatory parotid (a salivary gland on each side of the jaw) swelling, acute liver damage and dental enamel erosions, especially if self-induced vomiting is one of the prominent behaviours. As part of the initial workup and subsequent follow up, the doctor may want to monitor the liver enzyme levels. Elevated levels of liver enzymes can occur in weight loss and fasting situations and are commonly seen in people with body mass index (BMI) of less than 12 kg/m<sup>2</sup>. In fact, the refeeding process can also cause a transient elevation of the liver enzymes. A liver ultrasound scan may be ordered if the liver enzymes continue to rise. Patients and caregivers will be naturally alarmed as it seems that the liver enzymes will be raised in both the setting of starvation and refeeding. Often with time, such levels will gradually normalise with weight restoration.

### **Neurological Complications**

Brain atrophy, which is defined as reduction in the volume of brain matter can occur in individuals with Anorexia Nervosa. Magnetic resonance imaging (MRI) can reveal findings such as abnormally enlarged brain ventricles and decreased grey matter. Mental functions such as judgement, attention and memory can be affected when structural changes occur. The worrying long-term consequence of irreversible brain change can potentially happen. Weight restoration may not bring about an immediate reversal of such a complication. Some of the consequences we see in patients with extreme starvation include poor concentration, inattentiveness and forgetfulness, leading to adverse effects on their school or work performance.

## **Skeletal System**

### ***Bones***

Bone accrual occurs during childhood and adolescence and peak bone mass is usually attained when one is in his/her mid-20s. Low bone density often affects individuals with Anorexia Nervosa, placing them at risk of osteoporosis and subsequent fractures. This is especially so for females who had missed several consecutive menstrual cycles and for males who had lost a significant amount of weight. People who are afflicted with the disorder before or during adolescence have a higher risk of long-term consequences compared to people who develop the disorder when they were older. This is because people who became ill younger may never get the chance to reach their peak bone density. The low bone density is secondary to the increased bone resorption and decreased bone formation. So far, low BMI and longer duration of amenorrhoea have been identified as predictors of low bone density (Mehler, 2011). Unfortunately, we have seen some patients who were athletes before but because of the disorder, suffered injuries and fractures at a young age. Fractures at major joints such as the hip can result in serious permanent gait disturbance and mobility problems.

Males with Anorexia Nervosa may also suffer from osteopenia and osteoporotic changes. Predictors of low bone density in males are lower BMI and longer duration of illness. Low testosterone levels also predict lower bone mineral density. Males with Anorexia Nervosa seem to have lower bone mineral density than their female counterparts (Mehler, 2008).

The doctor may order dual X-ray absorptiometry (DEXA) scan to examine the density of the bones. A temporary abstinence from exercise will be required for most underweight patients, until the body weight has been restored. Exercise, especially high impact sports, should be avoided to prevent injuries and fractures. Although it can be very difficult to convince one to stop the exercise, and usually the cessation is abrupt, we often impress upon our patients and their caregivers the physical impact the eating disorder had already caused.

## **Endocrine System**

Individuals with eating disorders often are found to have deranged thyroid function tests results. Thyroid hormone replacement is usually not required and in fact should be avoided. With nutritional rehabilitation and weight restoration, these hormone derangements will resolve. Most of the time, the psychiatrist will continue to monitor the thyroid hormones over the next few months and these levels will generally normalise.

Hypoglycaemia (low blood sugar level) can occur in individuals with Anorexia Nervosa. Chronic starvation, weight loss and excessive exercise can lead to disruption in regulation of glucose and glycogen stores in the liver. Monitoring for hypoglycaemia is also important in the initial stages of hospitalisation and refeeding. Patients can sometimes develop coma due to severe hypoglycaemia.

There has been association between eating disorders and Type 1 diabetes mellitus, wherein patients are required to control their sugar levels closely using dietary means and insulin injections. Studies have shown that patients with Type 1 diabetes mellitus are at higher risk of developing abnormal eating behaviours such as restrictive dieting, binge eating and purging behaviours. Patients may sometimes omit the insulin dose in order to trigger a hyperglycaemic state and loss of glucose via the urine, as a form of purge behaviour (Goebel-Farbri, 2009). Such persons are at higher risk of developing serious complications from poorly controlled blood sugars, such as neuropathy (damaged nervous system), nephropathy (permanent kidney damage), impaired vision and even death.

## **Blood**

### ***Haematological***

Bone marrow suppression may occur in individuals who are severely underweight or who have been chronically malnourished. The composition of red blood cells, white blood cells and platelets may be affected in individuals with Anorexia Nervosa — there can be findings of low cell counts in blood investigations. Patients may complain of physical symptoms such as shortness of breath, lethargy and appearance of

bruises. There should be a lower threshold for suspicion of an infection in an underweight patient (Brown, 2005). The doctor may arrange for a full blood count at the first visit, and from time to time subsequently.

### ***Electrolytes***

Electrolytes are the essential chemicals or nutrients in the blood which ensure normal functioning of the body, for example, in muscle contraction and conduction of electric impulses in the nervous system. Some examples of electrolytes include calcium, potassium, sodium and phosphate. When a person is severely malnourished or has recently purged, these electrolytes may become deranged and present at either very high or low levels in the blood.

In mild cases, a person may experience tingling sensations, weakness or may not even experience any physical discomfort. In severe cases, persons may experience palpitations, chest pains and even face the risk of seizures and lapsing into comas.

Refeeding syndrome is a medical emergency. It usually occurs in the early stages of hospitalisation when there is an increase in food intake, characterised by falling trends of serum phosphate levels. One study has quoted the risk of refeeding to be highest in the first seven to 10 days of hospitalisation when reintroduction of food has been started (Kameoka, 2016). Hence for such reasons, the doctor may need to monitor the serum electrolytes very closely in the early stage of hospitalisation and blood tests (such as renal panel and serum phosphate, calcium and magnesium) may even have to be repeated daily. Physical symptoms such as swelling of the lower limbs, chest discomforts and shortness of breath are warning signs indicating medical instability and the indication for an immediate review by the doctor.

### **Dermatological**

There may be several dermatological manifestations of malnutrition and dehydration. Dry skin and poor skin integrity may give rise to frequent cracks and splits in skin. Vitamin C deficiency can also give rise to oral stomatitis an inflammation of the mucosal membranes. Decubitus ulcers, or pressure sores, may develop over prominent bony structures such as the buttocks, hip and back. Acrocyanosis, a bluish discoloura-

tion of the skin, may occur at the extremities such as tips of fingers and toes. This reflects the shunting of blood to the central of the body, especially under cold conditions, in order to conserve heat loss. Carotenemia, which is the orange discolouration of the skin due to an excess in the beta-carotene ingested, may be a common finding in patients who restrict diet intake to only fruits and vegetables. We had noticed this phenomenon in patients whose diets comprised exclusively of carrots and sweet potatoes.

Lanugo hair may also be found on the face, nape of the neck and upper limbs of low body weight patients. This is the fine downy hair often seen in babies. Russell's sign refers to the formation of skin thickening over knuckles and back of hands of individuals who self-induce vomit using their fingers. Bruises may also be commonly found in individuals with Anorexia Nervosa due to low platelet count.

## **Gynaecological and Pubertal Development**

Individuals with Anorexia Nervosa may have delayed puberty and amenorrhoea. Generally amenorrhoea is defined by the absence of menses for three cycles. Delayed puberty is generally defined as the absence of secondary sexual characteristics (for example, development of pubic hair, enlargement of breasts) by the age of 13 years old for girls and 14 years old for boys (Abitbol, 2016). Generally, patients who suffer amenorrhoea are the ones with low BMI, low caloric intake and excessive exercise. Even normal weight individuals with Bulimia Nervosa and Binge Eating Disorder may have menstrual irregularities from binge episodes and purging behaviours. Malnutrition can also result in lower sex drive and sexual dysfunction such as lowered libido and higher sexual anxiety. Sexual consequences of starvation apply to males as well, translating into a decrease in sexual interest and masturbation.

Use of hormonal therapy (oral contraceptive pills) to aid the restoration of menstruation cycles is generally not useful in individuals with Anorexia Nervosa. However, there may be a role for hormonal therapy for individuals who are severely underweight. It was observed in a study that such individuals had an increase in their bone density when given oral contraceptives compared to their counterparts who were not given any (Klibanski, 1995).

With regard to pregnancy or infertility, the rates of occurrence of these among patients who are in recovery from Anorexia Nervosa are not lower compared to the general public. It should be highlighted that such patients may even report higher rates of unplanned pregnancy compared to the average public. This is because pregnancies may be missed in a background of long standing irregular menstrual cycles. Contraception should still be advised if the patient is sexually active. Individuals with Bulimia Nervosa and Binge Eating Disorder are at higher risk of infertility and miscarriage. They are also more prone to gaining excessive weight during their gestational period.

During the recovery, patients may experience delay in the return of menstruation. Generally, if the return does not happen for six months, even as weight restoration has been achieved and maintained, referral to the gynaecologist may be warranted. Investigations such as an ultrasound scan of the reproductive system may be required to rule out other causes of amenorrhoea.

## **When the Patient Needs Hospitalisation**

Given that eating disorders can be associated with such medical complications, some which can be potentially life threatening, the doctor may advise for a period of hospitalisation for various reasons. Discussing when hospitalisation is required and setting limits and attainable treatment goals should be topics regularly visited during the doctor's reviews. The table below briefly lists some of the indicators for hospitalisation.

### ***Indicators for hospitalisation***

- Body mass index is too low
- Significant postural drop in blood pressure or raised heart rate
- Hypothermia
- Irregular heart rates: either too high or too low
- Low blood sugar
- Significant electrolyte imbalances (for example low levels of potassium, calcium, sodium)
- Raised liver enzymes



- Significantly low red blood cells, white blood cells or platelets
- When patient is suicidal or agitated
- When outpatient management is not yielding weight gain

*Source: Hay, 2014*

## **What Is Discharge Against Advice?**

We have come across parents or patients who had requested for discharge against advice or discharge at own risk (AOR). Some of the possible reasons for such requests include patient's reluctance to continue with treatment, when dietary recommendations have increased or when privileges (for example, meal outings, home leave) have been revoked.

We will advise that should such situations arise, speak to the doctor in charge of the patient before making the decision to discharge the patient. Patients are often required to be hospitalised for reasons such as need for medical monitoring, restoring weight and re-establishing near normal eating behaviours. Sometimes, their mood may still be poor and they may be at risk of self-harm or even suicide. Hence, before making such decisions, always speak to the doctor to have an understanding of the situation and why the patient may be requesting for discharge earlier than advised.

I often ask parents in such situations if they feel they are ready to care for and refeed the patient. If they are not, it will be better to continue the hospital stay. Most parents will agree that even getting the patient to seek treatment at the beginning is faced with resistance. Hence requests to terminate hospitalisation or treatment are not unexpected. Being prepared for such tricky situations and remaining focused on recovery is the best one can do as a caregiver.

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# Recovery from Eating Disorders

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## Learning Points

- Eating disorder (ED) is a serious mental illness having physical psychological and social impacts.
- Treat the illness separately from you to get rid of it. (You are not the ED, you have an ED; just like you are not diabetes, you have diabetes.)
- Full recovery from ED is possible.

## Overview of Eating Disorders

*Anorexia Nervosa* — The person takes in very few calories, as there is an intense fear of weight gain despite being significantly underweight, or there is an increased level of activity or behaviours to maintain the low weight. Anorexia Nervosa has two types: restrictive, where the person mainly restricts intake; and binge-and-purge type where the person will binge and then resort to purging.

*Bulimia Nervosa* — The person is of normal weight or overweight and resorts to bingeing food, and then compensates by purging or other compensatory methods (excessive exercise, use of laxatives or other products or drugs/alcohol) to control weight and body shape.

*Binge Eating Disorder* — The person is usually overweight and can eat an excessive amount of food in a short period of time with a feeling of loss of control over eating, and does not compensate by any method. However, this behaviour can be quite distressing to the individual.

People with ED usually have a dissatisfied body image, and often swing from one ED to another, or sometimes have an overlap of symptoms. Females might have no menses (primary amenorrhoea — patients have not had menses before; or secondary amenorrhoea —

patients have had normal menses before the ED started). Boys might have low testosterone levels.

For other ED diagnoses, refer to DSM-5 classification criteria for eating disorders or ICD-10 classification methods for eating disorders.

## **Who Develops EDs?**

Both males and females develop ED, however, girls are 10 times at a higher risk than boys. Girls usually strive for leanness, whereas boys strive for leanness and a muscular body shape. EDs start during the teenage years usually, although some develop it in their twenties or thirties. If left untreated, the illness will continue throughout the life of an adult.

## **Warning Signs You Should Watch Out For**

The first step to recovery would be to acknowledge that you have an ED so that support and treatment can be sought. Seek help early if you find yourself displaying any of the below tendencies:

1. Obsessing/thinking and devoting a significant amount of time on your weight/eating/appearance so much that it interferes in your routine or it starts affecting you physically, mentally or socially
2. Restricting intake of foods, omitting foods and ‘eating clean’, skipping meals, reducing food portions, doing excessive exercise, repeatedly checking your body in the mirror, snacking and skipping meals, bingeing, over-eating, using compensatory methods like vomiting, chewing and spitting out food without swallowing, using various slimming products or laxatives in an attempt to control weight or to attain the ‘ideal body image’
3. Being physically weak and tiring out more easily, unable to squat due to loss of power in the proximal thigh muscles. Hair loss, feeling giddy, collapsing at home, or having any other symptoms that are unusual for you

4. Experiencing mental fatigue, ruminating or being fixated on certain things and not being able to see beyond these, feeling fat, counting calories, checking the body, being ambivalent about eating, feeling depressed or anxious, or having any symptoms out of the norm, failing in your academics, unable to meet with family and/or friends for meals as you are worried about what to choose to eat, withdrawing, and feeling isolated, irritable, angry and having tension with family and/or friends

(Please refer to the chapter on Complications in Eating Disorders for other warning signs for patients and caregivers to detect the onset of an ED and indication for seeking support and treatment.)

## **Causes and Risk Factors for Developing EDs**

EDs are usually a result of a multitude of causative and risk factors due to the interaction between genetic and environmental factors manifesting in the illness. The same factors are also responsible for relapse after the recovery of ED. A patient with an ED usually goes through several relapses before attaining complete recovery.

*Biological factors* — Family history of ED, dieting, puberty, certain physical illnesses where weight and diet need to be watched (e.g., Diabetes Mellitus).

*Psychological and social factors* — Stress at work, interpersonal difficulties with family and friends, low self-esteem, isolation, maintaining a sense of control in their life only through food or weight, abuse or neglect of any form, loss of someone or something cherished (e.g., relationship, abilities, etc.), bereavement, entrapment in life circumstances, distressing life events, certain cultural practices where fasting is observed, engaging in certain professions where a certain weight and diet are required (e.g., dancers, actors, models, athletes), certain psychological conditions (e.g., anxiety disorders, depressive illnesses and addictions), and anankastic (obsessive-compulsive) and perfectionistic traits that predispose one to develop an ED, irresponsible reporting in the media portraying an

excessive emphasis on thinness, social and peer pressure to be ‘slim’, family and significant others commenting on weight, shape or size.

## **Factors Responsible for a Relapse**

Factors specifically responsible for relapse include resistance to working with the care team, taking sides with the ED and justifying ED behaviour, patients and caregivers becoming complacent about the treatment or premature termination of treatment, and defaulting from treatment.

Relapse after full recovery is the rule rather than the exception in ED. A patient might have several relapses before attaining full recovery.

## **Recovery**

Complete recovery from ED is possible. Complete recovery means having an optimally and healthily balanced diet to maintain all normal functions of the body, and being free from all disordered thoughts and behaviours of the ED. Seek help as soon as possible to maximise recovery chances. Understand the illness and work with the care team as long as is needed to get rid of the illness. Identify relapse indicators and seek help at the earliest if there is a relapse.

## **Full Recovery Versus Partial Recovery**

Fully recovered patients have Body Mass Index (BMI) within normal range, with no behaviours or thoughts of the ED. Partially recovered patients have some symptoms of the eating disorder interfering in their everyday functioning (Bardone-Cone et al, 2010).

## **What Is Recovery from ED?**

Recovery from ED is both physical and psychological. Physical recovery is getting back to minimum healthy weight range, attainment of normal and regular menstruation for girls and normal testosterone levels for boys. Recovery is cessation of the abnormal eating behaviour and having an optimal and balanced diet. Recovery is a full return of all the organs

to normal functioning as confirmed by normal blood investigations, bone scan and ECG (Electrocardiogram) reports.

Psycho-social recovery occurs when there is cessation of the thoughts and behaviours of the ED (obsessing about food and weight, body checking, taking control of others food, arguing and bargaining around meal time, eating secretively or restricting/skipping meals, bingeing, purging, ED-induced exercise urges, stealing, obsessive about calorie intake, self-harming, using other compensatory methods to lose weight). Accepting body image and realising that everyone is unique with his or her own strengths and weaknesses. Getting back to studies, work or routine, and socialising with family, friends and significant others also signal recovery.

### **Time to Recovery**

ED can be a chronic debilitating illness with both physical and psychological implications with multiple facets to it. Hence, it is important to address all the important issues in recovery. The three main EDs are anorexia, bulimia and binge eating. ED might last longer than expected, but aggressive treatment contributes significantly to weakening the disease state and death rate from the eating disorder in the long-term (Strober, Freeman, and Morrell, 1997). A larger number of patients with Bulimia Nervosa achieve full and partial recovery compared to Anorexia Nervosa (Herzog et al, 1993; Herzog et al, 1999) by around seven years of the illness. A significant number of patients remained ill six years after first admission for Anorexia Nervosa, and the restricting type of Anorexia Nervosa showed earlier recovery compared to the purging sub-type (Herzog et al, 1993). Patients with long term Anorexia Nervosa have recovered some time after 20 years of the illness (Lowe et al, 2001).

### **Predictors of Outcome in ED**

Poor prognostic factors included impulsivity, severity and chronicity (Fichter, Quadflieg, and Hedlund, 2006), late onset and longer duration of illness, previous psychiatric inpatient treatment, interpersonal

difficulties with the family and problems in personality before the illness develops (Morgan and Russell, 1975). Late onset and longer illness duration and previous psychiatric inpatient treatment were not specific outcome predictors (Le Grange et al, 2012; Le Grange, Accurso, Lock, Agras, and Bryson, 2014). Interpersonal difficulties with family and obsessive personality were also associated with poor outcomes (Morgan and Russell, 1975). Comorbid psychological disorders including disorders of the autistic spectrum increase the death rate in Anorexia Nervosa, and co-morbid depression had poorer outcome in Bulimia Nervosa (Berkman, Lohr and Bulik, 2007).

Improvement early on in therapy indicated a better outcome of Bulimia Nervosa (Agras, 2000). Severe Anorexia and Anankastic personality respond best to Family Based therapy (FBT), which is a behavioural mode of therapy (Le Grange et al, 2012; Le Grange, Accurso, Lock, Agras, and Bryson, 2014). This therapy is more suited to patients up to the age of 19. When parents take control over the behaviour of the ED, that is when patients respond best to FBT and progress towards remission (Ellison et al, 2012). Patients who have received FBT show good outcome, if they have gained weight early on in FBT (Le Grange et al, 2012). Patients who recovered at end of treatment and maintained recovery had higher BMI, fewer binge/purge behaviours, greater motivation to improve, decreased body image issues and co-morbid illnesses, and improved interpersonal relationships and fewer family issues (Lock, Couturier, Bryson and Agras, 2006; Vall and Wade, 2015).

## **What Should You Do in Order to Recover?**

In order to recover, you need to first acknowledge the disorder and seek help. An ED is a serious mental illness which impacts the body, mind and social functioning. Stop blaming yourself, and stop self-recovery. It is essential you seek help from professionals. We, at Singapore General Hospital (SGH), have a specialised ED service which involves a multi-disciplinary Team (MDT) of professionals with specialised interest and training in ED to look after you. Members of the team include



psychiatrists, psychologists, art therapists, occupational therapists, dietitians, medical social workers and physiotherapists. If you are worried that you might have an ED, book an appointment to see us.

If you are diagnosed with an ED, attend the appointments regularly and commit to the treatment plan if you want to get rid of the ED. Follow the meal plan, exercise and activity advice from the professionals. If you are given medication, take it regularly, and if you have any doubts about the treatment plan or any concerns regarding the ED, discuss with the professionals.

Patients themselves felt that their own willingness to recover as well as having a separate identity from the ED helped them recover. Motivation to recover also played a part (Keski-Rahkonen and Tozzi, 2005). Patients felt that with improved self-regard towards their body and the ability to develop better problem-solving skills helped them to recover from eating disorders (Patching, and Lawler, 2009; Vanderlinden, Buis, Pieters, and Probst, 2007). Patients felt support from their treatment team, family and significant others in their life, along with better relationships with others played a part in their recovery (Fichter, Quadflieg, and Hedlund, 2006). Adolescents recovering from Anorexia Nervosa particularly valued the treatment and social support system around them as contributing factors to recovery (Nilsson and Hägglöf, 2006).

## **What Happens at the First Appointment and Thereafter?**

At the first appointment, a psychiatrist will see you and take a thorough history of how the ED developed, the symptoms, its progress, its causes, and its impact on your physical and psychological health and social life. Then there will be a physical examination, followed by investigations that the doctor will ask for. You and your parent/caregiver will be asked to come into the room and you will be given an explanation of your diagnoses, complications of ED and how you need to manage these at home. You will be referred to a dietitian and/or psychologist or medical social worker. These Allied Health professionals work as part of the team and play various roles in helping you recover from the illness (as explained in other chapters of the book).

## **Even If I Complete the Treatment Entirely, Is There a Chance That I Can Still Continue to Be Ill?**

There is a small group of patients that continue to have residual symptoms despite having received the full treatment. Consult your doctor to lead a good quality and meaningful life with residual symptoms.

### **Post-Recovery**

It has been found that certain obsessive concerns with order and exactness continue to exist in the post-recovery phase of Anorexia Nervosa.

### **“Pearls of Wisdom”**

- You can recover completely from ED.
- Acknowledge the disorder and seek support and treatment.
- The patient suffering from the illness might not have any insight; it is therefore the duty of family, friends and significant others to support and help the patient to seek treatment as long as is needed.
- Untreated EDs have the highest death rates amongst all psychiatric illnesses.

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# **Dietary Management of Eating Disorders**

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## **Nutritional Knowledge of Eating Disorders Patients**

Patients with ED generally feel that they are well-versed and knowledgeable about all matters related to nutrition. In reality, these patients have a poor understanding of their nutritional requirements and are usually victims and believers of common myths and misconceptions surrounding food, nutrition and fitness. One common misconception is that fasting or skipping meals is effective for weight loss. Contrary to this claim, severely limiting caloric intake can make our bodies go into famine mode and start adapting to restricted caloric intake and use fewer calories to perform daily activities. It is common for ED patients to believe that a ‘healthy’ diet should exclude nearly all dietary fats and red meat as they think that red meat is an unhealthy food choice. Currently, high protein, low carbohydrate diets like the Paleo diet and the Atkins diet are popular weight loss regimens amongst ED patients. It is not surprising to see many ED patients avoid eating rice, bread and noodles. Today, the typical ED patient aims to avoid high-fat foods, red meat and carbohydrate foods and views food as either ‘good’ or ‘bad’.

## **The Body’s Need for Good Nutrition**

We live in a ‘weight obsessed’ world, in which many people especially ED patients have lost sight that the purpose of food is to provide essential nutrients necessary to support life and health. In order for our bodies to function properly and stay healthy, it is important that we follow a well-balanced and nutritious diet. Food provides our bodies

with energy, protein, essential fats, vitamins and minerals to live, grow and function properly. We need a wide variety of different foods from various food groups to provide the right amounts of nutrients for good health. Nutrients are the nourishing substances in food that either provide energy or promote the growth and proper functioning of the body. In addition, nutrients aid in regulating body processes such as heart rate, digestion and supporting the body's optimum immune system. Restriction of food intake leads to serious health consequences. Physical changes include hair loss, gastrointestinal discomfort, decreased heart rate and cold intolerance. It is very common to see ED patients wearing sweaters even when it is warm. Cognitive changes include: poor concentration, impaired comprehension and lack of alertness. As a result, school academic performance will be affected.

Carbohydrates, proteins and fats are considered macronutrients as our bodies require them in substantial amounts for normal function and good health. There are three main types of carbohydrates: starches, fibre and sugars. Starches are found in rice, bread, noodles, cereals and grains, starchy vegetables and legumes (e.g., beans and lentils). Sugars can be found naturally in fruits, milk and honey and in processed food such as soft drinks, cakes, candies, jams and other sweetened foods. Carbohydrates are the body's main source of energy as they provide fuels for the brain, kidneys, heart, muscles and central nervous system. Fibre improves digestive health, helps one feel full and lower blood cholesterol levels. A carbohydrate-deficient diet may cause headaches, fatigue, weakness, difficulty concentrating, nausea, constipation, bad breath and vitamin and mineral deficiencies. Protein is the main structural component of all the body's cells. It is made of units called amino acids which are essential for growth and repair of cells. Animal sources, such as chicken, pork, fish, beef and eggs provide a complete source of protein; containing all essential amino acids. On the other hand, plant sources, such as vegetables, beans, legumes with the exception of soybean and products are incomplete protein; lacking one or more of the essential amino acids. Most fruits contain either no protein or a negligible amount of the nutrient.

For many years we have been told over and over again that fat is unhealthy and most people actually do believe it. Therefore, it is very common for ED patients to have strong fear towards dietary fat. Most

patients need to be reminded repeatedly that fat is a necessary nutrient, as it provides essential fatty acids and facilitates absorption of fat soluble vitamins. Unsaturated fats are considered to be healthier than the saturated fats. One subdivision of unsaturated fats, the omega-3 fatty acids and omega-6 fatty acids are particularly important as they cannot be synthesised by the body, but are vital for health and bodily function. Omega-3 fatty acids help protect the heart and are likely important for emotional and mental health as they maintain the structure and functioning of brain cell membranes, nerve fibres and neurotransmitters.

Minerals and vitamins are essential for the maintenance of a healthy body. ED patients are more likely to have mineral and vitamin deficiencies due to the poor quality of their diet; particularly minerals such as calcium. Calcium is a primary nutrient in the development of strong bones and teeth, the maintenance of muscle tone, control of blood pressure and function of the peripheral and central nervous systems. Chronic calcium deficiency leads to osteopenia, and eventually osteoporosis. Phosphate, another mineral obtained from milk, dairy products, spreads and cereals is essential for bone development and energy release from food. A range of vitamins is needed to regulate body processes and allow growth and reproduction. For example, vitamin A is needed by the eyes for vision in dim light. Vitamin B and folic acid are essential for the maintenance of the nervous system. Vitamin deficiencies, especially in vitamin B and vitamin C, can cause mouth ulcers, sore gums and poor dentition.

## **A Nutritious Diet**

Healthy eating is not about strict dietary limitations, staying unrealistically thin and depriving the body of the nutrients it needs. Rather, it is about eating a variety of nutritious foods for sufficient intake of all nutrients to maintain good health and help one feel his or her best. There is no good or bad food. The key is eating in moderate portions. The concept of moderation allows an individual to choose appropriate portion sizes of any food as well as to indulge occasionally in high calorie and high fat food such as desserts, fried foods and fast foods.

## **My Healthy Plate**

In order to achieve a well-balanced diet, one can use My Healthy Plate as a guide to form a daily eating plan based on the number of servings of different food groups recommended. My Healthy Plate is developed by the Health Promotion Board in Singapore to provide a visual representation of what a healthy meal might look like. It illustrates the approximate relative proportions of each food group that should be included in a healthy meal. My Healthy Plate can be a useful nutrition tool but it does not address individual needs with medical conditions.

## **Role of the Dietitian in the Management of ED**

ED patients have different physical characteristics and different nutritional goals. When treating patients with ED, it is important to enlist the help of a dietitian to ensure their nutritional needs are met as ED is a complex and life-threatening mental illness. Patients with anorexia nervosa may need to begin the weight restoration process and a dietitian is an important component of this process.

## **Weight Restoration Phase**

Weight restoration is one of the fundamental aspects of recovery from anorexia nervosa. It helps restore cognitive, physical and emotional functions as well as to minimise the medical complications of malnutrition. A specialised ED dietitian is vital in developing a treatment plan that is tailored to individual medical problems and needs. The dietitian has to collaborate with medical providers to support weight gain in a secure setting. It can be extremely dangerous for a person with anorexia nervosa to attempt to gain weight on his or her own, without the medical supervision of a doctor and an experienced dietitian. A carefully planned weight restoration is needed in order to prevent refeeding syndrome (a potentially fatal shift in blood electrolytes that occurs with a rapid increase in energy intake after severe restriction). Therefore, close monitoring of blood electrolyte levels is crucial while feeding malnourished patients.



The dietitian's role is to establish the goal of weight restoration with patients, provide appropriate guidance regarding nutrient requirements and develop an individualised meal plan. In addition, the dietitian also shares about the benefits of weight restoration, rectify food-related misconceptions and help patients overcome the challenges associated with weight restoration. A full psychological recovery is not achievable via weight restoration alone. Other aspects including behavioural and psychological recovery have to be taken into consideration as well. Patients who have recovered or are in remission stage are able to eat a wider variety of food and 'unsafe food' such as desserts, fried foods while exhibiting less obsessive food-related thoughts and behaviours.

When patients are actively gaining weight during the weight restoration phase, the weight gain target set ranges from 0.5kg to 1kg a week until they reach their 'ideal healthy weight' or 'biologically-appropriate weight'. 'Ideal healthy weight' or 'biologically-appropriate weight' is maintained with ease without dieting, inappropriate food intake and compensating behaviours, including exercise, purging, laxative or diuretics abuse.

During the initial visit, the dietitian would advise patients to follow a healthy-balanced diet that focuses on normal servings of food intake, which typically consists of three main meals. Patients' meal plans are adjusted accordingly based on their weight gain progress. Patients who are unable to achieve the weekly weight gain target will be recommended to consume nutritional supplement drinks as this may be easier than increasing their food intake. Therefore, nutritional supplement drinks are beneficial for patients with high nutritional needs.

## **Weight Maintenance Phase**

This is the phase whereby patients' physiological functions and tissues are restored to normal or near-normal states with maintenance of 'ideal healthy weight' or 'biologically-appropriate weight'. It is only during the later stages of this phase that the restoration of bone health, abdominal fat distribution and basal metabolic rate will take place as they require longer time to normalise.

Regular and normal servings of meals and snacks help in the returning of hunger and satiety cues in patients. At this stage, they

should be enjoying food and experience satisfaction with eating. Patients will gradually become less rigid in keeping up with their strict dietary rules, obsessing over the caloric value of food and consuming meals at specific designated times. 'Unsafe food' will be introduced to patients slowly under dietitian's guidance. However, close monitoring and regular reminders are needed for patients who are still struggling with eating adequately to maintain their ideal healthy weight.

## **Preventing Relapse**

Studies show that relapse rates are as high as 50% in anorexia nervosa (Pike et al, 1998). To prevent relapse, it is essential that patients continue with regular weight checks and dietary counselling for at least a year after reaching their ideal healthy weight. If patients' weight decreases below ideal healthy range, it may suggest a potential risk of a relapse. In addition, dietitians and family members need to recognise behaviours that can predict relapse, for instance delaying or skipping meals or snacks, cutting food into smaller pieces, hiding food, choosing healthier food options, increasing exercise, binge eating and regular self-weighing or body checking. Ideally, dietitians have to reassess patients' food intake, thoughts and behaviours that hinder them from maintaining weight.

## **Managing Binge Eating**

Binges are categorised into subjective and objective binge. Subjective binges normally consist of smaller amount of binge food in one sitting, less than 500 calories whereas objective binges normally range between 1,000 to 2,500 calories in one sitting.

It is a well-known fact that food restriction increases the likelihood of binge eating. Restrictive eating often creates psychological and physical deprivation, which naturally and ultimately leads to binge eating. In binge eating patients, it is common that they virtually starve themselves during the day to save up calories for an expected evening binge. Some patients even restrict the intake of normal meals to compensate the calories previously consumed during a binge. In some cases, patients use the restriction-binge cycle as a way to relieve their negative feelings, such as stress, boredom, anxiety, anger and depression.

As a result, normal sensations of hunger and fullness are disrupted by cycles of restriction and binge eating. Patients may be bothered by abdominal pain, flatulence and bloating after a binge episode. In the long run, binge eating may result in obesity, which may lead to increased risk for other medical conditions, including diabetes, heart disease and hypertension.

Binge eating patients are advised to follow an orderly pattern of eating for 'recalibration' of hunger and for satiety cues to occur. The duration for the regulation of hunger and satiety cues varies in every patient; some individuals can take up to six months. Patients are reminded that binges must not replace meals or planned snacks. They need to return to the meal plan immediately and eat the next scheduled meal or snack if bingeing occurs. Cessation of binge eating may lead to modest weight loss in most patients. Patients are reminded to engage in behaviour strategies in dealing with binge eating urges, for instance avoid extreme hunger, eat three satisfying meals and one to three snacks a day, engage in non-food-related hobbies and avoid triggering situations with food.

## **Managing Purging**

Purging behaviours (self-induced vomiting, laxative, diuretic and diet pills abuse) serve as temporary relief from negative feelings such as anxiety, frustration, anger and fear of weight gain associated with binge eating in patients. There are cases whereby patients feel trapped in a vicious cycle of binge eating and purging in which they must binge to feel full enough to purge. Psycho-education regarding the harmful effects of purging can motivate patients to stop purging behaviours. Regular purging can lead to dehydration, electrolytes imbalance, esophageal burning, tooth decay, puffiness and soreness around the mouth, fatigue, irregular heartbeat and finger or hand calluses in patients. Misuse of over-the-counter diuretics may lead to rapid heart rate, headaches and trembling.

Some behavioural strategies that are helpful for patients to reduce purging episodes include: keeping a food diary, self-monitoring, stopping bingeing and delaying purging. Appropriate weight monitoring provides reassurance to patients who resist making changes to food intake for

fear of weight gain. Concurrent psychotherapy and medication should be considered if purging behaviours do not resolve quickly.

## **Safe and Unsafe Food**

All ED patients have their own list of ‘safe’ and ‘unsafe’ foods. ‘Safe’ foods are those which are very low in calories. They include fruit and vegetables as well as non-caloric drinks. ‘Unsafe’ foods are generally ones that are higher in calories and contain fat and/or sugar. All food groups should be included in a healthy eating plan, including foods which are higher in fat and sugar if eaten in moderation. Patients usually feel intense guilt if they eat an ‘unsafe’ food and this can lead to further restrictive behaviours. Most patients do want to eat ‘unsafe’ foods but are too frightened by their caloric content. This often results in them denying that they even like the taste of certain higher-calorie foods.

There are some healthy ways of reintroducing ‘unsafe’ foods into diet which the dietitian is able to help with. When selecting the unsafe food, it is important to select a normal-sized portion. If the snack choice is potato chips, for example, then a single serving packet is recommended, and not family-sized bag. It is likely that one will feel guilty after taking an ‘unsafe’ food. Therefore using distraction techniques such as having an activity planned to distract himself or herself for a few minutes will subside the feeling of guilt. Reintroducing ‘unsafe’ food into the diet can be a difficult process and the exercises below may help an individual to break the pattern of restriction.

### **Exercise 1: Lucky Dip**

Place a selection of ‘safe’ and ‘unsafe’ food into a box. For instance, a packet of plain biscuits versus a packet of cream-filled biscuits. Shake the box and pick up an item. It must be a random pick, you are not allowed to look into the box or feel the shapes of the items inside. The task is to eat the item whether it is ‘safe’ or ‘unsafe’. This challenge can be carried out once a week, gradually increasing the frequency.

## **Exercise 2: Climbing the ‘Unsafe’ Foods Ladder**

Create a list of eight to 10 ‘unsafe’ foods. On the top of the list, write down the ‘unsafe’ foods that gives you the most amount of anxiety. On the bottom of the list can be the least anxiety-provoking foods. This way you can ensure that you face your ‘unsafe’ food in a way that is more gradual, by starting from the bottom of the list and slowly working your way up. It is also important that you try the same food multiple times before moving on to the next one. If the anxiety has decreased in response to the particular food that you have been repeatedly exposing yourself to, it means that you are ready to move on the next ‘unsafe’ food in the list.

Remember, eating a well-balanced diet is vital for good health and well-being as food provides our bodies with energy, protein, essential fats, vitamins and minerals to live, grow and function properly. Therefore always check with your dietitian to ensure that your meals provide sufficient nutrients from different food groups at appropriate proportions.

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# Help! I Don't Like My Body

## — Body Image, Eating Disorders and Me

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### Overview

Poor body image and body image disturbance have long been associated with EDs. Often, it is difficult to not speak about one without the other. It has also become one of the key criteria in the diagnosis of an ED like anorexia nervosa or bulimia nervosa.

#### *What is body image?*

Body image is often described as not how our body really is or looks like, but rather, how we feel and perceive our bodies to be. Confused? Don't be. Let me explain. A person with poor or negative body image would feel that (s)he is too fat/too big/ugly/disgusting although (s)he could be within the normal healthy weight range or underweight, or even handsome/pretty. (S)he would also struggle with self-esteem issues, and may even avoid going out owing to the insecurities over presentation and appearance.

#### *How is poor or negative body image related to EDs?*

Well, people who feel inadequate about how they look, e.g., their body sizes and shapes, may experience negative impact on his/her self-confidence and self-esteem. These people would feel that others may not like them because of how they look, or that they cannot fit in unless they are of a particular look or size. This may lead to them wanting to do something to change the way they look by losing weight, as that is something 'easiest' for them. This can lead to further problems like developing an eating disorder. Negative body image can also lead to

other problems like depression and anxiety. Moreover, it can affect males as well as females, and is not limited to just adolescents. It should be noted that EDs are not due to vanity, looks or weight but are symptomatic of something deeper.

Perhaps it may be easier to understand this through the story of Lily; how she was first affected by negative body image, an ED and depression, and later how she made peace with her body image.

### **Help! I Don't Like My Body: The Story of Lily**

I met Lily when she first presented at our clinic at 17 years of age. She had sought help on her own accord as she was concerned about her constant purging and irregular menses. Her teeth were also hurting from the purging. Lily suspected she had an ED, and had Googled the signs and symptoms of Bulimia Nervosa. She had bravely gone to the polyclinic to get a referral to our centre, and came to see the psychiatrist here. She was diagnosed with Bulimia Nervosa and Major Depressive Disorder. Lily was then referred to see a dietitian and a psychologist (myself) for individual therapy. She was understandably apprehensive and worried.

During therapy, Lily revealed that she had been bullied all through her primary school years as she was on the plump side. She was teased and made fun of because of her size. Fortunately, she had some good friends, and that had helped her cope with the teasing. However, she had never really felt comfortable about her size, and was always self-conscious about her overall appearance. Her self-esteem was also not very good as she never felt good enough and did not think she was worth much. She was not one of the popular girls and was not very extroverted.

Lily also faced teasing at home. She was always called "the fatter one" by all her relatives as she was a little on the plump side while her sister was on the thinner side. Her parents and grandparents had even called her "Little Fatty". She had always felt awkward with that nickname but did not know how to tell her family to stop. The teasing and nickname made her feel very self-conscious and unhappy with herself and her body. Lily started to diet in an attempt to lose weight

by counting calories as well as omitting fried food and desserts. She also started exercising. It worked initially, and she managed to lose some weight. However, she began to binge as she felt very tired and hungry all the time. Eventually, she also learnt to use slimming pills and purging to compensate. When she was 15, she started to cut herself as she had seen other classmates do that. She also started to lose focus in school, become withdrawn and not wanting to even get out of bed on several occasions. There were times she had contemplated suicide. What had helped then were her friends and sister who kept encouraging and urging her to pursue her passions: photography and writing. Lily had aspirations to be a travel writer and to keep a travel blog. She did well enough in her GCE 'O' levels and subsequently went to a Junior College where she met her current boyfriend. Her boyfriend was the one who expressed concerns for her eating habits and low mood. On hearing this, Lily summoned up her courage and came to seek help.

### **The Journey to Recovery**

Therapy with Lily took about three to four years of hard work. It was not a smooth and linear journey; we had to face ups and downs, and good and bad periods but she persevered. The initial focus of therapy was using Cognitive Behavioural Therapy for Bulimia Nervosa to help regulate her eating and stop her purging. Stabilising her eating and stopping the compensatory behaviours took a while and with great effort and hard work on Lily's part. Fortunately, she was willing to trust the process and cope with the weight fluctuations and occasional binges. The focus on therapy then switched to working on her self-esteem as well as body image issues. For Lily (and many other individuals with an ED), her ED and focus on diet and weight were not about vanity or looks, rather, it was about having some sense of control of her life. She used her eating and weight as a way to exert some order amidst the chaos of her moods and emotions. Part of the therapy work was to deal with her depression and self-harm. Lily was also taught coping and stress management strategies to respond to her fluctuating emotions and distress.



## Body Image Issues

Lily had learnt to feel bad about her body and her size at a young age with all the teasing from school and at home. She had also hated her body so much that she took to cutting herself as a form of self-punishment, and she believed she deserved only bad things. There was so much self-loathing.

Much of the body image work was just focused on exploring the reasons she hated her body and herself. Issues of teasing and bullying had to be dealt with by allowing her to express how she had felt about all the teasing, as well as doing cognitive restructuring to challenge some of the internalised negative self-talk she had developed as a result of the bullying and teasing. Cognitive restructuring is a technique used to identify negative automatic thoughts that are irrational, and subsequently dispute them. This was not an easy process as she had really believed some of the self-blaming and shaming thoughts to be true.

Positive self-affirmations were gradually generated in session for Lily to say to herself daily in front of the mirror. Initially, it was too difficult for her to even say the words so we had to write them on Post-it notes and placed them on the mirror for her to read. We gradually also did exposure work with the mirror to get Lily to feel more at ease looking at her own reflection without criticising her body. She had tended to avoid the mirror or looking at herself as she would feel so much disgust.

We also explored how she felt about each of her body parts through a body part drawing exercise, and discussed the emotions and thoughts she felt about them as well as what these negative emotions and thoughts were really about. For Lily, she treated her body like a punching bag and took out all her frustrations and anger about other things onto her physical self. She had genuinely believed that things would change if she looked different. For example, she would think that “I would not be teased or bullied if I had been prettier”, “my friends would like me more if I were thinner” and “I need to be 45 kg and have thinner thighs and a flat stomach, if not, my boyfriend will leave me”. These thoughts and assumptions were not true but she was quite stuck with them for a long period. The truth was Lily was depressed and felt things around her (how people felt about her, being bullied, grades slipping) were beyond

her control. In a desperate attempt to maintain control, she turned to dieting and weight loss. She thought that there were at least two things that she could maintain control over.

A lot of work was also dedicated to stopping her self-harm behaviours. We worked on different strategies she could use to cope with her distress and frustrations, so that she would not turn inwards toward her body. We had to explore which strategies worked for her as each individual is unique. For Lily, listening to music, doing meditation and taking walks worked for her. We also explored what the cutting behaviours really meant for her. Lily was taught self-compassion, to be a little kinder to herself and to learn not to say harsh things (things she would never say to another person) to herself. Gradually, she was able to say one nice thing about herself every morning.

Exercise and having a healthy balanced diet were included as a treatment recommendation. The aim was to help Lily relearn what normal exercise was and how it could be enjoyable and beneficial as it was intended to be; exercise was not the punishment and compensation that the ED had made it to be. A healthy balanced diet was also crucial to establish a normal relationship with food again. To help Lily view food differently, we encouraged her to refrain from using words like "sinful", "decadent", "guilty", "cheat food", "scary" and "unsafe" to describe any food so that she would not be made to feel bad when consuming them. Instead, we explored new non-judgemental adjectives to describe the food and emphasised that everything was good in moderation. This was quite an important technique for Lily as she had often been made to feel bad when she ate her favourite chocolate cake or fried chicken wing.

Dressing appropriately was part of therapy as we discussed about how labelling and sizes of clothes may not be completely accurate and consistent. Lily also learnt more about her body type, and what would suit and flatter her figure instead of blindly following what her peers were wearing. She grew more confident in trying new clothes and different styles, and even developed a little quirky style of her own. She also had some very nice compliments from her family and friends, which made her feel more confident in her style as well as more comfortable with her body.

One of the other things we worked on extensively was Lily's self-esteem and self-image. She slowly gained confidence and felt good about herself when the photographs she took started to win prizes. Her writings were also praised by her supervisors at her internship placement. Lily began to have a better sense of who she was and who she wanted to be.

## **Today**

Lily is now well and has been discharged from all follow-up appointments with us. She has moved on to complete her studies at the University and even been able to enjoy overseas internship stints with the University. She is currently planning to pursue further studies in journalism and writing. She is still in a loving relationship with her boyfriend, and they are planning to get married. Lily still has some not-so-good days, where she feels lousy about herself and how she looks. However, she is more empowered to attend to those thoughts and feelings, as well as exploring what they are about instead of acting on them. She has also developed a positive environment for herself by not surrounding herself with toxic individuals. Her relationship with her body is in a much better place and upon discharge, she has confidently said she knows she has made peace with her body and self. She continues to write and keep a travel blog, and dreams of travelling the world.

*\*\*Lily is not a real person. She is an amalgamation of many of the individuals (males and females) whom I had treated in the many years in SGH. Needless to say, therapy is not so simple, and there is a lot more to what has been described. This is just a simplified story to illustrate a case example.*

## **What Can You Do for Yourself?**

### ***Tips to have a better relationship with your body***

1. Be kinder to yourself
  - Do not say things about your body and self that you would not say to a friend.

2. Focus on Function rather than Form
  - Focus on what your body can do and how strong and powerful it is instead of how it looks.
  - Appreciate and celebrate all the good things that your body can do: dance, run, walk, and jump.
3. Weigh yourself less
  - Try not to weigh yourself so frequently. Maybe just once a month.
  - Your weight will fluctuate, and weighing daily or more than once a day can only make you obsess about the numbers.
  - Scales are for fishes! You are not a fish!
  - You are worth a lot more than what you weigh. Do not reduce yourself to mere numbers.
4. See your whole body
  - Regard and see your whole body when you look into the mirror.
  - Do not scrutinise individual parts of your body as any part of your body under scrutiny is like putting it under a microscope; anything under a microscope would be magnified and look huge!
5. Respect and treat your body right
  - Learn to listen and heed your body and its needs.
  - Treat your body respectfully by eating (healthy balanced eating) and living right (exercise regularly, rest, don't push and hurt yourself).
  - Our body is like a car; you should not want to put in water when it needs petrol or deprive it of coolant when it's heating up so heeding what it (our body) needs will ensure that it would serve you well too.
6. Try not to compare yourself with others
  - Everyone is different. Every body is different and unique.
  - Try and focus on how unique you are and even consider yourself as a limited edition!

7. Embrace and accept your body
  - Accepting your body is about understanding your body type and shaping to be the best that you can be.
  - It does not however, mean that you should not care and give up on your body.
  - What we want is to focus on health and wellness and not try to be that size zero.
  - It's time to make peace with your body.
  
8. Dress for success
  - Wear clothes that fit your body. A well-structured and well-fitted outfit can do wonders for your body shape.
  - Avoid wearing oversized or baggy clothes as it can make you bigger than what you really are.
  - If you are having a "fat" day, instead of wearing a black baggy outfit, why not put on one of your favourite outfits; the one that everyone says you look fantastic in? That will help turn that day around for you.
  
9. Let your inner beauty shine
  - Nurture your inner beauty too.
  - Nurture your personality, your intelligence, your wit, your humour.
  
10. Do a positive list
  - Write a list of what you do like about yourself and your body.
  - Do not ignore even the smallest parts like your nails, eye lashes and fingers.
  
11. Create a body positive environment for yourself
  - Hang around individuals who have a good body image and self-esteem.
  - These individuals would not be body shaming or discriminating against size, rather, they focus more on what is on the inside.
  - They would also focus more on health and wellness and not on dieting and/or losing weight.

12. Create a diet free zone around you

- Gently let people around you know that you would like to not have conversations about diet, weight and size, and that you would prefer to focus on other topics of interests.

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# Motivating Yourself

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Many individuals often come to treatment with misgivings or varying degrees of reluctance. Some may even feel coerced into coming to treatment because of family, significant others or friends. This chapter discusses tips and exercises to help you to get started on your journey to recovery.

## **Choosing Recovery**

Motivation needs to be intrinsic for one to best engage in treatment. Only you have the power to change your behaviour and thus the responsibility lies with you. It is extremely important for you to be an active part of the treatment partnership. You have to be your own therapist outside of therapy sessions, and making changes by practising skills learnt during therapy or from self-help books.

Oftentimes, one may verbally express motivation to change. However, the key element lies in your behaviour. A common pattern that occurs often is the parking lot phenomenon (Fairburn, 2008). That is, the phenomenon of losing verbally expressed motivation in the time it takes for an individual to leave the clinic and enter one's car to go home. This is a common phenomenon and can be overcome by commencing or re-commencing behavioural change.

Here are a few exercises to guide you further as you consider behavioural change.

1. "Miracle question" activity (Berg & Dolan, 2001)
  - Imagine that when you wake up the next morning, a miracle has happened and all your current difficulties have disappeared. What would you notice is different? Would your loved ones notice a miracle has happened? What would they notice that is different?
  - What has stayed the same?
  - If zero equals the worst that life can be, and 10 equals the miracle, where are you?
  - How is the ED going to help you get to the miracle?
  - What is going to get in the way of the miracle?
  - What are some signs that the miracle is already happening? How did you achieve that?
  
2. Friends or foes letters (Serpell & Treasure, 2002; Serpell et al., 1999)
  - Write two letters: one to your ED as a friend and another to your ED as your enemy.
  - After writing these letters, reflect on the emotions that arise as you were writing them. Anger? Loss? Fear? What do these emotions tell you?
  
3. Decisional balance activity
  - Write down the pros and cons of having the ED.
  - Divide the pros and cons you have written into short-term and long-term.

You may learn from these exercises that while there may be various advantages of the ED, it also brings about a multitude of problems. Oftentimes, the valued benefits of the ED are short term while the drawbacks are longer-term and more pervasive in nature.



## **Ready? Set, Go!**

While motivation begins to move you into action towards change, you may be wondering if you are ready or getting ready to embark on an effort to make changes with regards to the ED. Having motivation does not mean that it can be sustained indefinitely while we adopt the behavioural changes. Moreover, change can be quite stressful and scary. Yet, any sort of recovery requires change. Motivation and change are very much interlinked, and they are not something that suddenly happens but a continuous process. Motivation can be changed, and you can be at different stages of motivation.

There are six stages of change based on the Stages of Change Model, and by finding out which stage you are in, it can help you to understand your readiness to change (Prochaska et al., 1995; Gold, 2016). Knowing the stage you are in can help you to apply appropriate strategies in making changes. This can be helpful in sustaining your motivation and minimising your risk of losing ground in your motivation to change. However, relapses are inevitable and are part of the process of change. As such, relapse to a prior stage in the stages of change may occur at any time during the process of change. It may be useful to re-examine your motivation from time to time and work to sustain or enhance it whenever necessary. Based on Prochaska et al. (1995) and Gold (2016), the six Stages of Change are as follows:

### ***Pre-contemplation***

People in this stage are typically not even considering about change. You may be aware of the ills of an ED but see the benefits as more significant. You may have a lack of interest in change and have no intention to change. This stage is described as being in denial.

### ***Contemplation***

At this stage, you are considering making a change, but not ready or not sure whether you want to make a commitment to change your behaviour. It is likely that you are exploring the potential benefits and barriers to change.

### ***Preparation***

At this stage, you are preparing to take action to change your behaviour. You may evaluate and test out various interventions to reduce ED behaviours. Most likely, you are willing to change and able to see the benefits of stopping or reducing ED behaviours. You may be making a commitment to change and making plans to start changing soon.

### ***Action***

Individuals in this stage are typically more active in implementing plans for change. You are probably making effort to change your behaviour, gain insights and develop new skills simultaneously. You may also seek external help such as therapy and medication, etc. Individuals are probably learning new behaviours, attempting to overcome challenges and staying on track with the objectives. This person is actively embracing change and getting used to the new behaviour.

### ***Maintenance and relapse prevention***

New behaviours have been developed, and maintaining the healthy changes you have made will be the main notion. You have probably mastered the new behaviour, and will be putting some effort in sustaining the new behaviour. It will be important to take note of high-risk situations, work on relapse prevention and work to sustain the new behaviour over a period of time. In other words, it is consolidating the behaviours initiated during the action stage, making adjustment and integrating the behaviours into your life.

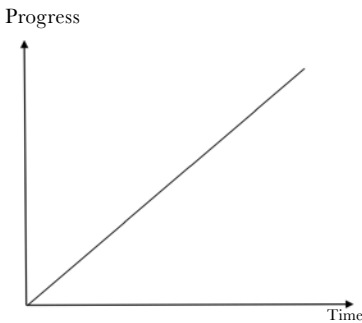
### ***Termination***

This is the ultimate goal of the process of change. If you are in this stage, you have successfully adopted and integrated the desired behaviour and lifestyle. You are unlikely to fall into temptations or high-risk situations. Mostly likely, you will be more confident of continuing the healthier lifestyle, enjoying the freedom from the ED or having a more meaningful lifestyle. In short, relapse is quite unlikely.

## Relapse Is Normal

Although you may envision or even idealise the road to recovery being clear, direct and trudging forward, the reality shared by those with an ED is that recovery is often a road strewn with slip-ups (minor influence), set-backs (moderate influence) and relapses (major influence) (refer to Diagram 1).

What you may want recovery to look like



What recovery may actually look like

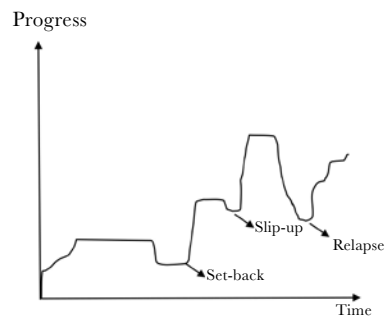


Diagram 1: Setting realistic expectations for recovery

Being realistic with expectations about recovery helps. Understanding that relapses are the norm rather than the exception, helps reduce disappointment faced by you and those supporting you. After all, if you expect pitfalls, you are better able to prepare for relapse and minimise self-blame when it actually happens. In most cases when there is a good medical support team aiding you with recovery, the severity of relapse can be minimised.

Embracing relapse gives you an opportunity to identify your “relapse signature”. Relapse signatures are patterns of behaviour, thoughts and ideas that occur before impending relapse, often referred to as early warning signs (Birchwood & Tarrier, 1992). Once you spot the early warning signs of a relapse, taking action earlier as opposed to later often reduces the harm relapse brings about. Some early warning signs could be gradual restriction of food portions, increase in tendency to weigh yourself, increase in comparison with peers and getting more socially

isolated. Identifying relapse earlier and getting the necessary help to get back on track with recovery often helps to keep one motivated to recover. By making efforts to reduce relapses to set-backs and set-backs to slip-ups, one can feel empowered to stay motivated throughout recovery.

Self-blame, regret and frustration are commonly experienced following relapse. These may fester feelings of worthlessness and hopelessness in yourself. To regain motivation for recovery, try your very best to forgive yourself when you have had a relapse. Instead of perceiving relapse as a failure to achieve recovery, try viewing relapse as a feedback or an opportunity to understand blindspots in recovery so as to get stronger to battle the ED. Your will to tolerate and overcome challenges grows stronger as this is important for battling your ED.

In addition to having realistic expectations about relapse, setting realistic expectations for recovery is also essential. Recovery does not mean that you will be entirely void of fear when making food choices and exercise only for leisure, and that you will be extremely confident about your body image. Rather, you will be able to lead much of your life with minimal interference from the ED. Recovery pans out differently for each person. For recovery, just reaching your target weight is not sufficient. Recovery is a holistic experience, where acceptance of yourself and being comfortable in your skin are far more imperative than meeting an acceptable weight.

## **Making Recovery Meaningful**

Just like how motivation needs to be a personal choice, recovery too needs to be a personal vendetta. “I choose recovery because I want to” usually seems to work more effectively as compared to “I choose recovery because I have to” or “I choose to recover for my parents/boyfriend/girlfriend/husband/wife”. Recovery needs to make sense. It needs to hold personal value and be worthwhile.

Values, also known as guiding principles (Wilson & Murrell, 2004) usually provide individuals battling with an ED with continued motivation for choosing recovery. Values can either be based on key life domains (see Diagram 2) or personal attributes. Personal values are crafted from a mix of family values, cultural values, societal values

and one's own personal experiences (Rokeach, 1973; Simon, Howe & Kirschenbaum, 1972). It is your choice which personal values you choose to live by.

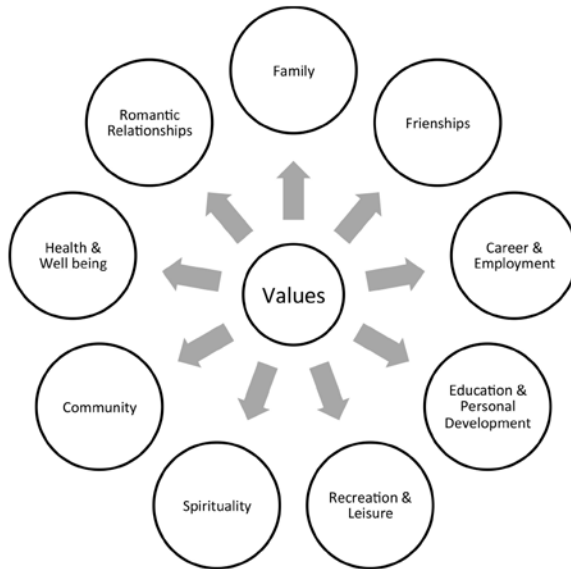


Diagram 2: Values based on key life domains (adapted from Harris, 2009)

Take for instance a situation where you avoid family functions for fear of having to deal with the dilemma of eating, yet, you feel increasingly sad and yearn for more connection. You remember fond memories of times spent together over family dinners and miss the conversations. This suggests that the impact of the ED has strained family togetherness. Given so, the value of family closeness holds importance for you.

Another example would be when the ED gives you a desired sense of accomplishment and makes you feel self-disciplined such that you pride yourself on your sheer determination for sticking to a stringent diet. In reality, the ED actually overshadows or even contradicts many other value-based attributes, such as flexibility, diversity, adventurousness and joy. Note that your values are not flawed because they align with the ED. Instead, the pursuit of those values become questionable when the

approach taken, such as subscribing to the ED heavily, compromises many other values that you find meaningful.

Values are ever-changing and keep undergoing revisions and modifications throughout your lifetime. You may drop some values, adopt new values and modify old values to suit the present. This is the norm. With values, you are meant to exercise flexibility. To keep motivated, recovery needs to hold meaning brought about by your own values, and they are not those others impose upon you. If chosen freely, values give you a sense of purpose and inner drive, and provide novel experiences and better life satisfaction. Sticking to values that matter for living a meaningful life are often incongruent with the values an ED promotes. If you are able to make living meaningful, then the ED will find it hard to thrive under such conditions.

Here are some quick tips on how to stay in touch with your values:

1. Identify them and write them down (example in Diagram 3). Identifying values are simple. Think about experiences that have been emotionally poignant for you. These are likely related to values you cherish (e.g., being very disappointed when you failed at a test, and being very excited and proud when you emerged second in class indicates values related to education, perseverance, hard work and achievement.)
2. Look at them regularly. Place them on a wall, in your wallet, in a file and as your desktop/handphone screen saver. This is to keep yourself in check with values that are recovery-focused.
3. Try to do things that align with your values (Harris, 2009). Set realistic goals. Set graded goals which are immediate (achievable within 24 hours), short-term (days to weeks), medium-term (weeks to months) or long-term goals (months to years) (Harris, 2009).
4. Write pending or successful goals as visual reminders to stay motivated.
5. Be flexible with your values. Modify them if needed.
6. Lost or confused? This will be an excellent opportunity to re-look at your values to guide you in making decisions.

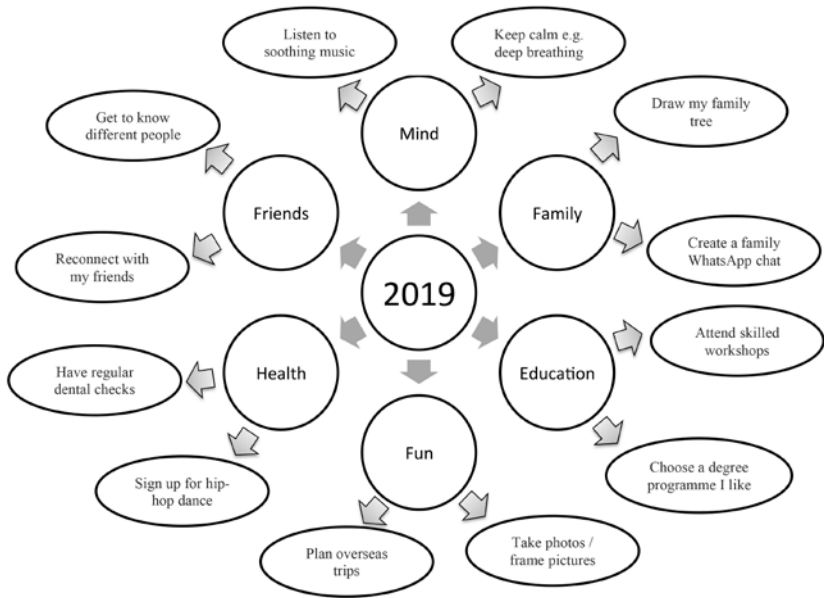


Diagram 3: Keeping in touch with your values

## Harnessing Strengths

The road to recovery is not easy. At times like this, the future may seem bleak, and you may be feeling discouraged. Hence, knowing your strengths and harnessing them to help you along your journey can be helpful.

Here are a number of activities that can help you explore your personal strengths.

## 1. Identifying your personal strengths

Look through the list below and select five personal strengths that you identify with.

To guide you along further, consider what might someone who knows you really well say about you, or what good qualities might they see in you that could help you make the changes you want?

Accepting	Committed	Flexible	Persevering	Stubborn
Active	Competent	Focused	Persistent	Thankful
Adaptable	Concerned	Forgiving	Positive	Thorough
Adventurous	Confident	Forward-looking	Powerful	Thoughtful
Affectionate	Considerate	Free	Prayerful	Tough
Affirmative	Courageous	Happy	Quick	Trusting
Alert	Creative	Healthy	Reasonable	Trustworthy
Alive	Decisive	Hopeful	Receptive	Truthful
Ambitious	Dedicated	Imaginative	Relaxed	Understanding
Anchored	Determined	Ingenious	Reliable	Unique
Assertive	Die-hard	Intelligent	Resourceful	Unstoppable
Assured	Diligent	Knowledgeable	Responsible	Vigorous
Attentive	Doer	Loving	Sensible	Visionary
Bold	Eager	Mature	Skillful	Whole
Brave	Earnest	Open	Solid	Willing
Bright	Effective	Optimistic	Spiritual	Winning
Capable	Energetic	Orderly	Stable	Wise
Careful	Experienced	Organised	Steady	Worthy
Cheerful	Faithful	Patient	Straight	Zealous
Clever	Fearless	Perceptive	Strong	Zestful



Can you think of instances in which each of the strengths you have identified helped you?

How might these strengths now help you to achieve the changes you want for recovery?

2. Coming up with your recovery box/first aid box

During the course of recovery, it can be useful to collect items that are personally meaningful to you. Likewise, it can be helpful to take note of activities that would cheer you up. When recovery gets tough, you can then use these items or activities to help you to feel better.

What are some objects or activities that would help you feel better? Examples of meaningful objects include messages from others, gifts, photographs of loved ones/pets, aromatherapy sachets, lists of your favorite songs and favourite quotes. Examples of activities include spending time with your pet, listening to music, journalling and colouring or painting.

There is no right or wrong item/activity. Different items or activities would suit different individuals. Consider yours and collate them to put into your recovery box. Feel free to decorate the box in any way you want!

3. Making use of others to support you

At times, our strength can also come from our loved ones and others around us. While there are people around you who will help you when you feel down, it is important that you act as well to make use of these helping hands. Consider a time when someone has helped you before. Firstly, consider who are the people who can help you overcome ED? Secondly, what can they do to help you? Lastly, how could you let them know what you need from them? Remember, you need to reach out to those helping hands extended to you — the responsibility of change lies with you alone.

## Goodbye Eating Disorder

The following are some tips to help you to say goodbye to the ED and work towards recovery (Paterson, 2008):

1. Recognise that mixed feelings are normal.  
It is normal to be experiencing both sadness and excitement about leaving the ED. You are probably experiencing the feelings of loss and anticipation that are part of life's transitions. Just give yourself time for adjustment and be open to various types of emotions.
2. Recognise your hunger.  
Write down whenever you feel hungry over the course of a week and rate each event from 1 to 10 (with "1" being slightly hungry and "10" being starving). You are likely able to notice a pattern. It is normal to get hungry at times but it is unhealthy to feel famished. You can aim to add an extra snack when you are feeling famished.
3. Write a letter to the ED.  
It may be beneficial to write a goodbye letter to the ED. This letter can be in any format you like. You can talk about the pain it has caused you or the difficulty you have in letting it go. Most importantly, you need to separate yourself from the ED and the control it has of your life.
4. Unhelpful thoughts and beliefs.  
Write down a list of your unhelpful beliefs and remember that these are the thoughts that keep you trapped in your ED.
5. A new wardrobe.  
Look through the clothes in your wardrobe. Getting rid of your clothes that do not fit (e.g., smaller size or extra large) can be symbolic in saying goodbye to your ED. You can also get clothes that are more fitting as a way of stopping hiding from the world and being more open.

6. Try a new food.

Introduce one new food into your diet and try it every day for at least one week or until you feel comfortable eating it.

7. Get some support.

It is normal to have struggles during the route of recovery, and it may be helpful to contact a close and trusted friend or family member to share your experiences or struggles. If not, meeting up and spending time with your loved ones can be a distraction or an enjoyable activity.

8. Recovered box.

A similar activity to the Recovery Box stated beforehand. It may also be beneficial to have a recovered box with items that can remind you that you have recovered so that you can completely say goodbye to the ED.

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# How Psychotherapy Can Help a Person with an Eating Disorder

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*There is a saying: “You can lead a horse to water, but you cannot make it drink.”*

This is what it can feel like when trying to help someone with an eating disorder (ED). The solution to an ED appears simple: getting the patient to eat, but the problem is, he/she will not because of the intense fear of putting on weight — a symptom of the illness — and no amount of logic or arguing succeeds in shifting the fear of weight gain. Individuals with ED may sit at the dinner table, but getting them to eat a normal portion can be an exercise in frustration, often ending in arguments, tantrums and tears.

Below is an example of a patient I shall call “Agnes”. She represents a composite of the many patients that I have seen.

## **Case Example: Agnes — Anorexia and Bulimia Purging Sub-Type**

Agnes is 18 years old and currently in her second year of Junior College. Agnes has always done well in her studies and is hoping to do accountancy in university. She has always been a perfectionist and now finds that she does not always have enough time to do her assignments to her level of satisfaction. She is also in the college band which requires a lot of practice hours. In addition, she has started dating one of her band mates and is finding it hard to juggle schoolwork with her active social life.

A year ago, Agnes’s 75-year-old maternal grandfather, whom she is very close to, was diagnosed with a serious heart condition. Agnes worries about him a lot even though he is under medical care.

Six months ago, Agnes started dieting and lost a significant amount of weight. She is pleased with the attention she has been getting for her weight loss, especially from her boyfriend. However, she realises that she is becoming a little obsessed about her weight. Physically, she has at times felt a little weak and has had difficulty focusing in class. Meals at home have become difficult as family members have started to worry about her weight loss and have been encouraging her to eat more. This has resulted in numerous tense moments and arguments at the dinner table as family members cannot understand why it is so difficult for Agnes to eat normal portions.

Recently, Agnes found that she cannot stop herself from thinking about food from the very start of the day, and has begun bingeing on biscuits, bread, ice cream and instant noodles in the evenings. She feels so much guilt about the amount of food she has eaten that she decides to purge it all out very soon after eating. One of her sisters overhears her purging and encourages her to seek help.

### **Some Challenges in Therapy When Working with ED Patients**

For therapy to work, the patient has to be in a state where he/she is sufficiently nourished and psychologically oriented. This does not mean that the patient must attain minimum healthy weight to begin therapy, but the patient must not be too starved as in the case of an anorexia patient. Very low weight can reduce the effectiveness of psychotherapy. I once had a patient who lost so much weight that she could not think logically. During one of her sessions, in all seriousness, she asked me how many calories there were in lipstick and whether she would gain weight by using it.

In addition, patients will often have the ED voice which is a form of negative internal dialogue. This ED voice will tell the patient to exercise more, eat less, skip meals or hospital appointments, make comparisons with respect to food portions and the weight and shape of other people. It will also tell the patient not to tell the therapist things in respect to their food intake or other symptoms. The patient may also stay silent during the therapy session (and at home) or in front of the doctor because this is what the ED voice has advised them. The ED voice

usually consists of harsh, negative and destructive thoughts (Alexander and Sangster, 2013). Therefore, the existence of the ED voice can make therapy a challenging experience for both the patient and the therapist. The ED voice ensures that a complex mix of anxiety, fear and tension is never far away from the patient.

## **What Happens in Therapy?**

The ED is usually an indication of an underlying psychological issue. Therefore, during therapy, I may touch on food, but only briefly, as I set out to understand what problems (aside from food or weight) the patient is concerned about. Where food and/or exercise is concerned, I will usually leave that to the doctors, dietitians and physiotherapists to handle. My point is that the patients know how to eat, but they would not. I have found that talking in therapy only about food or trying to persuade the patient to eat will not help recovery and will actually only result in frustration, especially since the doctors and dietitians may already be focusing on this.

Instead, my attention is on what the patient may not be addressing — for example, some issue(s) that they feel may be unsolvable or that they feel helpless about. I also seek to find out what coping skills or strategies they will need to learn, for example, relaxation or assertiveness skills, to deal with their problems. It has been found that fully-recovered ED patients have better coping skills than those with ED, and recovery is therefore possibly dependent on the patient acquiring coping skills equivalent to healthy individuals (Fitzsimmons and Bardone-Cone, 2010).

## **What Are Some of the Risk Factors for EDs?**

Knightsmith (2012) has listed the following risk factors for the development of ED:

1. Personality factors which include struggles with expressing emotions/feelings; giving in to others/compliance; perfectionism.
2. Home and/or family factors: valuing thinness; family members

who are over-controlling or over-protective; relationship issues in the family; sexual, emotional or physical abuse; neglect.

3. Extra-curricular activities: gymnastics; dance; martial arts (which may require achieving a certain weight); modelling.
4. Peer group: peer pressure to be slim and over-valuing weight and appearance; being bullied or teased.

These risk factors tie in with the real-world examples that my patients have brought up in their therapy sessions:

- Issues at school, e.g., being bullied, not doing well, being sidelined
- Difficulties with friendships/romantic relationships
- Bereavement
- Being overweight as a child and forced into a weight loss programme at school or by parents
- Being forced to do a course at university that the parents think will be good for the patient but which the patient is not keen to do and which the patient has gone along with in order to be a “good” child
- Absent parent(s), e.g., parent(s) working overseas, divorced parents, parents working very long hours
- Change in school/country of residence
- Family members who have mental health issues, e.g., depression, anxiety, obsessive compulsive disorder (OCD), anger or even ED issues which they have refused to acknowledge or seek treatment for but which impact the patient. One study has shown that for female children, the chance of developing an ED is higher if the parent has had a diagnosis of a mental health issue such as bipolar affective disorder, anxiety/depression or a personality disorder (Bould et al., 2015)
- Sexual, physical or verbal abuse
- Parental marriage issues, e.g., constant fighting, arguing, separation, divorce
- Secrets in the family, e.g., parent having an affair
- The patient’s needs not being met and a parent’s needs taking precedence



- Low self-esteem
- Enmeshment with family; intrusive parenting; lack of individual independence or independence not encouraged by the family and too much involvement by the family; over-submissive behaviour by the patient
- Lack of validation of feelings, wants and needs and difficulty in expressing feelings

A renowned psychotherapist, Hilde Bruch (1978, 1994) who worked primarily with ED patients found that the ED patients she treated shared some common factors such as: being a good child; pleasing others; lacking in assertiveness; not being rebellious; protecting their parents from news that is disagreeable; that they may not have been encouraged to be themselves and instead to present a false front; have difficulty in showing their negative feelings; fear of being unable to meet others' high expectations and that there had been no acknowledgement of the patient's misery and pain.

### **The ED as a Coping Strategy**

The ED is therefore used by patients as a coping strategy and control over food may be providing a refuge from life's problems. The patients may feel they have not achieved very much, or worse, have been failing and they just do not feel good about themselves. Weight seems the only thing they can have control of. For the patient, relief is possible by escaping into thoughts of restricting food, losing weight, exercise or bingeing, away from problems that they feel helpless about or are unable to talk about or resolve. At its worst, patients have told me that the ED will occupy up to 90% of their day, i.e., they will spend a lot of time thinking about food restriction and how to buy food to binge at night. Most times, the patients themselves are unaware that the ED is used as a coping strategy.

There are studies which show that anorexia patients have difficulties regulating their emotions and that resorting to ED behaviours may help them avoid negative emotions. Likewise, the use of binge/purge behaviours may also be used to help reduce the effect of negative emotions. Therefore ED behaviours are used to regulate emotions and

thus may serve to maintain the ED symptoms. When the patient is in distress, in order to avoid distressing feelings, they may focus on weight, food restriction/bingeing or shape. It is therefore important to focus on more useful emotion-regulation skills (Racine and Wildes, 2013).

## **In Therapy**

In Agnes' case, I would begin therapy by asking her what are the problems she is facing, whether in school or at home. The aim is to increase her coping skills to deal with her problem(s) and in so doing, add resources to her psychological tool box to help her deal with the events in her life.

It is important to validate the feelings of the patient, e.g., how upsetting it is to see her grandfather ill and suffering and that it is natural to be worried. Here, the usual practical replies of “Don't worry” or “He will be fine, he is seeing a doctor” are probably not going to be helpful as Agnes can see that her grandfather is certainly not fine and she feels anxious about the situation. I may say to her “It must be very upsetting to see your grandfather so ill, as you have told me you are very close to him” or “I can see that you are still anxious about your grandfather even though he is receiving medical treatment. Would you like to tell me what you are anxious about?”

In addition, I would work with Agnes on identifying and acquiring useful emotion-regulation and coping skills, some of which are described in the next section of this chapter.

## **Acquiring Psychological or Coping Skills**

As you are reading this book, you might be someone who is suffering from an ED, a carer, a family member or a friend of someone who has an ED. What are some areas that might need attention? Here are some suggestions or key areas:

### ***Improve self-esteem***

Low self-esteem and lack of confidence can affect a person's view of

how they look and feel. Having low self-esteem may cause a person to try to lose weight in order to look better. It is therefore very important to have good self-esteem. Whenever I start to do self-esteem work with a patient, I will start by asking the patient to list his/her good points or strengths about themselves. Sometimes, the ED patient becomes very stuck and may name just a few positive things about themselves if at all. I have sat in silence with patients who for minutes on end, struggle to name a single good point about themselves. However, when I ask them to name some negative beliefs about themselves, they often have very little trouble doing this. Things about themselves which are not done to high standards are rejected; for example, when I ask whether they can sing, a common reply is that “I don’t sing well, therefore it doesn’t count”. The intention is for the patient to realise that it is not our point to reach a championship or competitive standard, but to record a fact about oneself that contributes to one’s identity, such as one being able to sing (even if it is only in the shower). This pre-occupation with results and achievements is not necessary. Transplanting the school model — where everything is graded — to adult life, is not helpful and can be stressful.

**Suggestion:** Make a list of your strengths, positive beliefs, good points and skills. Everything counts! Can you cycle, skateboard, dance, sing, draw or do martial arts? Did you pass your PSLE? Are you friendly, approachable, helpful, honest, responsible, etc.? Try not to be judgemental when you do this list. A sample list may look like this:

- Friendly and approachable
- Helpful
- Hardworking
- Responsible
- Enjoy singing in the shower
- Interested in travel
- Able to ride a bicycle
- Loving and caring
- Adventurous
- Loyal
- Honest
- Like animals

If you have trouble coming up with a list, try for a start to list down positive comments or compliments that others have said about you.

On the Internet are many lists of values which you can look at and pick those that apply to you. In this book, the chapter “Motivating Yourself” has a list of personal strengths that you can also look at. Remember, you are not competing with anyone when you do this list nor do you have to be the best at anything or everything. In psychology, the term “good enough” is often used and that is what you should be aiming for here.

The important thing is to hold all these facts about yourself in your mind and remind yourself of them. They contribute to the unique, individual and beautiful you and they belong to you. Remember, it is not about being perfect at something.

### ***Learn to be assertive***

Assertiveness is a skill that we can learn and develop over the years. It is important that we know how to stand up for ourselves without being passive, aggressive or passive-aggressive. We have a right to say what we need or want or to say “no” in order to keep ourselves safe and to put limits or boundaries in place. Saying “no” may engender some feelings of discomfort. In fact, it is normal to feel a little or even very uncomfortable when we say “no” especially if the other party may not like our answer. I also ask my patients to think about this point: why it might be okay for others to say “no” to them which they will be accepting of, but not okay for themselves to say “no” to others. Note that when your “no” is based on you being reasonable or the way you feel, but if the other party is disproportionately unhappy, then the problem may lie with them and not with you. When I role-play with my patients on saying “no”, they will often say to me that it is difficult at first but it gets easier with practice and indeed, over time it will. On a separate note, it is sometimes difficult to say “no” to ourselves for example: “No, I shouldn’t eat salad for lunch today if I want to recover from the ED and I need to follow the dietitian’s instructions.”

***Suggestion:*** Use visualisation to help you practise assertiveness: Think about all the times in the past when you perhaps should have said “no” to someone but instead said “yes” because you felt bad or guilty,

e.g., you would have liked to say: “Sorry, I am busy and have plans this weekend and no I cannot come and help you move house/do your homework/look after your cat/dog/hamster” but instead, you ended up saying: “Erm okay, well maybe I can come after lunch” and then feel resentful. Then visualise yourself saying “no” politely but firmly. One tip: keep it simple and only provide one reason. Too many reasons will begin to look like excuses and may give the other person an opportunity to think of ways to persuade you against your wishes (Hadfield and Hasson, 2010).

### ***Be honest with yourself***

Honesty often takes a back seat when someone has an ED. Sometimes it is because a patient feels ashamed of his/her behaviour. A bulimic patient may buy a lot of food to binge in private and will hide the evidence of food wrappers because he/she feels ashamed of the amount eaten. Often he/she may also say that he/she does not know why there is an urge to binge after dinner seeing that “so much” was eaten for dinner. The patient will somehow forget to remind herself that he/she had skipped breakfast and lunch and that dinner was the first meal of the day. In SGH, when patients are warded and they start having regular meals, their binge urges will start to reduce and eventually go away. Likewise, an anorexic patient may find it very hard to tell himself or herself that while he/she feels fat because of the illness, the truth of the matter is that he/she is severely underweight, as evidenced by the weighing scale.

**Suggestion:** For individuals with bulimia, please remind yourself that the reason you feel like bingeing is because you have restricted/missed/skipped many meals not only on that day but over many days. Therefore it is normal for you to feel very hungry. If you are suffering from anorexia, it may help to remind yourself that regardless of what you feel or what you think you see in the mirror, the reality is that you are underweight and therefore, you should not be dieting or restricting.

### ***Learn to love yourself***

Learning to work towards self-acceptance is very important in the recovery process. My patients often shake their heads sorrowfully

when I ask them whether they love themselves. ED patients often feel inadequate and lack confidence (which is usually a part of growing up) but unfortunately, ED patients will use weight loss and/or restriction of food as a way to overcome those feelings of inadequacy. One patient replied that she loves herself which is why she wants to lose weight and look good. I then replied that the weight loss should not be so excessive that an ED develops, and that love is unconditional and does not depend on one's shape or size. At that moment of realisation, the patient looked rather thoughtful.

What if you feel that learning to love yourself will make you a selfish person? I suggest you think of the airplane safety video. This video instructs that if you are travelling with a child during an emergency and the oxygen masks come down, the instructions are to put the mask on yourself first before putting it on the child. As an adult we have the responsibility to take care of our own needs first and should not expect others to take care of them for us.

**Suggestion:** Every day, say to yourself “I love myself” at least once a day. All my patients say without exception that they don't believe it when they say it. I will only say that repetition is very powerful. Try it and you might like it! Remember, we are all a work in progress; life is a marathon not a sprint. Try to talk to yourself and treat yourself with love, kindness and compassion. This is important as the ED ‘voice’ is the opposite of that and is often harsh and punitive.

### ***Learn to talk about feelings and express them***

This can be difficult for anyone. It is quite common for me to ask my patients how they feel and instead they will start to describe an event or incident. For example: “Well, today my mother said to me...” or “At work today, my boss...”. Learn to identify your feelings by telling yourself that a feeling is one word such as “happy”, “sad”, “angry” or “terrible”. It appears that anger is extremely difficult for the ED patient to express except when they are being pressured to eat. The ED then gives the patient an outlet to express their anger, allowing them to say it is the ED's fault and not feel guilty that they may have shouted at someone.

**Suggestion:** Try to identify how you feel throughout the day as feelings can give you clues as to what your needs really are.

If you are wondering how to start expressing your feelings, using a framework when communicating with others like this one can be helpful:

- Express how you feel: **I feel** (e.g., angry)...
- What is it about: ...**about the fact that** (you forgot to tell me that you will be late for dinner)
- What you would like: **I would like you to/want you to** (in the future to give me advance warning about how late you will be).

Do note that it is the last part of the sentence about what you want that is important and must not be left out. It gives clarity to others and yourself about what you require. People cannot read our minds and we must not assume that by telling them how we feel, they will know what to do the next time.

### ***Learn to self-soothe***

This is an important skill to learn and it is almost like a mental challenge. Yes, you can use external aids such as engaging in a sport, watching TV dramas or movies or playing with your pet hamster to distract you when you are feeling bad, but you will still need to have one additional skill in your psychological tool box: to be able to talk yourself into a calmer state of mind. Remember that the aim is to self-soothe and not to self-agitate! Examples of how to self-soothe may be saying things like “I will handle it”, “I can handle it”, “Tomorrow is another day”, “I may have failed my math test, but I am overall a success not a failure”, “No need to worry, it is not the end of the world”, “Twenty years from now, this probably won’t matter” and so on. And just as property agents say “Location, location, location” (when referring to what makes a piece of real estate tick), in order to learn to self-soothe, it is “Practise, practise, practise” until you find out what works best for you and this may take weeks, months and years, so it is best to start practising today!

**Suggestion:** Start observing how you talk to yourself. Is it negative most of the time? Do you call yourself names like “lazy” or “idiot”? Stop. Experiment with different soothing statements. Be patient. It

will take time to learn this skill. If you find this difficult, try talking to yourself as if you are giving advice to a friend.

### ***Learn to relax or be mindful***

There are many ways to learn relaxation techniques — through apps on your mobile phone, through structured classes or from a psychologist. These techniques include progressive muscle relaxation, deep breathing exercises, or (my favourite) visualisation exercises. It is also important to cultivate mindfulness. Mindfulness is about being in a state of awareness and of being fully in the present moment. A useful way to reach a state of mindfulness is to try and utilise all your five senses: vision, hearing, taste, smell and touch and to be aware of your body or your surroundings.

***Suggestion:*** Experiment with relaxation techniques. Read, research or take some courses. In the meantime, start with just five minutes everyday and gradually extend the time. Take note of tension in your body. If your shoulders are tense or stiff, try and relax and soften them. Alternatively, utilise your five senses, e.g., what can you hear around you? Identify all the various sounds; what can you see? If you are eating or drinking something, pay close attention to taste. If you can reach out and touch something, for example, the chair you are sitting on, what can you feel? This is a much better way to distract yourself than to think about the ED.

### ***Be careful about social media***

A study published in 2014 found that the use of Facebook could maintain EDs and that those with a Facebook account would pay greater attention to surveillance of the body, had a motivation to thinness and had ideals of thinness. Extensive use of Facebook may therefore contribute to dissatisfaction with the body (Mabe, Forney and Keel, 2014).

***Suggestion:*** Do you find yourself spending long hours on social media comparing your body to others' and feel increasingly dissatisfied with your body and/or shape and are thinking of dieting or losing weight? Please reduce use of the Internet and social media as you may be increasing your risk for disordered eating.



## Conclusion

The suggestions in this chapter form only a small part of what can take place in therapy (or outside of it), to help someone with an ED. An ED whether Anorexia Nervosa, Bulimia or even Binge Eating is a complex illness. While weight gain or stabilisation of weight can occur fairly rapidly, psychological changes will take time. Therapy will take many weeks or months. Unfortunately, there is no medication for this illness. For long term recovery to take place, it is important to remember that before the patient can let go of the ED, work needs to be done to find a replacement coping mechanism. Acquiring a feeling of self-worth, self-acceptance, self-love, better self-esteem, and body image or validation and expression of feelings, wants and needs, are important psychological tools for permanent recovery from an ED. Each has a part to play as a replacement coping mechanism.

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# Occupational Therapy and Eating Disorders

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Mention the term “occupational therapy” and most people might either think that occupational therapists are specialised in helping people find jobs, or that they only have a role to play in the field of physical disabilities. In fact, the roots of occupational therapy were present as early as 1840–1860 whereby the use of meaningful activities such as crafts, was frequently used to encourage relaxation and promote productivity among individuals with mental illnesses.

Occupational therapy is “a health profession that uses activities (occupations) with specific goals to help people of all ages to participate in activities of everyday living.” Activities of everyday living “include and are not limited to self-care, leisure, school and work” (Singapore Association of Occupational Therapy, 2012).

In other words, when a person finds himself or herself having difficulties engaging or participating in the activities they used to enjoy or need to do, an occupational therapist can play an important role with his/her interventions.

On the surface, it may appear that a person with an eating disorder (ED) merely has difficulty in only one aspect, which is that of eating his/her meals. Thus, it may come across as somewhat of a surprise to hear how occupational therapists are involved when it comes to rehabilitating a person with an ED. Indeed, those who have gone through an ED or have seen someone go through it would attest to the far-reaching impact it has on multiple facets of life.

Eating is seldom purely only about the food; the social aspects of eating can become very challenging as the person with ED struggles

with bonding with family and friends over a meal. Catching up with friends over a meal or having lunch with colleagues at work become daunting tasks for people who struggle with ED. Over time, the person with an ED may eventually become socially isolated.

Then of course, there is the nutrition within the food we eat that actually gives us the energy to carry out the tasks we need to accomplish throughout the day. Without an adequate or regular intake of nutrition, our brains will decrease in its ability to focus and concentrate on tasks. This can affect performance at school or at work. Mood swings and irritability set in as well, and these can impact relationships with people around us whom we interact with. Just recall the last time you had a meal later than usual — you would probably remember feeling increasingly fidgety and irritable as time passed and the hunger pangs grew.

The lifestyle of a person with an ED is often imbalanced as he or she becomes obsessed with the various rituals and behaviours required to maintain it. This may include having a regimental exercise routine or scheduled purging episodes to compensate for the food intake for the day. The focus on the ED can be so dominant that they would then increasingly forgo previous healthy occupations such as engaging in leisure activities and spending time with loved ones. By and by, in this way, the ED insidiously takes over and consumes the individual's time, energy and attention.

Occupational therapy addresses individuals who face performance concerns in the domains of their activities of daily living, productivity (work or school) and leisure. An ED can undoubtedly affect a person profoundly in these domains of life — often in all three, in fact. Therefore, some aspects that occupational therapists typically work on are:

- Goal-setting
- Activity scheduling/time management
- Planning and preparing meals
- Social skills training
- Leisure exploration
- Return to school/work/community

## **Goal-Setting**

Setting goals with patients is a fundamental component of occupational therapy practice. In the field of ED, occupational therapists can use goal-setting activities to help patients find their personal motivating factors and maintain their focus during the low points of their recovery journey. The occupational therapist facilitates patients to pause and reflect on where they are currently, versus where they envision themselves to be at, say, three months, six months, one year and five years later. This encourages patients to take ownership of their recovery. Well-set short-term goals, when achieved, would encourage patients to spur on in this long recovery process, and will help them ultimately re-engage in occupations and roles that are meaningful and important to them.

A good example would be that of Miss A, a patient whose studies were put on hold after months of battling the ED. When she had progressed to a better phase of recovery, Miss A was keen to pursue her long-term goal of studying the Arts. It was difficult for her to enter her preferred choice of art school without the necessary qualifications, but with short-term goals set with the guidance of the occupational therapist, Miss A took up bridging courses that eventually qualified her for the school of her choice.

## **Activity Scheduling/ Time Management**

Because an eating disorder can be such a powerful core, patients sometimes reach a point where they plan everything in their life around the disorder, including the way they spend their time daily. For example, some may wake up before dawn to clock two hours of exercise before going to school, then ‘conveniently’ plan to do school work during lunch time so that they get to skip the meal. It is also not uncommon for patients to be so tired out from late-night binge purge cycles after they return from school or work that they are unable to wake up on time the next day. All these would ultimately take a toll on one’s performance in school or work. The occupational therapist works with the patient to raise his/her self-awareness of his/her current time use patterns, identify problem areas and collaborate together towards developing a healthier daily activity schedule. This is often done by getting patients

to first fill up an activity scheduling sheet where they are asked to break down, in hourly blocks, how their time is typically spent. Together with the occupational therapist, patients get to review and reflect on how much time has been invested in ED behaviours and activities. This serves as a good platform to discuss how more of their time can be gradually replaced with healthier activities. Coping strategies that patients learn from their therapy sessions with the psychologist or other members of the multi-disciplinary team may also be incorporated to help them curb their urges as they go about their daily routine.

## **Planning and Preparing Meals**

The ability to plan and prepare a standard snack or meal for oneself is a life skill that an ED can have a tremendous impact on. The issue is not that the patient is unable to cook or put together a meal, but more pertinently, it is whether he or she is able to rationally handle feared ingredients or food items and add them into the meal(s) that he/she will consume. Patients usually find it a challenge to handle ingredients such as butter, oil and sugar, or may have difficulty in judging what an adequate portion is for themselves. The occupational therapist provides a therapeutic milieu where patients get the opportunity to go through the actual practical process of preparing a meal or snack. A hands-on session like this then creates a very valuable opportunity for the therapist to offer support and to normalise the experience, through subsequent discussions to process the experience and struggles faced. Through the discussion and processing, patients are encouraged to challenge their distorted beliefs about food. For instance, a patient who believes that touching butter will result in immediate weight gain will realise such beliefs are irrational and stems from his or her fear of 'unhealthy food'. With exposure to such feared food over time, it is hoped that the patient will gradually be desensitised, and a more positive experience around meals or snack time can be recreated.

## **Social Skills Training**

With the isolating nature of an ED, the person often withdraws him or herself from his/her social circle, thereby reducing the amount of

social exposure as compared to their peers. Patients sometimes refer to the years of having the ED in their lives as “the lost years”, when they realise just how much they need to catch up on emotionally and socially to match their chronological age. The aim of social skills training is to allow the patient to be exposed to typical social situations and provide a safe environment to discuss the nuances and complexities of social interactions, thereby honing their social skills progressively. For example, patients often fear having to attend events such as family birthday parties or Chinese New Year celebrations, as it would invariably mean having to catch up with relatives who may comment on changes in their body shape and size. For a person with ED working on recovery, he/she could still be trying to come to terms with the physical changes in his/her body, and any comments on the topic would understandably be highly sensitive, or inappropriate even. Occupational therapists, through the facilitation of a group activity or individual therapy, encourage patients to role play such social scenarios and discuss what might be appropriate responses.

Social perceptions — how a person processes the words and interactions of others to form an understanding of their intentions, are also an important area to work on, because social interactions are such an integral part of everyday lives. Difficulties in accurate social perceptions can be a very real obstacle for an individual who is trying to catch up on his/her social skills.

## **Leisure Exploration**

Engagement and participation in leisure pursuits and hobbies — activities that intrinsically bring us joy and pleasure, are fundamental elements of a well-balanced life. The ability to enjoy leisure activities is not often overtly thought about, but all too often, an ED can rob a person of this ability. For instance, a person may have enjoyed running as a leisure activity in the past, but if the ED currently causes a strong urge to over-exercise for the sake of losing more and more weight, he or she may find running to be more of a compulsion now and may no longer enjoy it. Similarly, an avid baker may find himself/herself still baking while struggling with an ED, but not quite enjoying the activity as before, as his/her mind is preoccupied with thoughts of weight gain, calories,

body image distortions and anxiety. Over time, patients may realise at some point that they no longer have an answer to the question “What do you enjoy doing in your free time?” The occupational therapist aims to help the patient reconnect with their leisure interests and inclinations, and gently facilitates them to make time for leisure in their lives again instead of allowing the ED to take control over their entire time schedule. The list of leisure occupations that are reintroduced to patients ranges from sedentary tasks such as reading and scrapbooking to participation in community activities such as volunteering. In doing so, the occupational therapist educates and reinforces to the patient on the importance of leisure activities as part of a balanced life and as a natural coping tool.

### **Return to School/ Work/ Community**

Returning to the school or work environment after a period of treatment is daunting. There are many fears and anxieties, especially with regards to how to handle comments and questions from others such as having to explain their period of absence during their hospitalisation stay.

Patients who may have been very underweight before seeking treatment will look different after weight restoration during their recovery, and well-meaning comments on the physical difference can be received with much dread and anxiety. Getting back into the rigours of a structured school or work schedule may also lead to physical fatigue and stress. The occupational therapist works on developing patients’ readiness as they prepare to return to school or work after their time away during treatment. This can include discussing and problem solving with patients on their comfort level with regards to how much they want to disclose or reply to others when faced with comments or questions. One common question would be, “Where have you been? I have not seen you around!” To that, depending on the patient’s comfort level, he/she can either choose to respond truthfully, or he/she could say “I have been busy with handling some personal matters. Things are better now, but I would prefer not to talk about it until I am ready to do so”.

Crucial life skills such as stress management are also a focus. The therapist also reviews the changing life demands in the new chapter



of recovery and develops relapse prevention strategies that reinforce healthy roles and occupations.

For a chronically ill patient who may have been out of the workforce for a prolonged period of time due to the ED (say, more than two to three years), the occupational therapist can also help in easing him/her back into work by going through the job search process with him. This could be done by going through appropriate jobs, preparing résumés and getting ready for job interviews.

Along with the possible change in body size during the treatment period, comes the issue of finding new clothes to fit into and feeling comfortable and confident in them. The task of shopping for new clothes may seem like a total breeze (and delight) to most people. But for a patient returning to school or work, this can often be an utter dread. An ED can often make a person fixate on a size labelling. In this specific area, the occupational therapist's aim is to help the patient understand that the size label is not the definition of oneself and provide a safe environment for the patient to go through the normalised process of browsing for clothes, trying them on and assessing the suitability, while being able to deal with any nagging negative thoughts going on at the back of the mind. In addition to therapy sessions where the occupational therapist processes these with the patient, a "shopping outing" can also be arranged. This allows the patient to have a practical hands-on session to put into practice the coping strategies that have been explored and discussed previously. Take for example a patient, Miss B, who was brought on a shopping outing. During the process, Miss B was anxious that she could not seem to buy the clothes she liked as most shops had ran out of her size. It was a good learning point for Miss B as she came to realise that the clothes in her sizes were all sold out as it fitted most regular women! It was through the shopping activity that the occupational therapist was able to normalise Miss B's perception of her current body shape and size, and challenge some of her distorted body image beliefs.

### **Activity Analysis**

In all the above aspects that an occupational therapist works on, an often invisible work done by the therapist is that of activity analysis.

In every single activity that a person does, it can be broken down into task components. This includes not just the physical carrying out of the task, but also the cognitive demands required, for example. When working with the patient on an activity that he or she may currently have difficulty in and hopes to engage in again, the occupational therapist would analyse the components that make up the full activity, and identify the specific task components to address it. Through the process of activity analysis, the following questions may be considered, among others:

- What are the demands of the activity?
- What are the performance skills required?
- What are the individual factors of the patient that might affect the carrying out of the task?
- What may be environmental or contextual factors?

Taking the example of the patient who finds it challenging to obtain new clothes to fit herself in the midst of her recovery journey, the occupational therapist may break down the activity of obtaining new clothes into the components of:

- The awareness of what type of clothes would suit her body frame and flatter it (cutting, fabric type, etc.)
- Deciding the type of clothes she is looking out for (personal style)
- The knowledge of where to browse for such clothes
- Handling possible comments from store assistants after trying it
- Personal assessment of the suitability and decision to purchase or not

For a complex and potentially very challenging task like this, the occupational therapist's activity analysis is vital as it then allows in-depth processing to be done over multiple therapy sessions, with the goal of preparing the patient to make an actual attempt at obtaining new clothes ultimately.

## **Conclusion**

Every individual holds multiple and concurrent roles — daughter/son, sister/brother, friend, student, worker, etc. Each of these roles carries a different significance to the individual. But when an ED sets in, every one of these roles will be impacted. As occupational therapists, we believe that an individual's well-being can be promoted through participation in meaningful activities, as determined by our life roles. It is through developing healthy habits and skills that we can achieve an occupational balance and prevent possible relapse. Most importantly, we work towards helping the person with an ED successfully integrate back into the community. The occupational therapist, alongside the multi-disciplinary team, aims to support and facilitate patients to re-establish connections to the roles that hold strong meaning to them.

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# Physiotherapy and Eating Disorders

*Kirsten Eve ABDUL, Physiotherapist*

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## Overview

Physiotherapists, primarily, are health professionals who treat patients with illness, injury or disability, with movement, exercise, education and advice. As experts in movement and exercise, we play a vital role in the multi-disciplinary management of patients with ED by helping them to manage excessive exercise behaviours, injury prevention, having a healthy relationship with physical activity and exercise as well as improving body image. Compulsive or excessive exercise is a trait apparent in many patients with ED which can severely affect recovery. Returning to appropriate exercise levels may require close monitoring and advice from a physiotherapist so as not to negatively impact recovery. In this chapter, we will look at how to identify excessive exercise from healthy exercise, as well as the steps to recovery and reintroducing exercise into a healthy lifestyle.

## Benefits of Exercise

Exercise is a subcategory of physical activity. The definition of exercise is a planned, structured, repetitive and purposeful activity. Exercise is an important part of a healthy lifestyle and body image. It strengthens our heart, muscles and bones; it keeps our body fit and improves our psychological well-being. It is recommended that exercise should be part of daily lifestyle. Due to this, many people, including people with ED, believe that it is impossible to do too much exercise. However this is false as excessive exercise patterns may be detrimental to health, a precursor to an ED or end up perpetuating the ED cycle.

Physical activity includes all our day-to-day movements from carrying shopping bags to walking to the bus stop. Besides excessive exercise, people with ED may increase their physical activity levels in an attempt to expend more calories.

## **Increased Physical Activity in Eating Disorders**

Signs that someone may be excessively exercising through daily physical activity include:

- Walking or pacing the room
- Refusing to sit down
- Making multiple trips to collect things that could be done in one trip
- Sitting on the edge of the chair, requiring excess muscle tension to keep that posture rather than sitting back
- Shaking of legs or other body parts while seated or standing or fidgeting on the spot
- Holding excess tension in muscles (clenched fists, tension in neck and shoulders)
- Walking rather than taking public transport/car
- Always walking up the stairs rather than taking escalator/ lift

These may all be attempts to expend extra energy or calories throughout the day in the drive for thinness. Often these behaviours are masked by the rationalisation of health benefits of walking and reduced sedentary time in terms of sitting down. If someone is recovering from an ED, particularly if they are below healthy weight, it is advisable to reduce daily physical activity levels.

## **When Does Exercise Become a Problem?**

Exercise may become a problem when the exercise routine interferes with health, weight, his or her work, school, social interactions or psychological well-being. Using exercise as a way to compensate for weight gain or bingeing can also lead to an unhealthy reliance and

relationship with exercise. He or she might also injure themselves due to the excessive exercise undertaken and lack of rest and recovery. Put simply the person is ‘over-training’ and ‘under recovering’. The balance between how much exercise or activity a person does and how much rest and recovery he or she gets has been upset. An innocent activity such as going for a jog once a week may spiral out of control and becomes a daily 10km run instead. Rather than enjoying exercise, it can become a chore or a form of punishment.

### **Identifying Not Just Physical But Also Psychological Signs of Over-Exercising**

Excessive exercise or activity levels can cause serious health complications. Initially the body may be able to cope with the increased activity levels but over time as the exercise and activity levels increase and the body is not getting sufficient nutrition or rest; physically the body is going to suffer.

Physical signs and symptoms of over exercising include:

- Lowered hormones (menstrual dysfunction in women, sexual dysfunction in men)
- Osteoporosis (thinning bones that are more prone to fracture) due to low body weight or poor nutritional intake
- Mood disorders
- Heart problems
- Permanent damage to joints, muscles and tendons (due to increased risk of injuries)
- Fainting or dizzy spells while exercising

Sometimes there may be no physical signs of unhealthy exercise. It can be hard to spot when someone is over-exercising as they may go to great lengths to hide what they are doing. It may not just be how much someone is doing. Rather, it is about the thoughts and feelings behind why they are exercising or how exercise makes them feel and how exercise affects their mental status and mood. It can be easy to get caught up in unhealthy exercise cycles when living with any ED,

whether it is compulsive thoughts about exercise, basing self-worth on how well you can perform, or causing damage to relationships because exercise takes precedence.

Signs to look out for that may indicate someone is over-exercising or has an unhealthy relationship with exercise include:

- Exercising in secret
- Suddenly spending more time exercising
- Exercising vigorously for more than one hour or multiple times per day
- Feeling guilty or anxious if an exercise session is missed
- Sticking to a rigid exercise regime despite injury, illness or bad weather
- Exercising because you have to rather than you enjoying it
- Choosing exercise over family, friends and social outings or other interests
- Basing your self-worth on exercise

## **What About Athletes Who Train Multiple Times a Day for Long Periods?**

This is an argument we hear many times from people with ED who excessively exercise: “Why can athletes/my friend train for three hours every day but I cannot?” The amount of exercise suitable for each individual depends on many things. A person’s level of exercise may be perfect for them but too much for someone else due to fitness levels, injury, illness, health status, body mass index (BMI), food intake and other variables.

## **It’s All About the Balance**

We can look at it as a balancing scale between training and recovery. Training is how much exercise we are doing (the type, duration, frequency and intensity). Recovery includes nutrition, rest days and injury prevention. As mentioned before the perfect balance is different for everyone, but what is important is that you find the balance for your body.

An athlete can train for many hours almost every day of the week, but if they train too much and if they don't do something to ensure that they have enough recovery then there will be negative consequences such as injury or malnutrition and a dip in performance. For the athlete to perform optimally they need to increase their recovery to match their training. This might be through increasing their food intake to make sure they are eating enough to meet the demands of their training for their body to stay fit and healthy, or seeing a physiotherapist to help relieve aches and pain, or having an extra rest day after a hard training session.

A lot of times people with ED train too much and don't let their body recover enough. People with ED almost always don't meet the nutritional needs of their bodies to complete the amount of exercise they are doing (either through restricting or purging). This is excessive exercise as over time it will cause physical or psychosocial harm to them. In the end something is going to break with this vicious exercise cycle

## **How and When to Reintroduce Exercise Back into Your Routine**

Doctors may recommend stopping all exercises initially until the ED, mood and weight have stabilised at satisfactory levels. Once the doctor has cleared the person to re-start his or her exercise, supervision by a Physiotherapist is required in addition to a Dietitian's input to ensure treatment goals are not compromised. Exercise needs to be appropriate for BMI, patient's wishes and goals, and medical conditions. Exercise privileges may be withdrawn when negative behaviours are displayed, for example weight drop, restriction, and purging (purging can cause an imbalance in electrolytes putting the person at risk of fainting or collapsing or stressing the heart when exercising).

Initially relaxation, deep breathing and stretching exercise may be introduced to ease body stiffness and alleviate excess muscle tension or pain. This should be done at the prescribed dose as even stretching can be done excessively.

As the ED improves and progress is made, low intensity exercise can gradually be introduced. This is a fine balancing act and as mentioned before needs to be done under the supervision of a Physiotherapist.



Strengthening, posture, balance and body awareness exercises can be started to help condition the body and work towards future exercise goals. Keeping an exercise diary may be useful to identify thoughts and feelings associated with exercise and help to monitor compliance to the prescribed exercise regime.

As progress is made, exercise intensity and frequency can be increased. Usually aerobic exercise is only started once healthy weight has been maintained, menses has resumed and purging has ceased.

## **Different Types of Exercises and Benefits in Recovery from an Eating Disorder**

### ***Intensity of exercise***

Low Intensity — Causes minimal increase in heart rate and breathing. You could continue the activity comfortably for most of the day. This includes stretching, slow-paced walking, yoga, etc.

Moderate intensity — You should still be able to talk but not have enough breath to sing. This includes walking, low-impact aerobics, dancing, etc.

Vigorous intensity — Causes a large increase in breathing and heart rate, you may be gasping for breath while exercising. This includes jogging, badminton, contact sports, etc.

### ***Types of exercises***

As described above, exercise is a planned, structured, repetitive and purposeful activity. Exercise can be broadly classified as aerobic, weight training or resistance training, balance exercises and stretching or relaxation exercises. Some exercises are a combination of aerobic and resistance training such as high intensity interval training (HIIT). Each of these exercises has different benefits.

Aerobic exercises aim to improve one's physical fitness, while weight training primarily increases muscular strength. Balance training helps with falls prevention especially in view of the higher risk of osteoporosis among individuals with ED. Stretching improves flexibility, which may

be a problem with the increased or excessive muscle tension seen in patients with ED. Common muscle strains include shoulders, neck, and lower back. Stretching together with breathing control helps to relax the muscles and reduce anxiety.

It is important to incorporate a variety of exercises and to empower the individual to see exercise as a tool for healthy living rather than as an addiction.

## **BMI and Exercise**

These are general guidelines for exercise based on BMI. However due to other factors such as physical and psychological health, your doctor may have different recommendations. Please check with your doctor before starting exercise when you are recovering from an ED.

**BMI less than 17kg/m<sup>2</sup>:** Avoid engaging in any exercise as it can affect weight gain and may be detrimental to your health. Breathing, relaxation and stretching exercises can help reduce muscle tension and exercise urges.

**BMI 17kg/m<sup>2</sup> towards healthy weight:** Build your strength, flexibility and endurance with low-intensity supervised exercise such as yoga, Pilates, walking or light resistance training. Exercise should not compromise weight restoration.

**At a healthy weight (as determined by your doctor):** Increase the intensity of your exercise gradually.

Unless otherwise advised by your doctor, follow the moderate intensity exercise guidelines.

Seek advice from your doctor before you start any vigorous intensity exercise.

## **Exercise and Osteoporosis**

People with ED, especially those who have been underweight and amenorrheic for more than six months to one year are at an increased risk of having thin bones that can break easily. We call this osteopenia or osteoporosis. A bone mineral density (BMD) test can be done to check the strength of your bones to see if you have osteopenia or osteoporosis.

If the scan shows that you have either osteopenia or osteoporosis, there are some precautions you need to take when exercising.

Exercise is often recommended for bone health, as like muscle, bone is a living tissue that can be strengthened through exercise. One type of exercise we recommend is weight-bearing exercise such as walking, strength training (lifting weights) and aerobics. It is important to note that these exercises can only help to strengthen bones when the individual is above healthy weight. As mentioned above, balance training is important to reduce falls risk and thus reduce fracture risk. When starting exercise for bone health, close monitoring is essential to ensure that it does not impact weight maintenance/gain, or cause exercise-induced amenorrhea in people with ED.

Precautions to take when exercising with osteopenia/osteoporosis include:

- Ensure a good form and posture with strength training (lifting weights)
- Avoid repetitive forward bending and twisting exercises (such as sit-ups and Russian twists) as these cause excess force in the spine and increase fracture risk.
- Avoid abrupt or explosive loading such as long distance running
- Avoid contact or high impact sports (rugby, basketball, karate)
- Avoid exercise with increased risk of falling (horse riding, ice-skating, skiing)
- Avoid certain combined bending and twisting movements of the spine such as in tennis, squash, golf, and some yoga poses

## **How to Deal with Excessive Exercise Urges**

It can be hard to curb the impulse and want to exercise excessively when recovering from an ED. Often the thoughts of exercising can become overwhelming and the patient believes exercising can only relieve the distress caused. There are in fact various techniques that may help alleviate this distress and ease the excess muscle tension and energy felt in the body.

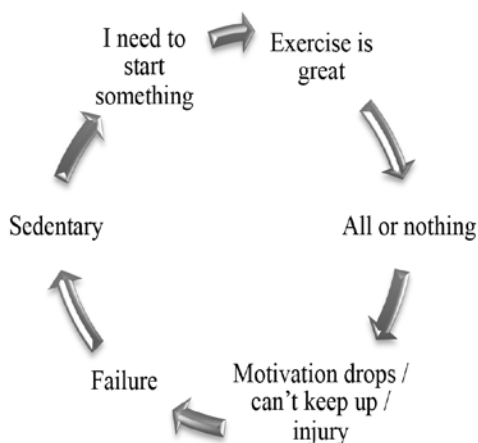
For when all exercise needs to be stopped:

- Distraction techniques: Reading a book, watching a movie, writing, drawing, crafting, listening to music, etc. Find something that works for you and helps to distract your thoughts away from exercise.
- Breathing, relaxation and mindfulness exercises can be great ways to get rid of the stress, anxiety and tension that you may feel when you have stopped exercising or you feel the urge to exercise.

For when you are allowed to return to exercise:

- Plan out a suitable exercise session ahead of time. Go with someone who can keep you accountable to ensure you don't go beyond what has been planned. Or plan your exercise session so that it will end just before you need to attend a meeting or meet someone else, etc.
- Keep a record of exercise done and show your doctor or healthcare professional to keep you accountable.
- Join a suitable exercise class so that you are exercising with other people and the intensity and duration is set by the class instructor.
- Do not return to an exercise previously done excessively/compulsively. Studies have found that those who return to exercise previously abused are more likely to relapse. For example: a person may have started running laps around the block, initially to stay healthy but gradually the motivation switched to weight loss. This person would then run 20 laps each day even when it was raining. The person would feel extremely guilty if he or she missed a run and would abstain from eating as a result. This is clearly ED driven excessive exercise. When returning to exercise again it would be advisable to stay away from running as this may trigger similar thoughts and feelings previously experienced resulting in a relapse. Instead it would be advisable to find another form of exercise that he or she would enjoy with a more social context than solitary running.

## Breaking the Cycle



This is a cycle of unhealthy exercise we tend to see in people with bulimia and binge eating. It can be just as harmful physically and mentally as excessive exercise. This is a cycle which begins with a positive intention of starting exercise. However, exercise is usually started at too high an intensity or duration for someone's fitness or motivation levels due to want of maximum effect of exercise ('no pain no gain' approach). Gradually the motivation to exercise drops or an injury is sustained which stops the ability to exercise, leading to a feeling of failure by the individual.

Exercise instead should be started at a level which is appropriate for someone's fitness levels. Most importantly, exercise should be something that is enjoyable and sustainable. If you don't enjoy the gym, you don't need to go to the gym! There are many other types of exercise to try. Find something that fits easily into your schedule. Start off small; try exercising once or twice a week for 30 minutes then as your fitness and strength improves gradually increase frequency, duration or intensity of exercise. This will help to reduce injury risk and make your exercise regime healthy and sustainable. Make sure your exercise levels are in line with those prescribed by your doctor or healthcare professional.

## **Listening to Your Body: Promoting Body Awareness and Positive Body Image Through Exercise**

Exercise has been shown to have a positive effect on self-esteem, mood and even depression. Exercise can be used to improve self-efficacy and content with one's body. The compulsion to engage in solitary, rigid or secretive exercise as a means to overcome guilt — as a form of punishment or part of a rigid routine — should be positively discouraged.

Physiotherapists using the knowledge of anatomy, physiology and movement science will be able to re-educate the impact of excessive exercise on the body, reduce risk of musculoskeletal injuries due to overuse or poor posture, and reduce fatigue. This will allow one to enjoy the ability to exercise in the long term, as well as, positively reinforce healthy exercise behaviours.

Quite often people with ED have a negative or altered body image with the difficulty to see their body objectively. This causes them to distance themselves from their actual body, ignoring how their body feels and moves. Exercise can help people with ED become more aware of how the body moves, enjoying the sensations rather than feeling distant from the body. Exercise can also help them to appreciate and celebrate physically what their body can do for them. During supervised exercise, physiotherapists are able to help one to be aware of one's body position and body image during physical movement to encourage self-acceptance and confidence. In the process, physiotherapists may challenge these individuals with ED to re-look at their altered beliefs of exercise and regulate excessive exercise behaviour.

### **General Tips for Exercise**

- Make it social: Exercise with your friends or family members
- Make it fun: Choose an activity you enjoy
- Listen to your body: If you feel unwell, have an injury, or your ED has relapsed, refrain from exercising until you have recovered.

- Promote positive body awareness: Develop a positive body image through exercise; focus on enjoying the activity and look at physical improvements (such as strength, flexibility and endurance) rather than just the numbers on the scale. Celebrate what your body can do for you.

*With thanks to Li Whye Cindy NG, PhD, Senior Principal Physiotherapist.*

# Caring for a Child with an Eating Disorder Through the 6Cs

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As a family therapist working with parents whose child suffers from an eating disorder (ED), I often hear the pain and anguish that parents go through in their child's recovery journey. Feelings and emotions frequently experienced include guilt, anger, sadness, anxiety and hopelessness especially when the ED is strong in the child. Some common terms parents use to describe their care-giving experiences include "walking on egg shells", "24/7 job" and "no light at the end of the tunnel". Indeed, it takes supernatural strength from a parent's love to persist in supporting the child who is going through the throes of ED. The good news is that the child can recover from the illness, and parents' efforts can pay off even though the journey may be likened to that of a roller coaster ride. The following are some ideas that I have gleaned from working with parents, which I have found to be helpful in supporting the child through recovery.

## **Compassion**

It can be very frustrating caring for a child with an ED. Often, parents find the child's behaviours to be very confusing and senseless. Some may attribute the behaviours to personality defect and feel very angry and disappointed with the child. In caring for a child with an ED, it is important to remember that the child is suffering from a psychiatric illness and in need of help. In particular, Anorexia (AN), a type of ED usually characterised by low body weight, fear of gaining weight, food restriction and other compensatory behaviours like excessive exercise, is one of the most serious of psychiatric conditions with high mortality rates due to the severe impact on the person's physical, mental and emotional health.



Having an ED is like having an external force take control of the person. There are behaviours and urges especially surrounding eating and weight control that the child finds hard to manage when the illness is strong. Thus, it would be difficult for the child to make logical and sound decisions at the initial stages of recovery, and it may be unproductive and frustrating for parents to expect the child to be able to do the obvious (“just eat”) to help themselves. This is especially evident in persons suffering from anorexia as the brain literally shrinks when the body is starved, thus affecting the executive functioning including the decision-making ability of the person (Weider et al., 2014). Being able to separate the child from the illness by remembering how she was like before the illness and recognising the symptoms of the illness such as changes in eating habits and fears of certain foods can help parents put things in perspective and develop the compassion to help the child.

## **Communication**

Meal times can be especially challenging as emotions run high when there is ED in the family. It is important for parents to stay calm when communicating with each other and the child with an ED, so that messages are conveyed across effectively and ED does not get away in the midst of arguments or fights. It is recommended that parents send the same monotonous message — that the child eats and finishes the food during meal times — and avoid getting distracted by other issues or engaging in logical discussions with the child if he or she is struggling with eating. However, should the parent sense his or her own emotions escalating and about to get out of hand, it would be helpful for him or her to take time out, to cool down and sort out his or her thoughts and feelings before returning to deal with the issue at hand.

As the illness progresses, families may find that their conversation topics tend to revolve increasingly around food and eating. Over time, both parties may forget that there is more to the child and life than just the ED. Outside meal times, it would be helpful if the caregiver could show interest in the other aspects of the child’s life by asking open-ended questions such as “How was your day?” versus close-ended questions such as “Have you eaten?” In addition, it would be helpful to allow the child a chance to talk about his or her struggles and for

the caregiver to listen and empathise with the child outside meal times and when both parties are calm. The patients I work with often share that they find parents' encouragement and acknowledgement of their efforts helpful in their recovery rather than criticisms or rejections. Parents' recognition that the child is not the ED (i.e., seeing the illness as separate from the child's identity and being) and is in need of help is also useful.

## **Contracting**

In order for everyone to be on the same page in the treatment of ED, it is helpful to set a contract with clear goals and targets preferably jointly with the child when he or she is calm. Examples include completing at least three main meals and two snacks per day as decided by parents, consuming meals within 45 minutes and making weekly weight gain targets of at least 0.5kg or 1kg depending on the child's needs. Within the contract, it would also be necessary to specify the consequences such as those mentioned below should the child be unable to keep to any of the targets. Having a written agreement and targets allow the child and parents to be clear of what is expected and to have something to fall back on and know what they could do especially when the child with ED acts out. Below is how a sample contract could look like.

### **Goal: To normalise eating habits.**

Steps to achieve goal:

1. Take all three meals and two snacks as decided by parents daily.
2. If meals or snacks are incomplete, to take a milk supplement as a top-up.
3. Complete all main meals including fruits or desserts within 45 minutes.
4. Return to the ward if there are two consecutive meals that are incomplete.

Agreed between

\_\_\_\_\_  
Signature of Parent(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Child

\_\_\_\_\_  
Date

## Consequences

When ED is given room to manoeuvre, it can grow and become more entrenched over time. It is critical to be very firm and set limits with ED by specifying consequences if breaches are made. Examples of some helpful consequences that my patients and their parents have come up with include: not being allowed to leave the dining table till the meal is completed; having to take a top-up of milk supplement when meals are incomplete; and having to take both breakfast and lunch (not brunch) regardless of the time the child wakes up in the morning especially if ED is driving the child to wake up late so as to avoid breakfast. A point to note is that consequences are only effective if they are targeted to the specific needs of the child and have a deterrent effect on the ED. For instance, if the child does not mind milk supplements and would rather take it than a rice meal, giving milk supplements would not be as effective as having the child take only rice meals for the whole week as a consequence of not completing her meal.

While specifying consequences for ED is helpful, they are only effective if caregivers are firm and consistent in implementing them. It can be very tempting for parents to give in to the child and allow bargaining as some may feel that it is “better for the child to eat something than nothing at all” when it comes to trying to challenge the child with feared food. However, once the ED is allowed to bargain, it would be difficult to prevent it from going down the slippery slope, and engage in more and more negotiation. Thus, even though it can be hard to watch the child struggle with eating or taking feared foods, caregivers need to remember that these are necessary struggles for the child to overcome in order to recover and not give in to the ED.

While consequences that are well planned and implemented consistently usually work in keeping the ED at bay, there are instances when the ED is so strong that the child becomes violent during meal times. Parents can include in the contract that they would send the child to the hospital when violent or self-harm behaviours manifest.

## **Consistency**

In order to help the child with an ED effectively, caregivers need to be consistent in how they manage the ED in terms of implementing consequences when agreements are broken. Parents need to send the same messages to the child and ensure that the child goes for treatment. In fact, as family therapists, we often tell parents that they need to be not just on the same page but on the same line and even same dot with each other. Parents need to be prepared for resistance from the ED especially at the initial phase of treatment and not give in or give up when the going gets tough. Getting the child to seek help early and consistently no matter how hard the child resists is critical as it helps to increase her chances of recovery.

## **Caring for Self**

It is easy for caregivers to neglect themselves when they are heavily involved in caring for their sick child. Some literally become “slaves” to the ED when they feel compelled to do certain things such as cooking in a certain way for the child who would only eat food prepared by a specific person in a certain way, e.g., only steamed food without any seasoning. In the course of my work, I have come across mothers who felt that they had to rush home from work every day just to cook for their child. In addition, it is not uncommon for families to stop going for social outings especially when such occasions involve food due to fear that the child would feel out of place or have a meltdown. As ED is not something that is easy to comprehend, families may find it hard to explain to friends and relatives about the child’s condition and end up isolating themselves from others. It is common for us to find family members (including the child’s siblings) suffering from anger, anxiety, burnout and/or depression after some time especially when they do not have other support or when family relationships are affected.

With much time and energy being channelled to managing the ED, it is essential that caregivers focus on taking care of their own basic needs first so that they could be an effective help for their child. This is similar to instructions given in airline safety videos for adults to put on their

oxygen masks first before helping their children during emergencies. Examples include having adequate rest and taking meals regularly. If they have family members and friends who could help, they may wish to tap on them, e.g., for emotional support, meal supervision or to reach out to patient. For school-going children, parents could consider getting support from the school by sharing with the school the child's condition and areas of need such as helping to keep an eye on the child to ensure that he or she takes proper meals in school and not exercising unnecessarily.

ED usually impacts everyone in the family, with some being more affected than others. Besides tapping on informal support network, family members may want to seek professional help for themselves if the need arises. By practising good self-care habits, not only can the caregiver be of greater help but he or she would also serve as a good role model for the sick child in the recovery process.

Last but not least, it is important for caregivers to be kind to themselves, and let go of any guilt or self-blame feelings that may be present by recognising that it is not anyone's fault when a child develops an ED. By doing so, they would be better able to conserve their energy and direct it towards helping the child.

## **Conclusion**

Though the process of caring for a child with an ED sounds daunting, parents can help increase the child's chances of recovery when they adopt the 6Cs and persevere through the difficulties. I have personally witnessed major transformations in the child as he or she recovers and families strengthened along the way. Families can and have been able to see light at the end of the tunnel as the child steps out of the shadow of the ED to go on to lead a normal life again.

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# **Mealtimes and the Child with an Eating Disorder: Some Tips for Parents and Caregivers**

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If food is like medicine to a child with an ED, then meals and mealtimes would be the battleground for all parents and families. Caregivers want to do their best to be supportive to their loved ones but often feel helpless at mealtimes — they either give in to the illness to avoid conflicts and tension or end up venting their anger and frustration at the child, leaving him or her feeling unsupported and discouraged. From enjoying meals together and bonding over food as a family, parents are suddenly being thrown into the situation where they have to try in every possible way to get their child to eat the food that is on the table.

Friends and relatives may provide ad-hoc support during mealtimes by sharing meals together, encouraging the person to eat, and providing emotional support after meals. However, for the majority of young individuals who are ill, parents are likely the ones who carry the greatest responsibility in supervising mealtimes from the moment their child enters treatment till they make some progress in their weight and can regain some of the control of their meals. Parents become frustrated yet anxious while they watch their loved ones struggle at mealtimes and fight family members who try their best to help them get out from this illness and ordeal. Furthermore, it can be a lonely journey for parents since some may feel embarrassed to let others know and ask for help. Even for those who have some support, most parents may still need to carry the burden of supervising the meals on their own.

In this chapter, a child is defined as anyone who is under 21 years old and would be pursuing his or her studies and largely financially

dependent on the parents. It is developmentally normal for the relationship between the child and parents to evolve over time as the child individuates to be an adult. Different challenges would emerge for a 13-year-old adolescent as compared to an older youth at 20 years old. Some of the pointers may still be useful as a guide for adults with ED but parents would need to exercise judgment and find a balance given that the nature of parent-child relationship would be quite different for a working adult in their 20s or even older living with his or her parents.

Below are some tips that may be helpful for parents as they support their child during mealtimes.

1. Take charge of the meals

In order to help their child to fight the ED, one of the most critical tasks parents need to do is to take charge of all the child's meals. While the child may be a high functioning and independent teenager who is capable of reasoning and making decisions, ED now controls any and every decision related to food and exercise.

As parents, it is natural to think that at their age, the child should know that he or she needs to eat in order to recover. Unfortunately, everything changes once your child is diagnosed with an eating disorder. Every time your child needs to make a decision concerning food, ED steps in to decide on behalf of your child.

Hence, parents need to decide the types of food and portion sizes in order to work towards weight gain and/or regulating meals for the child. It is important to note that food choices and portion sizes directly affect treatment progress. For example, it would be hard to expect good weight gain if the child takes a piece of waffle or has plain porridge for main meals. Every child may have different challenges and fears so parents can discuss with the treating doctor and team members of the multi-disciplinary team (e.g. dietitian) as to how a typical meal plan would look like to ensure consistent weight gain and progress. Parents could consider the child's habits and preferences prior to the onset of ED to plan out the meals. The new meal plan may be quite different from the meal plan before the start of the illness — parents need to remember that the goal is weight gain, not merely weight maintenance.

At times, we have seen patients suddenly become vegetarians in order to lose weight. A new meal plan may thus have to include meat – at least during the treatment phase till the child’s weight is stabilised and the symptoms are no longer present.

## 2. Expect resistance from ED

The goal of ED is to make sure the child continues to restrict, avoid or totally skip meals. Hence, parents should expect the ED to be very active and strong at every mealtime, or in any situation when food is involved. Expect the ED to put up all kinds of resistance to prevent the child from eating or completing the meal. Parents should stay alert to ED’s tricks and tactics while maintaining a firm stand on their task to get their child to finish the meal.

As long as parents remain steadfast on the task, it strengthens the child’s efforts to fight ED by completing the meal one bite at a time. There may be certain days when ED is extremely strong, which means the child is going to struggle a lot with the meals. Breaking the meal down into smaller tasks may help to make it more manageable for parents and the child instead of feeling overwhelmed with the entire meal. Parents need to be persistent, almost like a broken record, and stay focused on the task. This could be as simple as repeating phrases like “You have to finish your meal.” and “Pick up your spoon.” until the child finishes the meal or time limit is reached.

The duration of meals and timings would be important to keep in mind as well. Given the challenges in eating and completing the meal, it is not uncommon for the child to require a longer period of time. To help the child regulate his or her meals, setting a time limit helps to reduce the impact of ED symptoms such as cutting food into very small pieces, moving food around the plate, taking very tiny mouthfuls, or repeatedly picking up and putting down food, ruminating about the food or meal, or having intermittent pauses during meals. In the Eating Disorders Intensive Treatment (EDIT) programme at SGH, a time limit of 45 minutes is set for mealtimes including a fruit or dessert.



### 3. Recognise ED as separate from the child

Resistance from ED comes in all shapes and sizes such as throwing food away, hiding food, crying, pleading, bargaining, coaxing, using vulgarities, throwing tantrums, hitting, emotional blackmail, or even threatening to harm themselves. Parents should separate the ED behaviours from their child and remain firm in their responsibility to supervise meals (Treasure, Smith, & Crane, 2007). Parents should not take these behaviours personally since they arise due to ED and were largely non-existent at mealtimes prior to ED.

Parents have their own limits and should try and realise how these ED behaviours can push their buttons and affect their mood. No matter what behaviours parents have to manage, they would need to assess each situation and observe the child's coping. In most situations, it could get worse before things get better but the child's safety is priority at all times. It is imperative to consult the treating doctor and team regarding safety issues if parents have such concerns and how to balance them with the task of meal supervision.

There is no fixed way of providing support to the child in treatment and during mealtimes. The best way to find out how to support the child is to ask him or her directly in addition to going by gut feel or past experiences so that support can be most effective to the child. While the child may want to recover, having the ED voice in his or her head 24/7 can be a real mental torture. It is helpful to affirm and praise the efforts put in by the child. From my experience and conversations with patients with ED, the child often wishes that parents could acknowledge their efforts despite their slip-ups and lack of motivation. This encourages the child to persevere and not give up, knowing that parents are on their side, and not fighting against them.

### 4. Avoid using logical reasoning

It is not uncommon for parents to resort to logical reasoning if their child does not want to eat or complete the meal. "You need to finish the food because you need all the calories for your body in order to help you recover.", "If you finish your meal, then you

can concentrate in school and do well for ‘O’ levels right? You said you want to do well so that you can go to JC and university?” While it makes sense to the rest of us, the child with ED, who is struggling with food on the table, would not be able to respond in a logical manner.

Logical reasoning can take up a lot of time and energy but may not yield the results that parents wish to see in terms of completion of meals, increase in motivation or compliance, or treatment progress. Parents often get exasperated and even more upset when the child does not respond in the way that parents expect. Many times, parents may get into a debate with the child, hence creating further tension at both sides. At the end, the child is still resistant, parents become mentally exhausted and the food is left unfinished. At the end of the day, parents need to focus on getting their child to finish his or her meal and not get drawn into arguments or debates because these usually do not help during meals.

#### 5. Refrain from comparing

During mealtimes, parents may use the other children as a standard to pressurise the child to eat at mealtimes. Since siblings are closer in age to the child, they tend to compare what the child is eating with the rest of the siblings. “Look at your sister — she is eating more than you and she is younger than you.” This often puts siblings in a difficult position and may result in unintended effects such as siblings feeling pressurised to eat so that their ill sibling will also eat their food. They may also feel responsible to eat more even when they are actually full or eat certain kinds of food, especially if parents coax them to go along with their wishes. Siblings’ roles during mealtimes are different from their parents’ roles — they play a supportive role. They should not have to be a ‘spy’ for parents or police the meals of their sibling who is ill.

#### 6. Stay united as a team

Parents often have differing views and approaches regarding how best to support their child, how to talk to him or her, food choices, what to do when their child throws tantrums, etc. Very often,

one parent will be firmer and wants to push while the other is 'softer' and prefers to go slow. Like any parenting situation, parents affect one another, that is, one parent gives in in order to balance the situation when he or she perceives the other parent being too firm. Over time, the parent who is firm gets exhausted pushing the ED, and frustrated being the only one doing the job while the 'softer' parent feels disempowered by the ED and gets blamed for constantly giving in to ED.

Regardless of different approaches, it is critical for parents to work together so that they can fight ED as a team, and not each other. Parents need to be on the same page regarding decisions concerning the child so that ED does not have a chance to split the parents. In order to maintain its hold on the child, ED would look for the weakest link and push the boundaries. If parents are not aware of ED's tactics, they may fall right into ED's trap and start blaming one another. If parents do not resolve these differences and work out a plan, ED will continue to attack and cause further tension in the home.

#### 7. Model normal eating and portions where possible

In addition to being a role model in other areas, parents can also model for their children in terms of eating and portions. When parents start to model normal eating and portions, it sends a signal to the child that having normal meals is part and parcel of leading a normal and healthy life. It can be very reassuring for the child to observe parents eating normal portions and choosing a good variety of foods.

Having said that, every family has a different culture regarding food and meals and the definition of what's normal will differ, depending on what is important to the family and the specific needs of the members. For example, a father who is diabetic will have a different diet than the rest of the family. A mother who works permanent night shifts will have her meals at very different timings than her husband who works regular hours. Families may need to make some adjustments with the child while ensuring that their own needs are taken care of as well.

At the same time, we have also encountered parents who may have their own issues with eating and/or dieting. If parents themselves know that they have their own issues, it is critical that they seek professional help and advice as this can impact their child's perception of their treatment and cause further confusion in the process. In severe cases, it might even get in the way of treatment progress or sabotage treatment goals for their child.

#### 8. Stay calm — threats and force hardly work

When the child refuses to comply, parents may resort to using threats. For example, parents may say “If you don't eat, I will send you to the hospital to be admitted”, “If you continue to argue, I will chase you out of the house.” The child may comply for the first few times out of fear, but once they realise that parents do not have the intention of carrying them out, it loses its effectiveness and this can greatly undermine parents' authority over the child, especially over a long period of time. Hospitalisation may be required for some situations and can be used as a consequence but parents need to be mindful so that it remains an effective option.

In some situations, parents can feel so overwhelmed that they hit the child out of frustration or even hit each other. Physical fights further strain the relationship and add immense tension to the relationship. If parents are overwhelmed at any point in time of the treatment, they should take a break where possible, seek additional support on their own or consider professional help so that they can continue in their role to support their child.

#### 9. Consider using consequences

What happens when parents have tried their best to be firm but the child still refuses to comply at mealtimes? Consequences can be used when the child continues to have difficulty complying with the meals and weight progress is slow over a period of time. It can serve to motivate the child to comply with the task in

order to avoid the consequences set by parents. Some examples of consequences include increased portions at the next meal, increased supervision and accountability, reduced activity level, withdrawing the child from PE, CCA and other school activities, taking leave of absence from school or internship, cancellation of holiday trips and so on.

A few things about consequences: they should be set well ahead of time, definitely before the start of the meal (Lock, & le Grange, 2005). Furthermore, consequences only remain as a plan until they are carried out. Lastly, they work best when parents carry them out in a calm and consistent manner. Just like the child who is defeating the ED one meal at a time, parents would also be encouraged to know that they would gradually feel empowered as they implement the consequence for their child one at a time and fight ED.

#### 10. Keep pace and recharge

The journey as a caregiver can be extremely lonely and challenging. Barely just finishing the meal after a long time and mentally exhausted, parents brace themselves for the next onslaught, with hardly any time to take a breather to rest. How does one stay the course and persevere till the finishing line? Those who do well and can sustain in the long run temporarily re-prioritise their commitments, take regular breaks and work together with their spouses and extended families. Other strategies that parents have utilised include reach out and ask for help, learn to let go, allow others to take over, talk to friends and professionals, spend time with the other children, resume their hobbies, pick themselves up after they fall, laugh at their mistakes and many more.

If there are sudden issues at work, other children need more attention, or emergencies crop up, parents would need to adjust their schedules and responsibilities in order to attend to these matters. While there could be some impact in terms of treatment progress or meals, parents should not feel bad or blame themselves for the change in plans. They could review the situation after a

period to assess if it is possible to revert to the previous plan or make changes to the plan. These decisions must be considered in the context of current needs of the family and the resources available.

## **Some Practical Considerations for Meals in Schools**

If the child who is attending school while recovering from an eating disorder, parents may have some questions:

- Is the child stable enough to attend or return to school?  
Discuss with the doctor regarding the child's ability to resume school and continue with outpatient treatment. The treating doctor and team will usually advise if the child is able to continue with school or ready to return to school. It is best to raise any concerns with the treating doctor regarding school, especially if the child has been absent from school for a period of time.
- Who can supervise the child?  
Depending on the stage of recovery that the child is in, he or she may need supervision of lunch, snacks or supplements in school. If the child needs supervision, parents need to decide who is the best person to supervise the child in school. It could be one of the parents, a helper or even a relative who is able to help out with the supervision.  
In some schools, it might be possible for a teacher or counsellor to assist with the supervision of lunch, though this may not apply to all schools. Some teachers or counsellors may offer to keep an eye on the child or remind him or her to take their meals during school hours. Over time, as the child progresses in treatment, he or she may not require supervision and would be able to complete the meals independently. The frequency of supervision may also decrease over time if there is progress.

- Should the child bring home-cooked food or buy from the canteen?

There is no right or wrong answer but it depends on the comfort level of the child and/or parents and the child's specific challenges at that point. Home-cooked food allows more control by parents and saves time for the child during recess or break-time. On the other hand, buying from the canteen can train the child to make good food choices and reduce preparation time on the part of the parents or helper.

- What kind of support is available in school?

If the school and teachers are unaware of the child's illness, this may be a good time to arrange for a meeting with the child's form teacher (and other teachers if necessary) to inform them about it. Let them know about the tentative plan regarding mealtimes.

Explore if there is any support available in the school e.g. form teacher or school counsellor who can check in with the child if there are any difficulties, a quiet room in the school for parents or the helper to supervise the meal, informing the parents regarding ad-hoc observations from the subject teachers in school. Different schools have different policies and regulations so it would be important to understand their constraints so parents do not feel frustrated why some schools are unable to extend the same level of support as compared to other schools. In general, schools do understand parents' concerns and try their best to provide as much support as possible.

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# Creative Journalling for Recovery

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## Learning Points

1. In this section, you will learn about the benefits of creative journalling in your Eating Disorders recovery journey.
2. Learn some tips and tricks to start your own creative journalling.

## Visual/Art Journalling

*“You can’t use up creativity, the more you use, the more you have.” (Maya Angelou)*

Visual/art journalling is a documentation method that is commonly used by artists to record their thoughts, ideas, feelings, fantasies, dreams, hopes, personal musings and much more. I will use the terms “visual journaling” or “art journaling” interchangeably in this article.

There are many styles of art journalling. Many artists combine writing with visual art making such as sketching, drawing, painting or collaging. Leonardo Da Vinci and psychiatrists such as Carl Gustav Jung are also known for their art journalling. When Jung was in a tough stage in his career, he dealt with his difficulties by making mandalas, painting his dreams and writing reflections in an art journal that is famously known as the “Red Book”. Da Vinci used his ‘art journal’ to extensively document his ideas on science, anatomy and medicine.

Some may feel more comfortable writing their feelings and thoughts only. Some may feel they are not “artistic enough” to even start a visual journal. However, not to worry, there are many ways that a person can express themselves. In the next section, we will discuss the benefits of incorporating art making in your current journal or starting a new



visual journal. This is so that you can make an informed decision on whether art journalling is for you.

## **How Can Visual/Art Journalling Help My Recovery?**

In art therapy, art journalling can be a powerful and healing tool for mental health recovery. Malchiodi (2017) suggests that visual journalling helps traumatised clients to cope with distress and hyper arousal symptoms, manage stress, and promote self-soothing.

For those who are working hard to manage their eating disorders (ED), art journalling can be an invaluable tool. Recovering from ED comes with its ups and downs. Sometimes, fears and insecurities take the driving seat, eager to make the big U-turn to the comfort and safety of ED. There are those days when boredom and loneliness creep in, and ED comes knocking at the door, offering to fill that void and to give the illusion of achievement and gratification through the control of food intake and losing weight.

The visual journal can be used to offload complex thoughts and feelings about recovery. Like a compassionate and non-judgemental friend who is always available for you, it can also help you manage triggers and ED behaviour. For example, a patient reported that whenever she felt the ED urges, she started to write and doodle the urges down. By the time she finished unloading "these calls" in her journal, the urges had become more manageable so that she could practically just ignore them. Journalling bought her some time to "cool down" and to think carefully about the ED urges.

Another patient who had recovered stated that after adding art making in her initial "writing only" diary, she began to notice a shift in her perspective. Looking back, she used her diary for a daily rant, and often 'hid' behind complicated and smart words. Until one day, while flicking through an old magazine, she saw a photograph that provoked her. The photograph spoke to her of her pain and struggles in a way that words could not describe. She then began to incorporate these photographs in her "writing only" diary, and without realising it, she had begun an art journal. Sometimes, she used the images as a conversational focus point in her psychotherapy sessions and vice versa, and found that these sessions inspired her to search for more meaningful

pictures and words. She said that these images helped her tremendously in letting go of the ED mask and putting her in touch with the ‘real her’ that words alone could not.

## **Sounds Interesting, How Do I Start?**

### ***Step 1: Overcoming your fear***

There is no right or wrong way to start a visual journal. The most difficult part of this process is to start it and to overcome what is commonly known as “perfectionist traits” such as self-criticism, procrastination, and fear of failure and others that can grind you to a halt. The following are some examples of ways to engage with the “bothersome trio”:

To the “critical self”, which may say “I can’t draw” or “I don’t know how to draw” or “I haven’t drawn since primary school”, you may want to say: “I get that I have not made art in a decade and that my drawings are bad, but I only do this for myself and not for a grand exhibition.”

To the “fear of failure”, which may say “I fear that my drawing is ugly”, you can say: “Thank you for your reminder, but really, I have nothing to lose here. I will lose out even more if I don’t try.”

And to the “procrastination”, which may say “I’ll do it later” or “I don’t feel like doing it now”, it might be helpful to say: “It is better that I do this today imperfectly rather than waiting for the right moment to do it because the right time may never come.”

Then, after this quick, compassionate talk, swiftly move on to Step 2. This is the exciting part of art journalling. Alternatively, you can also choose to ignore Step 1 and go straight to Step 2 instead. The choice is yours.

### ***Step 2: Gathering your resources***

Or in other words — shopping for materials. They need not be expensive or fancy. You can use the following list as a guide:

– The journal

This could be as simple as a plain, unlined, medium to heavy weight notebook that you can get at any bookstore. Size wise, A4 is a good start as it allows plenty of room to make art and write. However, if you prefer something small and portable like an A5 size, it is also good.

Alternatively, you can also get a sketchbook or an artist's book from your local art shop. If you are feeling adventurous and creative, you can make your own art journal using a loose-leaf folder and fancy paper. Be as creative or as unconventional as you want to be.

- A marker set and a black marker with a fine tip (useful for doodling)
- Oil pastels
- Coloured pencils
- A glue stick and scissors
- Old magazines to make collages

The possibilities are endless. Alternatively, materials such as washi tapes, photos, old postcards, brochures, found objects, string or yarn can also be used.

### ***Step 3: Finding a safe place for your art journal***

Your art journal will contain your deepest secret, thoughts and dreams. Find a lockable cabinet or space where you can keep your art journal safe. Keeping your journal safe is part of protecting your privacy. You will be more inclined to be more honest with yourself when you know that your journal is kept safe and private.

You are in control of your journal and to whom you want to share its content with. Find a supportive, trusted and caring person for this task such as your therapist or your close friend. When you are ready to share your journal, be assured that you are under no obligation to share all of its content. Remember, it is your journal, and you are in control of it. This is also a good way to train yourself to be more assertive with your needs.

### ***Step 4: Keep calm and create an art journal***

Once you gather all the materials listed in Step 2, find a quiet time and a private space to begin the art journal. An environment, be it at home, library or cafes that make you feel relaxed and comfortable, is conducive to the flow of creativity and self-reflection.

It is a very typical response for feeling 'blank' or uninspired when you begin. Keep calm. Below are some ideas that you can use to help you move forward:

1. Place the palm of your hand onto a blank journal page. Trace the palm of your hand with a different colour marker. Write a “HELLO” inside the tracing in different styles or write your intention for this journal. You can begin with: “With this journal, I intend to...”
2. Close your eyes and start scribbling with your eyes still closed. Write some words that describe the scribble or your experience of doing this activity. Was it scary, good, liberating, and easy to do? Was it difficult to do or fun? Transform these words into a short sentence or a poem. Figure 1 is an example taken from someone’s journal using this directive.

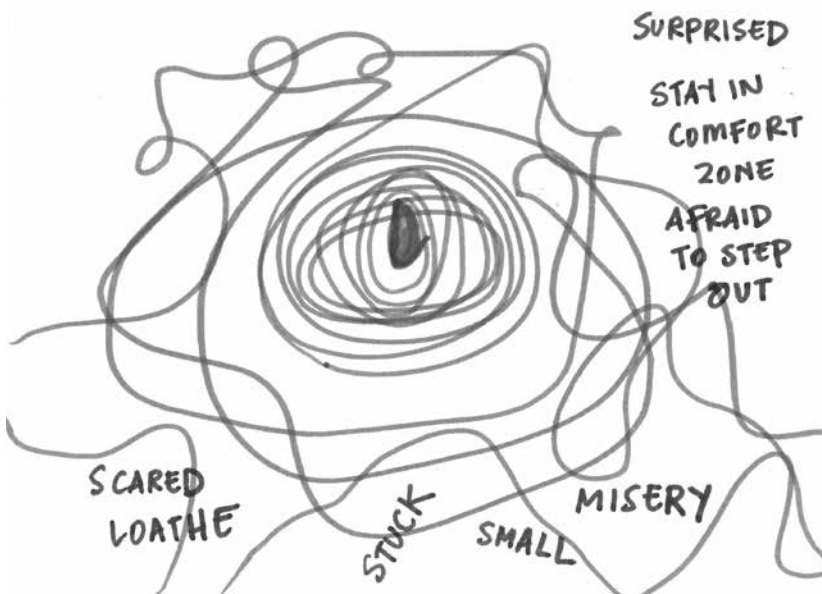


Figure 1: An art journal example of a scribble exercise with eyes closed and the reflection of the exercise

3. Find some motivational quotes for eating disorder recovery. The Internet is a good place to start. Choose one that speaks to you the

most and write that down in the journal. This is also a great opportunity to practise your calligraphy skills. Decorate this quote.

4. Go through any old magazines that you have collected. Find a few images that capture your attention. Cut and paste these pictures into the journal and write a reflection on them. What is it about this image that captures your attention?
5. Pick a colour or two that represent how you feel today. Fill a page or two using oil pastels of these two colours. Write down a reflection of your thoughts and feelings after performing this exercise.
6. Find a poem that gives you the inspiration to persevere in the recovery journey. Rewrite this poem in your journal and decorate it. Write a reflection piece afterwards. Notice the feelings that arise from doing this exercise. Does this poem inspire you to do things differently? To be brave? To be authentic? To be free?
7. Imagine yourself in a year's time when your symptoms are much more manageable. What do you see yourself doing differently? Will you have more smiles on your face? Will you be more relaxed and easy around food? Do you see yourself having a good time dining with your closest friends? Draw or make a collage of these possibilities. Research suggests that visualising possibilities and enhancing it with art making may help strengthen the brain's 'knowing' network. In other words, it helps your brain to see your dreams and wishes as real and hopefully, will motivate you to start taking small steps towards realising your dreams.
8. Recall the last time you felt tranquility and calmness. These feelings usually arise when one is faced with nature's beauty or the calming sound of the waves on a beach. Find colours that represent these calming and peaceful feelings. Paint or sketch using these colours. You can revisit this page whenever you need to refocus and ground yourself again.

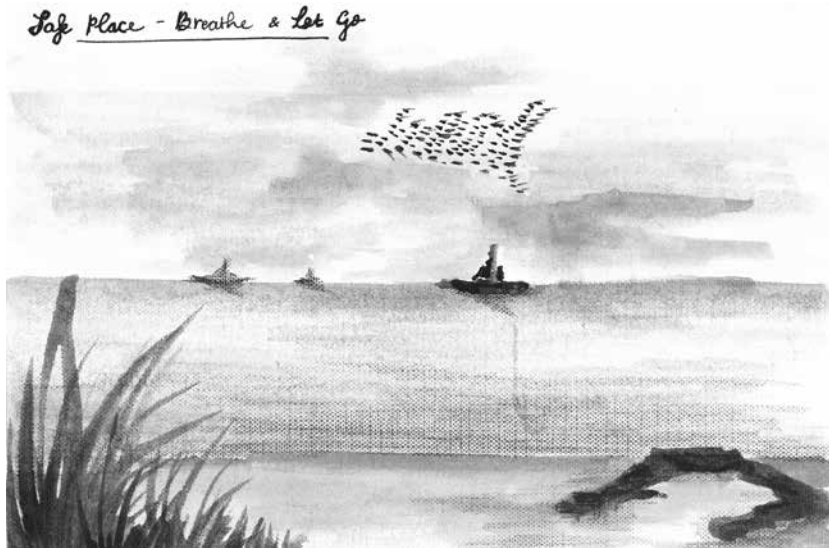


Figure 2: A creative journal example of sketching

## **Last Thoughts**

The above ideas are by no means exhaustive. We encourage you to be spontaneous and free. The more you are engaging in the creative journaling process, more ideas, thoughts, dreams and feelings will soon follow. Like Maya Angelou says: “You can’t use up creativity, the more you use, the more you have”.

Take the journal book and some markers wherever you go or prepare a separate travel pack or artist travel kit that you can purchase at art stores. It helps to have the journal instantly accessible to you at times of crisis. It is also highly advisable that you immediately do some journaling work after a particularly difficult meal, a tough day at school/work, a particularly boring and not so productive time, or when strong feelings arise. Done this way, you are training yourself to use positive coping skills whenever difficult times happen. With continued use and habit, we hope that your journal pages will bear witness to a resourceful and creative person you have become at times of crisis, and that you have acquired an extra coping skill.

## The Dos and Don'ts of Creative Journalling

1. Do ignore "the inner critique".
2. Do tell yourself that there is no right or wrong way to start a creative journal. Do assure yourself that you are doing it for own benefit and not for an art exhibition.
3. Don't go digital. The sensorial elements of papers and art materials are conducive towards the flow of creativity and promote self-soothing. The process of drawing and writing may also encourage the development of new insights and facilitate deeper reflections.
4. Do have fun and do it as often as you can
5. Do be aware if your journalling starts to veer towards supporting ED or weight loss and dieting or contain ED-related materials. These could be a small indication of recovery struggles or even an impending relapse. Seek help immediately and refocus your effort on recovery.

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# **The Eating Disorder Intensive Treatment Programme (EDIT) at SGH**

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## **Evolution of the Programme**

Eating disorders (EDs) are complex psychological problems with potentially serious, even fatal, medical complications. EDs are not only about food and weight, but are frequently symptoms of deeper, more complex psychological and biological issues like poor self-esteem, negative body image perception, abuse, family conflicts and relationship issues. The SGH Eating Disorders services were started in 2003 (the same year the department of Psychiatry was set up in SGH) to address the physical and psychosocial problems commonly associated with EDs through a holistic, multidisciplinary approach. The team provided inpatient and outpatient care, utilising an evidence-based treatment approach consistent with international practices and catering to individual patient needs.

In the absence of a dedicated psychiatric inpatient ward then, patients with EDs needing inpatient care were initially admitted to an open general medical ward under the primary care of the psychiatrist. EDIT was originally conceived in 2003, as a step down group therapy programme to help support patients who had just been discharged from the ward. It started out humbly in the medical wards as there was no other available location then. It started catering to the needs of the inpatients first with the eventual plan of moving it out of the wards so that patients could continue coming as day patients upon their discharge. During their inpatient hospitalisation stay for nutritional re-



feeding, patients had very little to occupy their time with in between meals and some would spend the long hours pacing up and down the ward corridors. Group therapy sessions then helped to keep these inpatients occupied and engaged in treatment. The programme started with just one group therapy session a day in the ward from Mondays to Fridays. At that time, the team was small and consisted of a psychiatrist, a dietitian, an occupational therapist and a psychologist — who would take turns running the programme.

In 2005, a dedicated psychiatric ward with 15 beds was set up within SGH. The ward allowed us to cater more specifically to the needs of patients with EDs. Firstly, the ward was staffed by nurses trained in mental health who were more aligned in providing specialised care for psychiatric patients. Secondly, there was an activity-cum-dining area, which allowed the staff to group patients with EDs to eat together. This allowed for closer supervision at meal times, and for us to run lunch support groups, where staff would eat together with patients. Thirdly, the ward was secured and much smaller than the open general medical wards — allowing closer monitoring of patients and limiting excessive patient movements and activities.

The year 2008 marked another milestone when the Lifestyle Improvement & Fitness Enhancement (LIFE) centre opened in SGH. It was Singapore's first hospital-based centre promoting integrated and holistic care for patients with lifestyle-related medical conditions — in particular obesity and EDs. As the centre was built with the intention of running EDIT, it came equipped with group therapy rooms, a large functional demonstration kitchen and dining area, as well as a fully equipped gymnasium which was shared with the obesity programme. That same year also saw increased funding from the Ministry of Health, which allowed us to grow our multidisciplinary team. Thus EDIT went into full swing, running five days a week with a complete multidisciplinary team. Once EDIT moved out of the wards, we were able to take in both inpatients and day patients — fulfilling the original plan conceived almost five years ago for EDIT to be a step down care programme.

## **Programme Description**

EDIT runs five days a week from Mondays to Fridays. It operates from 10 am to 3 pm on Mondays through Thursdays and ends earlier at 1 pm on Fridays. The programme is staffed by a multidisciplinary team comprising an art therapist, dietitians, family therapists/medical social workers, occupational therapists, physiotherapists, a programme coordinator, psychologists, psychiatrists and an ED specialty nurse.

The programme runs as a closed group and patients sign up on a weekly basis beginning on Mondays. It is designed primarily for patients with Anorexia and Bulimia Nervosa.

The programme aims to help patients in three ways:

1. Optimise their inpatient stay in hospital with additional therapy and support
2. Support patients as they transition from inpatient back to daily life outside of hospital
3. Provide patients with more structure and support as outpatients

Patients can join as an inpatient or as an outpatient (day patient). They often join as an inpatient whilst they are hospitalised and upon discharge, participate as day patients. There are some, however, who join directly as day patients without prior hospitalisation. All patients have to be first assessed by their treating doctor for medical stability, suitability and psychological readiness. As it is a voluntary programme, patients need to possess a certain level of willingness and motivation. Contraindications to joining EDIT include acute medical instability and suicidality. Those identified and agreeable to join EDIT are subsequently referred to the specialty nurse who further explains the goals and rules of the treatment programme. The programme is able to take in a maximum of 12 patients at any one time.

## **Programme Groups**

EDIT is a group-based programme targeting these main aspects of recovery:

1. Physical aspect and nutritional rehabilitation, including weight gain in patients with Anorexia Nervosa. Meal plans are approved by the dietitian. Lunch and liquid supplements (if any) are supervised by the staff.
2. Psychological and behavioural aspect.
3. Social aspect in re-integrating into school and society.

Patients are therefore expected to attend all the different groups, each group lasting for an hour. The baking group, however, runs for 90 minutes.

The following is a description of the various groups in EDIT.

### ***Feedback group***

This is usually the first group of the week and is attended by all staff members of the multidisciplinary team as well as all the patients in EDIT. The team meets to discuss each individual patient's progress prior to joining this group. Both positive and negative feedback are collated before the team comes up with individualised challenges for each patient. Patients themselves are also expected to reflect on their own progress and think about their own challenges for the week ahead. During the actual feedback group, each patient will receive consolidated individualised feedback regarding their progress during the past week in EDIT. They are expected to share their own personal challenges within the group, and at the same time receive the team's challenges for them for the coming week. Patients are expected to work on both their personal challenge as well as the team's challenges in the week ahead. Feedback group is also a time for new patients to be introduced to the group, giving both staff and new patients time to get to know each other.

### ***Check-in group***

Check-in group is convened after the feedback group, usually on the same day after lunch — by which time patients would have had time to reflect on the team's feedback and challenges. It is run by one of the psychiatrists in the team. The smaller group setting allows the therapist to “check-in” on each patient. Patients' experiences from the past week,

reactions and queries arising from the feedback as well as challenges are explored during this time.

### ***Motivational enhancement and psychological skills group***

ED patients are notoriously ambivalent about treatment and often lack motivation to change. Motivational Enhancement (ME) group is run based on the tenets of Motivational Enhancement Therapy (MET) — a directive, person-centred approach to therapy that focuses on improving an individual’s motivation to change. Research has shown that MET could be valuable for the treatment of patients with eating disorders (Dean, Touyz, Riegel and Thornton 2007). Through MET, individuals can hopefully begin to view their behaviours more objectively and may be empowered to begin the process of change.

This group is run by a psychologist and focuses on discovering motivational factors which may affect the patient’s recovery journey. It aims to help patients find their motivation and explore their ambivalence towards recovery. In addition, other psychological skills and coping strategies such as assertiveness and values (to name just a few) are also discussed.

### ***Nutritional group***

Nutritional counselling is an important component in the treatment of EDs. Patients tend to have extensive knowledge about nutrition but their knowledge is often highly selective, derived from dubious sources and often incorrect (Beaumont, Chambers, Rouse and Abraham 1981). The goals of treatment should focus not only on correcting nutritional status, but also aim to correct the misconceptions that many patients have towards food and supposed “healthy eating”. It also aims to assist patients in establishing normal eating behaviours and develop a normal attitude and response to food.

Nutrition Group comprises a series of both didactic and interactive talks conducted by the dietitians. It covers key topics on food and nutrition relating to eating disorders with the hopes of achieving the above aims.

### ***Baking/Cooking group***

This is a practical group run by the occupational therapist in which patients are taught how to cook and bake certain foods and snacks. As part of normalising the whole experience, patients are also expected to eat snack portions of whatever food they prepare. Firstly, the group aims to address patients' struggles arising from preparing and eating snacks. Secondly, therapists help patients work through their difficulties in handling and managing food through support and by normalising the experience for them. Thirdly, teaching them cooking and baking skills is also part of life skills training which many patients with ED lack.

### ***Medical psychoeducation group***

Psychoeducation was originally proposed as a component of treatment for EDs (Garner 1997). Patients often suffer from misconceptions and lack of awareness of the seriousness of EDs. It is assumed that patients would be less likely to engage in these behaviours if they were made aware of the medical evidence showing the seriousness of this condition. Psychoeducation has gradually been incorporated to become a standard component of cognitive behaviour therapy.

This is a largely didactic group run by the doctors. It focuses on educating the patients on the various medical and psychiatric conditions and complications associated with eating disorders, medications and treatment.

### ***Life skills occupational therapy group***

Life skills are necessary for healthy living. They include adaptive and problem-solving skills that everyone needs to deal effectively with the challenges and demands of life, and to accomplish their life goals. Patients with EDs often lack these skills — a possible cause and effect of the ED. The lack of these coping skills and strategies in the first place may lead patients to turn to EDs as a way of coping and dealing with problems. Conversely, EDs can also innocuously take over the patient's life — physically, emotionally and socially — further affecting the way they cope and function in life. This group explores how EDs have impacted patient's social and occupational functioning. Its aims are to focus on teaching crucial life skills and develop relapse prevention strategies.

### ***Body image and self-esteem group***

Body-image disturbance and dissatisfaction are core features of eating disorders (Cash and Deagle 1997). In Western cultures, girls' self-esteem declines substantially during mid adolescence, with changes in body image cited as a possible explanation (Clay, Vignoles and Vittmar 2005). Thus, the group seeks to deal with this twin issue of body image and self-esteem.

It is a psychologist-led group which focuses on helping patients explore, express and challenge how they feel about their body, weight, shape and size. Patients are encouraged to challenge their body-image distortions and develop a more realistic view of their body. The main goal of this group is to help patients better understand themselves, specifically their relationship between how they feel and what they are, and ultimately guide them to be more comfortable with their bodies, self-image and self-esteem.

### ***Family group***

Previous theories of families being a cause of the illness are now recognised as over simplistic and erroneous. Current knowledge refutes that families are either the exclusive or primary mechanism that underlie risk (Le Grange, Lock, Loeb and Nicholls 2010). However, the family can still play a role in the development and maintenance of EDs. The majority of our local patients, both adolescents and young adults, still live with their families. Families, therefore, play an important role in the recovery process. Patients will get to explore their family relationships and dynamics within their families as well as the impact of the illness on the family through group therapy, activities, games and role play exercises. This group is led by the medical social workers/family therapists.

### ***Art therapy***

Art therapy can be a valuable tool in the recovery process. It can be introduced as an alternative method to let patients express their feelings related to the ED. Expressing themselves through art therapy can be less intimidating for those who find it hard to communicate their feelings verbally. It can also be learnt as a coping skill where patients

are encouraged to creatively express difficult and overwhelming feelings and emotions that are otherwise expressed through the control of food. This group is led by the art therapist and it provides a platform where patients can transform their ED-oriented thoughts and behaviours into constructive ones, and explore creative problem solving and resilience through art making.

### ***Group physiotherapy***

Physiotherapists lead this group and it has both a practical exercise and cognitive explorative component. Excessive exercise and activity has long been recognised as a characteristic symptom of EDs. Many treatment programmes totally prohibit exercise. This can be difficult to enforce, strains therapeutic relationships and possibly hampers recovery.

The group aims to address patients' feelings and thoughts towards exercise. As with their distorted nutritional knowledge, patients often know a lot about exercise but many are misinformed and harbour misconceptions concerning exercise. These false beliefs are countered by providing accurate exercise information with an emphasis on deleterious side effects of excessive exercise.

On the practical side of it, patients are taught how to exercise safely by learning appropriate exercises to improve flexibility, posture awareness, toning and balance. By providing a model of healthy exercising that is not excessive, this serves as a basis for maintaining a reasonable level of exercise when they are eventually discharged from hospital or EDIT.

### ***Weekend planning group***

This is the last group of the week, and is conducted on a Friday by the ED specialty nurse. Weekends present a challenge both for inpatients and day patients. Day patients do not report back at all on weekends and inpatients are often challenged with meals out of hospital with their families, or during home leave when they return to their own homes for the weekend. So for both groups, weekends present a challenge as there is less structure, support and supervision from the team while inevitable real world situations present themselves. The group therefore aims to assist patients in preparing and planning for the weekend, such as focusing on possible difficulties, drawing up solutions and ways to cope and validating the progress that has been made for the past week.

### ***Supported meals***

Daily supported lunches, snacks and supplements are an essential part of this programme. Different staff members of the team are rostered to facilitate the lunches and to eat together with the patients. Day patients, and inpatients who have progressed on to non-hospital food, will also need to buy their own lunches under supervision. There are several goals we hope to achieve:

1. Patients are often faced with intense anxiety and apprehension when allowed to choose and buy their own lunches. Being able to choose, buy an appropriate meal and finish it, is a very real world situation which many patients struggle with. Often, they battle internally with the ED over the myriad of choices. The team is on hand to support and encourage them to choose and buy an appropriate amount as well as a good variety of food.
2. By eating with the patients, the facilitators model appropriate and normal eating behaviours. At the same time, the facilitator attempts to ease the tension around food and normalise meal times by chatting with patients about non-food or weight-related issues. The aim is to distract and attempt to make meal times enjoyable and sociable again.
3. Facilitators also have to ensure and monitor that patients behave and eat appropriately during the meal and ultimately complete their food portions. Patients may often need reminders to not cut up their food, take bigger spoonfuls and complete their meal within the 45 minutes allocated for lunch.
4. Finally, facilitators have to sit with patients for at least 30 minutes after the meal. We acknowledge that this is a difficult time for patients when they have to sit with the feeling of fullness following meal completion, as well as the emotions that are associated with it. Many may feel anxious, irritable, frustrated and have urges to purge. Sitting and talking through this anxiety will allow them to habituate and learn to eventually be comfortable with the sensation of normal post-meal fullness.



## Conclusion

Whilst EDIT has served both inpatients and day patients well in the past 15 years, our programme is also constantly evolving with the emergence of new data, evidence and treatment modalities in the field of EDs. With the introduction of Family Based Therapy for adolescents with anorexia nervosa, many patients no longer need inpatient treatment/day treatment with additional family support. The team is currently reviewing EDIT and the need to cater to a changing profile of inpatients and day patients.

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# Inpatient Care for Individuals Struggling with Eating Disorders

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## Learning Points

- Getting admitted into the hospital
- Staying in the hospital
- Transition from hospital to home

## Overview

There have been a lot of misconceptions about inpatient treatment for ED. Many perceive the inpatient treatment for ED as being locked up with prison-like restrictions. Hence, a lot of resistance has been observed whenever admission is recommended for inpatient treatment. This chapter describes the process from admission to discharge planning for the treatment of ED in general.

## Admission

Inpatient treatment is warranted when individuals who are suffering from ED cannot cope as outpatients. They are either medically unstable, deteriorating or having suicidal thoughts or intents. Individuals suffering from ED are often frightened when they are first admitted into the hospital. They can behave aggressively despite their ill health and even try to run away from the hospital as they fear losing control.

Most patients find the ward terrifying when they learn that they have to stay in a ward with people who are ill with various mental health problems. Already overwhelmed with the voices of ED in their heads,

they have to struggle with coping in a new environment, away from their family and not realising that they have to stay inpatient longer than expected. Some may feel that they do not require inpatient stay, as they do not regard themselves ill enough to require admittance to the ward. Most feel that they are still in control and are able to cope on their own as outpatients. They do not realise that the illness has already taken over them, and that the signs of struggles and/or drastic weight changes that they have experienced are visible to others. On the other hand, some patients have expressed relief upon admission, where they are not able to make any choices as the control is given to healthcare professionals to help them deal with their struggles. For example, they know they should eat to recover but they find it hard to do so as the ED voice continues to haunt them. Therefore, they find that it is easier for them to tell the ED voice that they have no choice but to eat the three meals in the ward under supervision. They may feel that they are out of control with the illness and cannot cope with the emotional and psychological struggles that accompany it. They often feel guilty of making the decision to fight for recovery and tend to give in to the illness when given a choice to recover.

The inpatient treatment is set with several restrictions for safety precautions to enhance the treatment and recovery process. These include closer monitoring by nurses and other healthcare professionals to look out for and prevent any destructive behaviours such as exercising, vomiting, and deliberate self-harm and others. In view of low body weight or medical instability, restrictions on the patient's activity levels through bed rest and/or using aids are also set to conserve energy and prevent avoidable falls. These limits can help a lot in the patients' recovery process even though it can be very distressing, as they are not given control of the situation. With the struggles of fighting the illness, they often give in to the urges to compensate, such as exercising surreptitiously.

Parents feel relieved when their child is admitted into the hospital even though they may disagree at times when their child calls them through the phone incessantly to express their unhappiness with the treatment recommendations. The struggles that parents have to overcome can be very overwhelming. They cannot bear to see their child being very upset resulting in them tending to forget that their cries

stem from the demands of the ED. At times parents end up discharging their child prematurely upon hearing the cries of their child. Typically, it is observed that the initial experience of inpatient treatment tends to be the hardest when parents themselves struggle emotionally and often get agitated and disruptive in coping with the demands and bargains of the illness as well as upon hearing their child's emotional struggles. However, the situation does improve after the child has been admitted for at least a week. Once they have learned about the overall process of the inpatient treatment, they are assured of its effectiveness. Most times, they are able to adhere to the treatment process after they have more insight into the illness with further psycho-education and encouragement given. However, the recovery process is never a linear progression and resembles a bumpy road with an uphill and downhill journey. When the illness is challenged, every child's responses varies in intensity. The most severe response is to have urges to self-harm or attempt suicide.

## **Inpatient Care**

The main aim of inpatient care is refeeding management where patients learn to eat adequately through proper guidance from a multidisciplinary approach. The dietitian will review patients periodically to ensure adequate intake for weight restoration. Liquid supplements may be introduced to help in weight restoration. Certain limits are put in place to help in managing the ED better. These limits could come in the form of no soft diet and only one vegetarian meal allowed in a week, unless contraindicated for religious or medical reasons. Pattern of meal choices is also monitored. Meal times including time limit for meal completion are reinforced to set limits to the illness. Meal supervision will be carried out by the nursing team to ensure adequate food intake and normalise their eating behaviours as patients often see food either as a torture or prescribed medicine. They require a lot of emotional and psychological support, especially during and post meal times. Therefore mealtimes can be very tense as patients find it tough and often struggle to follow the refeeding process. These limitations will help to ease the overwhelming experience of eating by reducing the load of things left to the patients themselves to handle.

Sometimes patients refuse to eat despite much encouragement because of their struggles with the illness. They may even cry and become hostile during mealtimes. At times, they have been observed to “zone out” when food is served. Most tend to display disordered eating behaviours such as hiding food in clothes, mashing up food, spitting food into their drinks or tissue paper, cutting food into tiny pieces, draining gravy from dishes, and more.

For those with life threatening low body weight, they could be fed through a nasogastric (NG) tube temporarily to prevent further weight loss and/or for weight restoration. Some patients feel relieved when they are fed through the NG tube as they find even the simple act of picking up cutlery to feed themselves a tremendous torture. Some felt threatened by the suggestion of NG feeding if they do not eat. In these cases, they succeed in completion each mealtime. However, they may not see that as an achievement but rather guilt for feeding themselves on their own. They may continue to struggle physically, emotionally and psychologically after meals.

Refeeding management includes close weight monitoring whereby patients are weighed weekly or more frequently depending on their weight response during the refeeding management. The dietitian will review the patient’s intake periodically and whenever necessary to ensure adequate intake to prevent any medical complications which may arise during the initial refeeding process, such as refeeding syndrome which can be fatal. Patients are required to follow a standard weigh-in procedure to ensure weight accuracy. This involves fluid restriction from the night before, and bladder emptying first thing next morning before immediately scanning the bladder for any residual urine. Patients will be weighed only in a standard hospital gown and only once the scanning of the bladder does not show any significant amount of residual urine. This procedure has to be carried out without any time gaps to ensure accuracy of the body weight measured at that point of time.

The activity level of the patient is also closely monitored not only for the patient’s own safety, but to also limit any expenditure of energy, which may affect weight restoration. Hence, patients are recommended to rest in bed to conserve energy. However, they find it tough to comply despite their will to recover. They may be observed to be pacing around unnecessarily to compensate their energy intake. They may also engage

in other compensatory behaviours such as exercising excessively or secretly, intentional vomiting and abusing laxatives or diuretics, etc. They may also deliberately harm themselves through cutting, scratching and other destructive behaviours as “punishment” for gaining weight.

It is normal for parents to experience stress during the refeeding process. Their anxiety is expressed by a tendency to be disruptive towards the refeeding management especially whenever their child expressed unhappiness and even anger towards the parents for following the treatment recommendations. Family involvement is very important in promoting recovery; thus, it is crucial that parents learn to differentiate the thoughts and feelings of the ED, from their child’s to ensure that care for their child is not disrupted by the demands of the ED. Often, parents feel overwhelmed by their child’s ranting and have difficulty in following the recommendations in treatment. They tend to fall into the ED’s traps and end up disagreeing with the treatment team who are managing the illness because they have difficulties tolerating the anxiety and distress of their child who is “under attack” by the voices of ED.

Some parents find it helpful to take a break from the ED by not visiting or answering calls from the child temporarily to allow their child to adjust to the change of routine and environment. As much as it hurts them to be away from their child, they were aware that it is done in the best interests of their child so as not to lose their child to the fatal hands of the illness. Periodic communication through family sessions are carried out to inform parents of any changes in treatment and to promote consistency of care from both family and treatment team. This will allow the patient to be more focused and not allow any gaps for bargaining during the treatment process.

Patients are also recommended to participate in group activities conducted in the inpatient unit during their stay. The activities help them to learn coping skills and explore various activities to equip themselves with constructive coping mechanism as well as help them develop new interests for their post discharge planning. These groups are mostly conducted during post meal supervision to double up as a form of distraction. Sometimes, patients decline to participate in such groups as they are not comfortable sharing in a group setting or they are still preoccupied with their thoughts about the meals that they just had or even the meals that they have yet to have for the day, as well as

ways to compensate their intake. It is important that parents continue to encourage their child to participate in such groups so as to encourage social interaction and break that rumination cycle.

Outings and home leaves are usually granted when patients have made consistent weight gain, good mood progress and when both the patient and family are ready to challenge the illness on their own while still under the care of the multidisciplinary team. Parents and other family members are strongly encouraged to replicate the structure of disease management carried out in the ward in the home setting. This is to ensure consistency of care and provide continuous support for the child struggling with the ED.

## **Discharge Planning**

Discharge planning begins when both patient and family are ready to transit to outpatient care. This is also dependent on the consistency of weight gain and emotional readiness of the patient. Hence, both patient and family are encouraged to continue going on outings and home leave before actual discharge to gradually cope with the transition of care from hospital to home. This transition is often accompanied with other outpatient treatment options which include Family Based Therapy (FBT) or a partial hospitalisation programme named the Eating Disorders Intensive Treatment (EDIT) programme. FBT is a treatment approach which caters to children and adolescents. This approach is carried out as outpatient care and guided by assigned family therapists to empower parents in managing their child struggling with the illness. The EDIT programme, on the other hand, currently caters to both inpatients and outpatients, and runs five hours every weekday for a week to empower patients to accept responsibility and manage their independency during the programme. It provides support for patients through engaging them in group therapies that work on managing every aspect of the illness, and provides additional support for parents and other family members during the transition period. This partial hospitalisation programme also functions as a day care treatment for outpatients. Patients are recommended to commit their time in the EDIT programme each week and continue attending on subsequent weeks until they are fit to

be discharged from it through weekly assessment by the treating team. This is to ensure that patients are not taken out from the programme prematurely which may affect the smooth transition during the recovery process.

Parents' continuous encouragement for their child's attendance is crucial in reinforcing the need for them to comply with the treatment recommendations during the transition period so as to not disrupt the recovery process.

## **Important Tips**

### ***Admission***

- It is normal to face resistance because of the nature of illness. Therefore, it is important for parents to encourage proper help-seeking behaviours early on for better prognosis of the illness. Admission may be avoided if the illness is identified early and if there is quick intervention before it worsens.
- Parents and family members may need to enforce admission onto their child when faced with a situation where the patient is dangerously ill and unmanageable at home despite their child's cries of resistance. This is in the best interests of their child.
- Inpatient treatment is warranted only if a patient cannot manage as an outpatient.

### ***Inpatient care***

- Family involvement in a patient's care is of utmost importance in the recovery process.
- Parents' proper decision making in the treatment process is important in preventing their child from falling into the death traps of the illness.
- It is crucial that parents learn to differentiate between the thoughts and feelings of the ED from their child's to ensure that care for their child is not disrupted by the demands of the ED.
- When family members feel torn apart between their child and treating team, it is instructive that family members communicate with the treating team to avoid unnecessary conflicts during the



treatment process which results from the demands of the illness.

- Length of stay is dependent on individual progress.

### ***Discharge planning***

- It is important that premature discharge from hospital stay is avoided to prevent disruption of recovery process.
- Premature discharge requested by parents, which is not recommended by the treating team, may lead the family to a “revolving door” phenomenon where frequent admissions may occur due to the struggles from the illness. This phenomenon may contribute to long-term effects involving financial issues and quality of life.
- Family members need to know that patient may not be completely well upon discharge from the hospital.
- Treatment still continues upon discharge through recommended outpatient treatment options by the treating team.
- It is crucial for parents to continue to replicate inpatient care in the hospital into the home setting temporarily until the patient can accept responsibility in maintaining recovery.
- It is important for family members to look out for any warning signs that may pull the patient back into the traps of the ED.

***Treating Eating Disorders: The SGH Experience*** is a compilation of experiences by a team of psychiatrists, psychologists, dietitians, medical social workers, art therapist, nurse clinician, physiotherapists and occupational therapists in the Singapore General Hospital (SGH). Since 2003 when the first eating disorder patients were seen in SGH until today, the treatment of eating disorders requires dedication and perseverance. Written by these practitioners in their own style, each chapter is an intimate and unique glimpse into the complicated treatment profile of eating disorders in Singapore. Besides introducing the multi-disciplinary approach used in SGH, this book also serves as a useful reference to anyone who is looking for more information about this challenging mental health issue.



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