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'Nutrition in clinical management: the eating disorders'**

**The dyslipophobias: a view of the psychopathologies involved and the hazards of
construing anorexia nervosa and bulimia nervosa as 'eating disorders'**

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The term 'eating disorder' is in widespread use. Like a 'cough' due to underlying tuberculosis or lung cancer, it may be all that is symptomatically evident but it is of little diagnostic value in itself. Simply to attempt to modify the eating pattern is likely to be ineffectual and may be counterproductive or dangerous.

The powerful force at work in both anorexia nervosa and bulimia nervosa is the underlying 'dyslipophobia' (a distressing fear of 'fatness'). In the case of anorexia nervosa it is fear of and a need to avoid the 'fatness' of normal (female) mature body weight, which is promoted by puberty. In mainstream bulimia nervosa occurring at or above normal adult body weight, it is the intense fear of excessive fatness, reinforced by the belief that others also see this as a shameful 'loss of control'. Problems of control relate to the pubertally-driven sexual impulse with normal 'fatness' as its marker, especially when this process is threatened by periodic or sustained gorging on excess calories. Under such circumstances vomiting becomes the necessary first line of defence if periodic abstinence and laxative abuse are insufficient to curb weight gain.

The overlap between these conditions relates to the perceived level of acceptable body weight. The individual female with bulimia nervosa who nurses a secret wish to be about 7–7.5 stone (45–48 kg) or less has the seeds of anorexia nervosa and a worse prognosis than the individual accepting of a weight about 8.5–9 stone (54–57 kg). A complicating variant of bulimia nervosa (and potentially a feature of some individuals currently in the avoidant posture of anorexia nervosa) takes a multi-impulse-ridden form, with the individual also prone to equally unfulfilling and sometimes promiscuous sexual behaviour, violence, self-harm, stealing, drug and alcohol abuse.

These pubertally-driven disorders have little in common with the more aptly designated 'eating disorders' of childhood wherein unwillingness to eat food as such is 'chosen' by the child as the family battleground in an otherwise unequal struggle.

ADAPTIVE ELEMENTS

It is sometimes difficult to appreciate that the anorectic is as she needs to be. The disorder is 'egosyntonic' (synchronous with the sense of self) rather than perceived as 'egodystonic' (alien to the self). The anorectic has taken flight into the condition which

she experiences as a refuge. She is in a profound bio-psychological avoidant stance which is highly unstable and which she needs to defend at all cost. The condition, with all its crippling physical, social and psychological handicaps, some of which she will recognize herself, is her only way of coping. This converts the typically compliant scrupulous child into a desperately wily, secretive, manipulative and tyrannical person. These tactics may seem bizarre to others if no understanding exists of the individual's underlying strategic needs, concealed as they often are by denial of illness and weight concerns.

The individual with bulimia nervosa is not in the same biological avoidant position. However, she may also be secretive to the extent that she experiences great guilt, low self-esteem, shame and anger at her predicament. These feelings, generated by her incapacity to control her food intake and its impact on her dyslipophobia (which is then only containable by defensive vomiting and dehydrating tactics such as laxative abuse), can variably sway her willingness to divulge information. Such individuals may, for example, temporarily seek asylum from an endless binge by fleeing to a hospital casualty department and securing admission whilst, for instance, thyroid function or pyrexia of unknown origin or unexplained diarrhoea become the focus of attention for a while. Alternatively, for example, they may be content to be diagnosed as having seasonal affective disorder where they can then rest, safely locked into hours of bright light treatment during the long winter months when they might otherwise especially succumb to gorging. The underlying bulimia nervosa is carefully concealed.

In contrast to the predominant panic that is a feature of anorexia nervosa and the complex dysphoria that characterizes bulimia nervosa, the majority of the obese are content, the exceptions being mainly younger adult females. Exceptions will include many of the massively obese for whom obesity is egodystonic and who determinedly seek surgical intervention. These individuals will almost invariably be female with the same dyslipophobic concerns as characterize bulimia nervosa. We often understand obesity to have genetic and nurturant developmental origins associated with relatively high growth rate and short life span. Its finer tuning by socially- and psychologically-driven factors further influencing food intake and activity levels are the most profitable ones to address at primary, secondary and tertiary preventive levels. Whereas there are major resistances and adaptive strategies in the body to the threat of weight loss, there are few in relation to weight gain. Those that exist are social and, in their most extreme, rooted in a similar dyslipophobia but this time in relation to much higher body weights and a similar sense of loss of control over the maintenance of a particular bio-psychologically meaningful level (often about 14 stone or 90 kg).

For many obese individuals, however, the accompanying inertia (especially above about 90 kg in the female) meets psychological and interpersonal needs which render it acceptable but which may still be associated with denial of 'dietary indiscretions' that are again linked in the mind with perceived 'loss of control'; also backup defensive tactics such as vomiting and laxative abuse may well be concealed.

SOME UNDERLYING BIOLOGICALLY-BASED PROCESSES

Gorging

This behaviour is sufficiently close to being natural for it to be readily unleashed, for instance following dietary restraint. Excess food intake may have been apparent in childhood (related to high growth rate, over-protectiveness, etc.) but is common in

puberty when the growth spurt is at its greatest. It is then that individuals, usually female, most often become highly sensitized to it through its effect on emerging pubertal 'fatness'. Food intake becomes mentally linked to sexuality and a reinforced sense of loss of control.

The biological basis for gorging thus becomes subject to a further variety of social and psychological pressures which can facilitate or restrict it and thereby distort its metabolic foundation.

Puberty

Puberty, following adequate childhood growth and the pressure for mature differentiation and reproduction in anticipation of death, is triggered by body weight and, to some extent, degree of fatness usually at about the 40–45 kg level in females. The process serves to differentiate the male and female, particularly that aspect of 'fatness' which comes to characterize female shape and its sexual nature. This will come on average to comprise about 25% of her body weight.

These days puberty arises earlier than ever, primed by good nutrition and absence of childhood infection. The female menarche is a late event within this process which can start insidiously as early as 8, 9 or 10 years of age. Rapid growth is associated also with greater fatness and weight at all ages. Over-nourishment in childhood, maximizing growth rate, may be related to defensive maternal over-protectiveness or insecurity which concurrently fails to equip the growing offspring to cope with the challenges of such early puberty.

Puberty is not 'asked for', i.e. is not under personal control (except through anorexia nervosa!), and may itself be experienced as 'egodystonic'. An essential task for healthy development in life is to come to experience its impact as egosyntonic; to feel in charge of and to own the newly emerging body including its sexuality. Sex not food is now the major currency in relationships. A meaningful link between food, growth and sexuality is apparent enough, especially in those prone to think concretely and single-mindedly. Transition to adolescence requires parents also to adapt to what may be challenging circumstances, e.g. where there is adoption, underlying paternity doubt, gender identity doubt, other problems of individuation, separation anxieties, challenges to the family through adolescent re-enactment of long-buried parental adolescent turmoil which will sometimes have been conditionally resolved by the parental marriage. Under such circumstances assumed constitutional likenesses with one or other parent may be operating powerfully. Alternatively, such growth in an offspring may be taken as a signal to one or other parent that the marriage can now break up. These and many other scenarios can complicate the pubertal process and render adolescence brittle. Of all the maladjustments that can then arise, anorexia nervosa is the most dramatic; harnessing, in my own view, a reversal of the whole pubertal process as the primary defensive strategy. This is unwittingly achieved through reduction in energy intake (dietary energy) and the consequent selective rapid banishment of the newly established and, under such circumstances of threat, relatively expendable reproductive process.

After such a flight from the post-pubertal state, the problems it had generated disappear. They may never have been articulated. The price is continued anorexia nervosa, itself biologically unstable and requiring constant vigilance if the stance is to be sustained. The threatened body, unaware of the psychological strains that have

precipitated the disorder, generates an urge to forage and ingest that could become overwhelming and must constantly be kept at bay if anorexia nervosa is the posture. Fear of any weight above about 45 kg then becomes the main perception driving everything else. Since the position is biologically unstable the only alternative to weight gain may be weight loss and the established anorectic is usually prone to such further weight loss. However, most anorectics continue to report a weight of 41.5–44.5 kg as being ideal, although often too risky to permit.

The same sense of panic, incompetence, low self-esteem and inability to control one's destiny, which characterize the onset of anorexia nervosa, is also a feature of bulimia nervosa, but here the emphasis is not on biological avoidance of the problems but rather a continued helpless involvement in them. It would seem that basic impulsivity is too great in the individual with bulimia nervosa and the avoidant mechanism less available. The individual lives with conflict but, in the classical form, this is mainly condensed into gorging, related weight and shape concerns, and vomiting.

Anxiety

Reference has already been made to 'dyslipophobia', implying a distressing and panic-driven reaction to normal adult female 'fatness'. The motor component to panic is avoidant flight, and anorexia nervosa is defined by this characteristic which serves to dislocate the individual qualitatively from the further impact of the pubertal process. Anorexia nervosa is, thus, a dramatic variant of the phobic avoidant disorders. Avoidant behaviour is also driven by experiences such as shame, disgust and guilt, and these can contribute to the anorectic stance and be condensed into comparable affect-laden concerns about any food that threatens to destabilize the absolute avoidant stance. When shame and/or disgust etc. predominate then earlier specific childhood sexual abuse may have been a marker for the developmental origins of such reactions which have now become inflamed by puberty.

Depression

In its full expression, depression is a state of inertia consequent on the pressure of problems to which there are no perceived solutions. In that sense it too is an avoidant position; avoidant of further unnecessary unavailing activity and distress. Such depression, along with anxiety, may have begun to colour the experiences preceding a response of anorexia nervosa. Recovery from anorexia nervosa naturally involves re-experiencing such depression, accepting it as a relatively mature state of mind but indicative of the need for problem-solving help.

A different kind of depression can come to colour the anorexia nervosa itself; when the individual feels abandoned by others who eventually give up trying to help, coupled with the exhaustion of needing to sustain the posture. The early-morning waking which characterizes anorexia nervosa is starvation driven. In bulimia nervosa, depression, at least in terms of feelings of despair and desolation, is a more active ingredient. In both anorexia nervosa and bulimia nervosa it can prime further self-destructive behaviour which, in the case of anorexia nervosa, accounts through suicide for up to half of early deaths from the condition.

OTHER CLINICAL FEATURES

The desperate need to sustain the avoidant stance leads the anorectic also to muster ritualistic defences and additional social avoidant strategies if she has an underlying predisposition to such behaviours. Excessive exercise may dominate. The labels 'hysterical' and 'self-inflicted' become pejoratively attached. Family and carers alike become totally deskilled in this new arena. Family conflicts now centre around the nurturing diathesis and are largely non-specific, giving little hint of preceding maturational crises and family conflicts relevant to the onset of the disorder and currently resolved by it.

If dietary restraint in anorexia nervosa is lost then vomiting, often secret, becomes the next line of defence, i.e. maintaining low body weight. The metabolic picture now changes radically with many kinds of food being eaten and then vomited leading to serious fluid and electrolyte imbalance. Laxative abuse can be massive (e.g. up to 200 times the daily dosage) and denied, as can diuretic abuse. Such problems, arising in perhaps 20% of all anorectics, are also features of bulimia nervosa and will have an equally devastating biological impact although usually against the background of more robust physical well-being.

Individuals diagnosed as having anorexia nervosa because of apparent low weight may in fact be much closer to normal body weight but severely dehydrated through laxative abuse. I have seen patients of average height weighing 38 kg but in fact still menstruating. The natural biological basis for this menstruation is evident when vomiting and laxative abuse are brought under control and weight soars immediately to about 50 kg, sometimes without any severe reactive over-hydration to account for the bulk of such gain. These circumstances can enable unexpected pregnancies and always need to be borne in mind if such events are to be guarded against.

Additional complications of anorexia nervosa which may command attention exclusively include hypercarotenaemia, massive unexplained oedema, epilepsy, drug and alcohol abuse.

NATURAL HISTORY

Both conditions usually erupt in adolescence with a mean age of onset in the late teens but anorexia nervosa, for example, can arise as early as 8 or 9 years of age when puberty would otherwise have been early. Equally, there can be occasional late onset in the 20s and 30s or later. Even the apparent anomaly of a post-menopausal onset for the first time can occur. With later onset the predisposing diathesis, of undue concern about shape and weight and concerns about impulse control, low self-esteem etc., will usually have been a long-standing feature. Occasionally the late onset disorder can erupt out of the blue. I find that it is then related to reactivation of an adolescent conflict to which a brittle initial adjustment may have been made by some non-anorectic strategy. This is now powerfully kindled by an event relevant to the original conflict such as a particular sexual encounter, marriage, childbirth, or loss of a given parent. The extremely rare post-menopausal onset syndrome seems to relate to excessive concerns about uncontrollable decay, perceived in bodily terms and responded to with the development of anorexia nervosa, still with fixation on similar low adult body weights as an insurance against alternative weight gain.

Anorexia nervosa can remit spontaneously but often takes a chronic form which progressively dislocates the individual from normal life in every respect. Early death can

arise in as many as 15–20% of the anorectic population by the time of 20-year follow-up if the condition is untreated. Death occurs from a variety of causes, usually obviously related to anorexia nervosa. Apart from frank suicide, it can be due to extreme starvation, inhalation of vomit, road traffic accidents or the impact on the cardiovascular system and the central nervous system of profound electrolyte upheaval etc. Anorectics would seem to be spared affliction with diseases related to reproduction such as cancer of breast and cervix. Predictors of poor outcome in anorexia nervosa include presence of vomiting, late onset, chronicity, poor childhood social skills, similar disorders in other family members, and probably childhood sexual abuse.

The natural history of bulimia nervosa is less well charted but the straightforward form often remits within 10 years of presentation. The more complex form involving generalized impulse-ridden behaviour has a worse outlook and blends with generalized severe personality disorder. Early death is usually through suicide or inhalation of vomit. The variant of bulimia nervosa in which the individual persists in seeking a lower than normal body weight also carries a worse prognosis. Such individuals can develop anorexia nervosa itself or else their bulimia nervosa is associated with especially severe vomiting and/or laxative abuse and resistance to change.

CONSTITUTIONAL ASPECTS

The constitutional aspects range from the biological through the experiential to the sociological and are interactive. The disorder runs in families (about 7% of first-degree female relatives are afflicted). Genetic factors may contribute about half the variance underlying the condition. These factors may include a propensity for dealing with strain and anxiety by avoidance (the family members are often conflict avoidant in many respects), a nurturant diathesis (tendency to high birth weight and growth rate independent of maternal age and birth order), a unimodal and relatively concrete style of cognitive organization (dominated by constructs concerning the importance of body shape and weight at different levels).

Constitutional aberrations of resting metabolic rate (Kaye *et al.* 1986) and serotonin function (Kaye *et al.* 1991) identified in apparently-fully-recovered anorectics have been postulated, but the former is not borne out by our own studies of fully weight-restored anorectics. Full recovery from anorexia nervosa requires rigorous definition and exploration, given the anorectic's propensity for denial. Such individuals, if biologically in any degree of conservation and/or withdrawal state due to impaired nutrition, will still be subject to an abnormal impulse to ingest and may also experience an excess of conflicting impulses related to panic and anger. Under such circumstances serotonin activity may well be disturbed. Continued secret vomiting, laxative abuse and denial of illness also render it difficult to make sense of measured body weight or to trust reports of menstrual function.

The greater risk for females of developing eating disorders has been attributed to social pressure in a male-dominated world. I believe the link to be powerfully related to the nature of female puberty. Adolescent males, subject to a qualitatively different process within puberty, become concerned about the regulation of their lean body mass in adolescence rather than any pubertally-driven fatness. Male maladaptive reactions to puberty consequently most often take a different form and anorexia nervosa in the male is very rare.

Background cultural factors are often implicated, especially fashion. Given the astute marketing philosophies of industry, fashion may be more a symptom of a given generation's need than a prompt to its sartorial destiny although the process is clearly interactive. More relevant may be the broader background structure and social norms of society and changes in these. Anorexia nervosa has often been common in the past and may yield a more stable incidence over time than is claimed. There is evidence that it was common in the 1920s let alone the 1870s. Social forces that loosen the structural supports within society may render it a less secure environment for the more vulnerable of adolescents who adopt flight responses when under strain. In recent decades, potentially protective customs such as courting and engagement have faded, the spectrum of maternalistic and paternalistic control from the Church through to the family has lessened, behavioural ground rules have become uncertain and complicated by freedoms such as those invited by the availability of female contraception. The adolescent rebellions of the late 1960s were perhaps a recent symptom of and watershed for inevitable changes in the limits that could thereafter be set upon behaviour. Perhaps anorectics and bulimics are amongst the casualties. Equally stifling can be an oppressive culture which for some may provoke anorexia nervosa as the means of continued bonding when, otherwise, rebellion and rejection would have resulted. This can be seen as the interface and potential clash between permissive cultures and those (e.g. Islam and certain evangelical sects) demanding strict codes of conduct including culturally-restricted marriage.

Constitutional family features include many systems, none of which seems specific to anorexia nervosa or bulimia nervosa. In anorexia nervosa, enmeshed and conflict avoidant patterns are common but dislocated parental relationships can also occur, e.g. where one or other parent is absent or alcoholic or abusive, and the given offspring needs to reject that side of herself through her anorexia nervosa as the condition for a reinforced enmeshed bond with the remaining parent, usually the mother.

Constitutional bio-psychological factors include a pervasive expressed wish, for many years now, amongst 16–18-year-old schoolgirls whether from the UK or North America for a precise weight of 50 kg on average compared with variable mean measured weights of about 55 and 60 kg respectively. This sought-after low body weight, stable over time and across continents, suggests that biological (e.g. pubertal) factors rather than social ones are operative. The substantial discrepancy between actual and preferred body weights in this population probably generates the variety of attempts at greater self-regulation condensed into greater control over weight (i.e. puberty and its consequences) that characterize such females and reflect dissatisfaction and emotional insecurity within their existence. Weight loss, when it does occur, generally leads to greater confidence and sense of competence about many aspects of the self and especially in respect of the sexual impulse. If this experience generates greater panic instead, then the way is open to further weight loss and entry into the avoidant path that ends with anorexia nervosa. Such vulnerability is likely to derive from both genetic and developmental aspects of the emerging personality and will include the potential for conflict avoidance or flight behaviour, lack of social skills, identity doubt and insecurity.

PRECIPITANTS OF ANOREXIA NERVOSA AND BULIMIA NERVOSA

These are life events and experiences meaningfully related to the developmental background and its current family context and include the consequent inability to cope

with such experiences as the onset of puberty itself, the menarche, moves to less supportive schooling, first boyfriend, first sexual experience, emerging adolescent preoccupations interfering with parentally cherished dedicated scholarship, leaving home, and so on.

ASSESSMENT OF THE CASE

Case assessment is a skilled and labour-intensive task. Our own approach requires about 3 h to be spent face to face in the first instance, involving both family and afflicted individual if the case is one of anorexia nervosa. This stems from the complexity of psychopathology, the denial that needs to be circumvented and mellowed, and the parallel task of enabling the individual to accept the prospect of substantial potential help. Because the bulimic exhibits less denial and is more ready to engage in treatment, an effective initial assessment can often be undertaken more swiftly but, sooner or later, the case will benefit from fuller assessment. In anorexia nervosa the diagnosis, in line with the model briefly outlined previously, can best be made at four levels:

- (1) the behavioural aspects of the syndrome, driven by the biology of starvation and defences against ingestion plus the associated physical features required by international classifications e.g. DSM IV (American Psychiatric Association, 1994);
- (2) the identification of the phobia of normal adult body weight and/or shape (often denied) e.g. most often initially detectable through more-readily-reported related body-image disturbances;
- (3) identification of the underlying maturational problem (now resolved, often never articulated and commonly denied);
- (4) estimation of potential psychological resources for recovery within the individual and family.

In bulimia nervosa the diagnostic features are more evident for reasons already mentioned but the process still benefits from access to other informants.

TREATMENT

Treatment is predominantly experiential and behavioural. In anorexia nervosa both family and individual relationship-based psychotherapy is significantly effective in both the short (Crisp *et al.* 1991) and long (Crisp *et al.* 1992) terms. With uncomplicated bulimia nervosa the individual is already more autonomous e.g. post-pubertal for a start, and can often be helped with a briefer behavioural programme plus cognitive (Fairburn *et al.* 1991) or relationship-based (Lacey, 1983a) psychotherapy, leaving them to renegotiate family relationships thereafter.

The behavioural approach to anorexia nervosa aims to promote weight gain; a process usually doomed to failure by itself but possible when the accompanying psychotherapy is valued and conditional upon it. Weight gain in anorexia nervosa is necessary to reactivate the maturational problem as a basis for meaningful therapy. The behavioural constraints on weight in the treatment of bulimia nervosa most often require the individual not to gain or lose weight or else to steer towards a weight agreed as normal for that individual.

THE ROLE OF THE NUTRITIONIST

A practising dietitian is an invaluable member of the assessment and treatment team. The pitfalls in the dietetic approach stem from the patient's psychopathology. For instance, our studies suggest that anorectics consume on average about half of what they report at initial assessment. Those with anorexia nervosa who binge and also those with bulimia nervosa are often more accurate but also tend to minimize the more shaming aspects of their eating behaviour. Vomiting and laxative abuse may be denied, especially in anorexia nervosa, being driven by the underlying dyslipophobia which may also be denied.

Female dietitians are more likely than male dietitians to have dyslipophobic elements in their own make up and these will need to be frankly acknowledged if the treatment team is to remain cohesively effective. The same can apply to all team members whether male or female and the therapy can benefit from achieving genuine consensus on the prescribed target weight in a given case at the outset.

Proper treatment of anorexia nervosa involves a prolonged growing-up process which can still be remarkably cost effective when application of the previously described model of psychopathology to a given case is accurate and treatment thereby soundly based. The dietitian has a major supportive role within this process. The range of dietary advice and counselling will vary, for anorexia nervosa, from attempts to halt weight loss to the re-entraining of growth thereafter, either to an optimal anorectic level or else to a fully-recovered level. Such diets are mapped out in our self-help book (Crisp *et al.* 1989).

With bulimia nervosa emphasis would be on regular eating and, usually, weight maintenance with concurrent behavioural controls over vomiting and laxative abuse (Lacey, 1983*b*). Primary preventive approaches to the eating disorders are suggested by the author elsewhere (Crisp, 1988).

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