Chapter 3

MORE ABOUT EATING DISORDERS

No one wants to be labeled "eating disordered," but we think everyone ought to know what the label means. For brevity's sake we will not list all the clinical eating disorder criteria in detail, however a limited overview taken from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth edition (2013), is provided below.[1]

Anorexia Nervosa: Those of us with anorexia struggled with obsessions over weight and body shape. Weight loss became of primary importance to the exclusion of most everything else. Weight and shape concerns often led to: frequent weight checking, body-checking behaviors such as looking in mirrors, having slight fluctuations in weight result in a dramatic impact on mood, and/or excessive exercise. Characteristics may have included persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected), intense fear of weight gain or becoming fat, or persistent behavior that interfered with weight gain (e.g. self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise). We typically experienced disturbances in the way we related to our bodies and shapes, and we persisted in not recognizing the seriousness and risks associated with low body weight. For more informa-

[1] For more detailed information, see: "Types and Symptoms of Eating Disorders." National Eating Disorders Association. Retrieved from *https://www.nationaleatingdisorders.org/types-symptoms-eating-disorders*

tion please see "EDA on Anorexia" under the Literature tab at *www.4EDA.org*.

Bulimia Nervosa: For many of us, bulimia started as a weight-control technique that quickly became a stress management tool when we discovered it suppressed unwelcome emotions. Once a pattern of bulimic behavior was established, it was incredibly difficult to stop. Common characteristics included: recurrent episodes of binge eating with a sense of lack of control during the binge episode, and inappropriate compensatory behaviors (e.g. self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise) to prevent weight gain. Symptoms included: self-evaluation that is unduly influenced by body shape and weight; rigid dieting followed by binge eating; hiding/stealing food; frequent over-eating, especially when stressed; disappearing after eating to purge; use of laxatives, vomiting or over-exercising to control weight; swelling of the glands in throat, face, and neck. For more information please see "EDA on Bulimia" under the Literature tab at *www.4EDA.org*.

Binge Eating Disorder (BED): BED is characterized by compulsive overeating, in which we consumed a huge amount of food while feeling out of control and powerless to stop. Those of us who were binge eaters often felt highly distressed about our inability to control food intake; however, we did not usually over-exercise or purge as might a person with bulimia. Warning signs included: eating large amounts of food without purging, a sense of lack of control with respect to eating, eating until uncomfortably or painfully full, feeling guilt or shame about our eating patterns, self-medicating with food, and hiding food. For more

information please see "EDA on Binge Eating" under the Literature tab at *www.4EDA.org*.

Other Specified Feeding and Eating Disorders (OSFED): OSFED may be a catch-all category, but don't be fooled: it is just as serious as any other eating disorder and the ambiguity can be misleading. We who did not meet all the clinical criteria for one of the above diagnoses might have suffered just as badly, and deserved as much help, as someone with any other diagnosis.

Examples of OSFED:

- All the criteria for Anorexia Nervosa are met except that our weight remained within or about normal range, despite significant weight loss.
- All criteria for Bulimia Nervosa are met except the episodes of binge eating and inappropriate compensatory behaviors occur less frequently.
- All the criteria for BED are met except the frequency of binges.
- In Purging Disorder, purging behavior aimed to influence weight, shape, or emotional state is present, but binge eating is absent.
- Those of us with Night Eating Syndrome have recurrent episodes of eating at night (i.e. eating after awakening from sleep, or consuming excess calories after the evening meal).

For more information please see "EDA on OSFED" under the Literature tab at *www.4EDA.org*.

Not one among us aspired to any of these designations![2] Most of us started out quite innocently, never imagining the condition we would find ourselves in further down the road. If you told us back when we thought we did not really have a problem just how desperate and hopeless we would become, we would not have believed you; we would have been offended and would have rejected the idea as preposterous. But over time, our eating-disordered thoughts and behaviors gradually progressed from something we engaged in only occasionally to something that we relied on to get through daily life. Some of us, faced with near-death experiences or total responsibility for the lives of others, were able to moderate our behaviors somewhat. Some of us were able to stop, sometimes for extended periods. But when we picked up old patterns, we soon became as ill as ever.

When most people first realize they have a problem with eating, they don't think it is particularly severe. We certainly didn't. If eating-disordered thoughts and behaviors are not yet well-established, you probably think you can recover on your own. We hope you can! We would not wish anyone the misery we endured. But understanding the true nature of an eating disorder before trying to work a program of recovery can be critical, so it may be worthwhile to conduct an experiment to see if you are really one of us. If you find yourself bingeing and want to stop, try some controlled bingeing. See if you can stop abruptly halfway through a normal binge, and stay out of bingeing

[2] There are many other eating disorders not covered above. Compulsive overeating, for instance, is not a diagnosis in the *DSM-5*, yet many of our members were struggling with the thoughts and behaviors associated with this form of disordered eating. Whether your situation is covered by the *DSM-5* or not, you are always welcome to attend an EDA meeting if you have a desire to recover from patterns of thought and behavior that feel like disordered eating to you.

behaviors altogether for the next week or two. Did you find that to be no big deal? If you are anorexic, try eating what and when everyone else is eating for a week or two. Can you do it? If you purge, try to limit your purging to just once over the next week or two. In all honesty, without resorting to any excuses, were you able to do it? If you are like us, you will not be able to manage eating normally, at least not without suffering serious emotional repercussions (such as anger, resentment, and self-pity) over any extended period of time.

If you see yourself in the above descriptions, you have probably already tried one or more of the following to address your eating issues: eating three wholesome and nutritious meals a day, eating five small meals a day, eating only in the company of other people, eliminating specific foods or food components labeled "problematic," eating only vegan food, eating according to a specific food plan, working with abstinence-based Twelve Step groups, seeking guidance from religious leaders and spiritual mentors, seeking resolution with the support of medical professionals and medication, surrendering to an intensive outpatient therapy program, and/or committing yourself to an inpatient treatment program.

Some people with eating disorders find lasting relief through one or more of these approaches, and many regain physical well-being under medical supervision. Let us affirm: *we strongly encourage everyone to make full use of every resource they can to support their recovery*. Many people do recover from their eating disorders through individual therapy, and almost everyone can benefit from working with a skilled and well-trained team of medical professionals, including a registered dietician. Such people can often shed much-needed light and provide valuable direction.

Yet, many in our fellowship were unable to make full use of available resources, disappointingly finding only temporary relief. Unable to let go of the patterns of thought that led to eating-disordered behaviors, we ultimately resorted to old ways of coping. How can this be? Some of us were privileged to work with some of the very best medical professionals in the field. Others had amazing spiritual guides and mentors. Some were able to work with renowned therapists at highly sought-after treatment centers. But despite our best efforts and the dedicated work of well-trained and caring people, many of us did not *fully* recover. Even though we had made progress, we returned to old patterns that we by then understood were injurious to mind and body. Why does this happen?

We can provide answers, of course, but they are trivial compared to the frank and urgent mortal peril we face when engaged in our eating disorders. We should note here that anorexia has the highest mortality rate of any mental illness, with bulimia and OSFED (formerly EDNOS) not far behind.[3] Obesity—a not-infrequent side effect of disordered eating—is implicated in approximately 300,000 deaths per year in the United States and may be second only to smoking in preventable causes of death.[4] Sadly, we came to the conclusion that our minds were so warped by entrenched patterns of thought and action that we lost the power of choice: we behaved as if compelled by stark insanity.

[3] Arcelus, J., Mitchell, A.J., Wales, J., Nielsen, S. (2011) Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Archives of General Psychiatry*. 68(7), 724-31.

[4] Flegal, M., Williamson, D.F., Pamuk, E.R., Rosenberg, H.M. (2004) Estimating Deaths Attributable to Obesity in the United States. *American Journal of Public Health.* 94(9), 1486-1489.

Michelle's "Strange Mental Blank Spot"[5]

Let us consider the case of Michelle. Michelle had been severely bulimic in her teens and early twenties, and had undergone inpatient treatment for depression and anxiety. She had a good working knowledge of how to address these issues through cognitive behavioral approaches. She was sober in AA and was working a program of abstinence in another Twelve-Step group where she had an excellent sponsor who was taking her through the Steps. Michelle was making good progress in her recovery and had been free of her eating-disordered behaviors for quite some time. At this point, the family kept only "healthy" food in the house. Home life was stable. Michelle's husband had a good job, money was no issue, and everyone was moderately happy and healthy. Michelle was not anxious or depressed.

Michelle's small children kept her busy, active in the community, and engaged with friends and neighbors. One day, after an enjoyable visit to the zoo with her own and several neighborhood kids, Michelle made dinner as usual. The children were not especially fond of vegetables, though these were a staple at evening meals. Dinner was unremarkable. Once the meal was over, the kids went out to play, her husband excused himself to watch television, and Michelle began to clean up as she had many times before without a problem. The neighbor children had not eaten their share of vegetables, and Michelle thought nothing of helping herself to an extra portion; wasting food that could not easily be reheated did not make sense. It tasted good. She had another serving. Though vaguely aware that this behavior was a red flag, Michelle did not take any of the obvi-

[5] *Alcoholics Anonymous.* (2001) New York, NY: AA World Services, Inc., 42.

ous steps to stop, to understand what was happening, or to prevent what happened next. Once the vegetables were gone, she searched the refrigerator for something else that would soothe what now felt like a case of jangled nerves. There was absolutely nothing in either the refrigerator or the pantry that would be of any interest to a normal person thinking of eating "binge food," but it did not matter. Within half an hour, Michelle managed to consume enough perfectly innocuous, "healthy" food to lead her to want to purge.

Even at that point, disaster could have been averted had Michelle called her sponsor, sought relief through the Steps, or been willing to divert her attention long enough to wait out the uncomfortable fullness. But she did none of those things, and so began a weeks-long return to the very behaviors that led Michelle to seek recovery in the first place. Despite having a good understanding of where a few wrong moves could take her, and despite having a good support network that might have changed the outcome had she leveraged it, Michelle had no effective mental defense against the return of her eating-disordered behaviors. Though she well understood that bingeing and purging had formerly put her life in jeopardy, and could well do so again, there had been no premeditation whatsoever before starting the binge, little consideration at several points during the binge, and only a few seconds of indecision before purging. At the time, it made no sense—least of all to Michelle. Nothing was obviously wrong at any physical level. Nutrition and electrolytes were not a factor. The types of food involved would not have been considered "problematic" by anyone, not even Michelle's sponsor at the time. Yet Michelle seemed to have experienced what the AA text calls a "strange mental blank spot"—a seem-

ingly inexplicable return to old patterns after new ones have been established.

It may come as a relief to know that no matter how unpredictable a return to old behaviors may seem at first, there is always some warning, and—while it may seem completely obscure at first—an underlying cause. When we become willing to look at our issues and attitudes (a daily 10th Step practice) and look for ways to leverage our experience, training, time, talent, and energy to serve a higher purpose (a daily 11th Step reflection), our recovery gradually becomes more resilient. We stop reacting automatically to triggering situations and start making deliberate, conscious choices with ever-increasing ease and reliability. Sanity is restored so long as we remain willing to do what is needed for recovery. It takes a while to figure this out!

Though initially baffled by the return to bulimic behavior, Michelle later reflected that more was going on with her than she had originally thought. When asked about what she had been thinking, she eventually told us,

> I was vaguely upset that the neighbor children who joined us at dinner had not eaten their vegetables. That set a bad example for my own children, and I thought I should have talked with them about the importance of eating their veggies. Those kids had dinner with us fairly often and they never ate their veggies, so this was nothing new. I didn't think it was proper to correct other people's children at the dinner table unless they were doing something really terrible, so my response wasn't new either. The neighbor family's circumstances, however, had recently taken a turn for the worse. I started thinking how unprepared I was to take over caring for these children, and I immediately became overwhelmed.

> Now, no one had asked me to "take over" the care of three additional children. The children needed support, but I was blowing my part all out of proportion. Even though I had been in Twelve-Step programs a long time, I did not recognize that I was making the situation all about me—my inadequacies and my feelings. Rather than doing the right things that would have put the situation back in perspective, I did all the wrong things. I barely thought about what I was doing at all! Rather than relying on my Higher Power to help me through the immediate situation so I could turn my feelings to some good purpose later, I turned to old habits to relieve my feelings within a few heartbeats of feeling overwhelmed. Because I hadn't been practicing reliance on my Higher Power, I lost my daily reprieve from my eating disorder with no thought about the consequences at all.

You may think Michelle is a ridiculous or extreme example, yet every one of us has experienced something disturbingly similar. We may have reflected more than Michelle did before engaging in old patterns, but there was always something going on with us—in tandem with perfectly rational thoughts—that blinded us to our issues and left us prey to insanely trivial reasons why it would, suddenly, be perfectly fine to sabotage our recoveries. Our good lives, our love of all that is just and right, and our ability to think rationally about our situations did not save us from insane thinking and behavior.

Once re-engaged with our eating disorders, we were filled with remorse, guilt, and all manner of other emotions that served as additional justification for continuing the insanity. We became shockingly immune to concerns regarding the potentially terrible consequences for ourselves, our families, and anyone else who depended upon

us for emotional, moral, social, or financial support. On an emotional level, we were unable to be genuinely present for ourselves or anyone else, abandoning our families, friends, co-workers, and communities. Things may have looked normal from the outside, but we knew better.

Despite knowledge of what she could have done instead, Michelle remained vulnerable *precisely because she had not been relying on practices that would have revealed what she was* really *thinking, which would have given her an opportunity to turn the energy of her emotions to some useful purpose.*

Self-Will and Self-Knowledge Are Not Enough: Marla

In the story of the jaywalker in the AA chapter, "More About Alcoholism," the authors pose a hypothetical case in which a fellow has a penchant for jaywalking. For whatever reason, the fellow gets a thrill from "skipping in front of fast-moving vehicles."[6] He does this sporadically and experiences no significant consequences for quite a while. Up to this point, people are inclined to write off his behavior as foolishness. Then the fellow's luck deserts him, and he is hurt, though slightly, a few times. Normal folks would, after a few consequences, stop doing things that result in injury. But not this chap. He is soon hospitalized with a more severe injury. When people go to see him, he is adamant that he has changed his ways and will not return to his old behavior. When he is released from the hospital, he pulls another stunt and is almost immediately in much worse condition than before. He is rushed to the hospital for a long stay, since the time required to recover is far more

[6] *Alcoholics Anonymous.* (2001) New York, NY: AA World Services, Inc., 37-38.

extended. This time he means business and is sure he will never dart in front of cars again, yet upon release, he is nearly killed in yet another jaywalking incident. This man would be considered crazy, wouldn't he? The AA text points out that if we substitute alcoholism for jaywalking, the story is a perfect fit for alcoholic behavior. People with eating disorders, too, may recognize the pattern of promises, broken trust, and physical damage. Even if our behavior has not been so extreme, we have usually been just as untrustworthy—and just as crazy—as the hypothetical jaywalker.

Some people who are temporarily engaged in fad diets, obsessed with their weight or body image, or prone to using food for emotional reasons, can stop obsessive and disordered patterns of thought and behavior without too much difficulty—all on their own. We think such people may be the norm rather than the exception. Many others who seek guidance and support can and do learn to recognize and effectively address their issues through hard work in individual therapy, intensive outpatient therapy, or inpatient treatment.

Many of us, however, were not able to recover on the basis of self-knowledge alone; eating disorders can be fiendishly intractable and obstinate. Let us consider another example. A young woman named Marla joined one of our EDA groups while also in an eating disorder treatment center for anorexia. Marla was a delightful person who seemed to catch on to new ideas very quickly. She soon made a full recovery in treatment. Marla returned to college and was immediately caught up in the fun and excitement of a national engineering team competition. Appreciating what we said about the importance of working with others, Marla continued attending our EDA meeting for a month, despite a busy schedule. She sounded great, bringing hope

and fresh courage to many who were still in treatment. Then Marla's schedule changed, and the EDA meeting was no longer possible for her. But she assured us that there was no chance she would ever return to an eating disorder; her newfound understanding just wouldn't permit it.

We heard no more from Marla for over a year. Then one day, a nurse wheeled a completely emaciated woman on intravenous support into the EDA meeting room. None of us recognized the exuberant and delightful person we had known in the sunken-eyed, shrunken visage sitting before us in a wheelchair, but it was Marla. Despite youth, good health, a brilliant mind, an engaging personality, a great sense of humor, a host of people who would do anything for her, and full knowledge of herself as an eating-disordered person, Marla had returned to the treatment center utterly defeated. As she later explained it, she had fallen madly in love with a young man who initially seemed to reciprocate her feelings, but who then took up with someone else. Almost involuntarily, while she was trying to sort out her feelings, Marla had started restricting her food intake. Eating made her feel ill. But rather than seek out people she knew would help her, Marla depended instead on the least trustworthy companion she had to help her cope: her eating disorder. Marla later confirmed what we were all thinking: self-will and self-knowledge had provided no defense whatsoever against the return of her symptoms. Like Michelle, Marla succumbed to the undertow of her eating disorder *because she stopped relying on practices that would have helped her regain perspective.* Happily, Marla was able to make a full recovery after her physical condition returned to a near-normal state. She worked the Steps, learned to apply more aspects of the program, and adopted a daily practice that keeps her safe.

We hope our stories bring home to you, the reader, that we of the "hopeless" variety are absolutely unable to stop engaging in eating-disordered behaviors on the basis of need, desire, self-will, and self-knowledge. We can be full of confidence, but when caught off guard, we can be reduced to human wreckage with astonishing rapidity. Despite having fully functioning intellectual capabilities, a reasonably well-developed amount of common sense, and ample motivation to want to remain fully engaged in life, we were prone to being caught off guard.

There Is a Solution

Yet, as you have read in the previous chapter, there is a solution. We have shown how we seem to have no effective mental defense against a return to old patterns—especially that "strange mental blank spot" described in AA's Big Book.[7] The defense must come from reliance on God, a Higher Power, or from daily commitment and surrender to a higher purpose, each of which provides perspective and opportunities to turn even the most troubling emotions into a form of energy we can use to make lives better for others. We repeat: our proposal is simple, but not easy. To be effective, we have to willingly give up our old relationship to life and our place in it. We have to take specific actions that humble us and restore us to sanity every day. We help others to remind ourselves why we need to remain disciplined about our daily practice. Working with others keeps us actively working the Steps and living in recovery. The self-sacrifice required to give freely of our time and energy helps keep us out of selfishness (self-centeredness),

[7] *Alcoholics Anonymous.* (2001) New York, NY: AA World Services, Inc., 42.

and safe from losing sight of what matters. Such work not only provides perspective, it keeps us honest and humble: we quickly learn we cannot be effective if we are not! With a daily practice of surrender and service, we become flexible and strong. Without it, we become brittle and vulnerable. The results of working the program are simply amazing. Rather than merely having "life restored" we found freedom, peace, camaraderie, enjoyment, and adventure beyond our wildest dreams.

The chapter "More About Alcoholism" in the original AA text, cites medical professionals' support for the Twelve-Step approach: Dr. William D. Silkworth, director of a treatment center, wrote, "Though not a religious person, I have profound respect for the spiritual approach in cases such as yours. For most, there is virtually no other solution."[8] In the next four chapters, you will read exactly what we did to recover. Whether you consider yourself religious, spiritual, agnostic, atheist, or someone who does not embrace any such label—you will find others like yourself in our Fellowship. We believe there is a solution that will work for you, too. In the next chapters, we show how we can work the Twelve Steps to find recovery from *every* position on the spectrum of faith.

[8] Ibid., 43.