Table 6.1 from Fairburn CG, *Cognitive Behavior Therapy and Eating Disorders*, Guilford Press, New York, 2008.

Main topics to cover when educating patients about eating disorders

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The Patient's Eating Disorder and its Treatment

- The patient's eating disorder diagnosis
- Its prevalence and main characteristics
- Associated health risks
- Its course and prognosis without treatment
- The treatment options and their likely effects

Clinical Features of Eating Disorders

1. Characteristic extreme concerns about shape and weight
    - Judging of self-worth largely or even exclusively in terms of shape and weight and their control
    - Various secondary "expressions" that maintain the extreme concerns
        - Repeated body weight and shape checking (including unfavorable comparisons with others)
        - Body avoidance
        - Feeling fat
        - Marginalization of other aspects of life
    - Drives extreme weight-control behavior (dieting, self-induced vomiting, etc - see below
    - Highly impairing (e.g., distressing; preoccupation with thoughts about shape and weight; social sensitivity; difficulty with sexual relationships)
2. Characteristic form of dieting
    - Demanding dietary goals with multiple rigid rules
    - Markedly increases the risk of binge eating
    - May, or may not, lead to undereating and a very low weight
    - Highly impairing (e.g., difficulty eating with others and eating out; preoccupation with food and eating)
3. Binge eating
    - An episode of uncontrolled overeating. (Clinicians tend to restrict the use of the term to episodes of eating in which an unusually large amount of food is eaten for the circumstances, but many people's "binges" do not involve eating such large amounts.)
    - Usually experienced as highly aversive overall
    - Typically triggered by breaking a dietary rule or by the occurrence of an adverse event or negative mood
    - Highly impairing (e.g., secondary shame and guilt; requires secrecy and subterfuge; expensive)

4. Self-induced vomiting
    - Either to compensate for an episode of perceived or actual overeating or is a more routine form of weight control
    - Relatively ineffective. About half of what has been eaten cannot be retrieved.
    - If compensatory, belief in its effectiveness maintains binge eating because a psychological deterrent against further overeating is undermined
    - Adverse physical effects, especially electrolyte disturbance (which can be dangerous as it may result in cardiac arrhythmias), salivary gland enlargement and erosion of the dental enamel of the inner surface of the front teeth
    - Highly impairing (e.g., secondary shame and guilt; requires secrecy and subterfuge)
5. Laxative and diuretic misuse
    - Either to compensate for an episode of perceived or actual overeating or are a more routine form of weight control
    - Ineffective. Laxatives have very little effect on food absorption and diuretics have none
    - If compensatory, belief in their effectiveness maintains binge eating because a psychological deterrent against further overeating is undermined
    - Both have a short-lived effect on weight by causing dehydration (through loss of fluid in the form of diarrhea or urine respectively)
    - Adverse physical effects, especially electrolyte disturbance
    - Highly impairing (e.g., secondary shame and guilt; require secrecy and subterfuge; expensive)
6. Over-exercising
    - Either follows an episode of perceived or actual overeating or is a more routine form of weight control
    - Relatively ineffective as a means of weight control
    - Can be "driven" in which case there is an inner compulsion to exercise and exercising takes precedence over other activities
    - Physically dangerous if significantly underweight or in the presence of osteoporosis or electrolyte disturbance
    - Impairing if "driven" (e.g., takes up a great deal of time; socially disruptive)
7. Being underweight - See Chapter 11 (especially Table 11.2)
