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The Egosyntonic Nature of Anorexia: A Roadblock to Recovery

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Imagine this. You are suffering from an illness which has brought with it incredible detriment to your life. It has left you numb to your feelings, and you feel trapped by its perilous grip over you. You are ridden with guilt over the worry and concern that your illness has brought to your family and friends, and you feel low and isolated as your health continues to deteriorate. Finally, you are offered help. Here it is; a chance to recover and reconnect to the person you were before this illness wreaked so much havoc in your life (providing you do the work)! Yet – you hesitate. You are reluctant. You are unsure if you're really ready to say goodbye to your illness, which in many ways has become a friend and guardian to you.

This is where outsiders are usually perplexed – if not incredibly frustrated – as they see their loved one resisting letting go of something which is so *obviously* detrimental to their life. Carers and therapists alike might even view this resistance to treatment as some sort of malfeasance or misconduct on part of the patient, when really, upon truly understanding the egosyntonic nature of anorexia nervosa (that is, the fact that patients often value their disorder), non-compliance might almost be *expected*, and should be considered a *symptom or artefact of the illness*, rather than a representation of the patient's own bull-headed stubbornness or defiant misbehaviour.

Consider recovery from anorexia nervosa (AN), and eating disorders in general, like traversing down a road – one that is unpaved, full of potholes, and for which there is no (Google) map. Common pitfalls encountered during recovery could then be considered normal "roadblocks" – the egosyntonic nature of the illness being among them.

In order not to stumble, it is important that patient, carer, and therapist alike fully understand what aspects of their illness AN patients may value, as well as get familiar with methods to bypassing pitfalls linked with egosyntonicity.

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UNPACKING EGOSYNTONICITY

AN is commonly considered a disorder that is "mainly about weight and shape", yet research into egosyntonicity has demonstrated that AN has a unique meaning for those affected that is far more complex than the common notion that AN, at its crux, is simply about desiring and overvaluing a thin appearance. Whilst the attainment of a thin appearance is certainly a perceived benefit which AN patients do endorse, it is not the only function AN serves for those affected, and (perhaps surprisingly) not the perceived benefit most commonly endorsed, according to research (Nordbo et al., 2006; Serpell et al., 1999). Two studies conducted in Norway and the United Kingdom in which patients' own words regarding their illness were explored shed light on several ways in which AN was experienced as beneficial to them.

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AN as a safety blanket: We've all heard it; "anorexia is really about *control*", a phrase repeated ad nauseum, almost so much so that it has begun to lose its meaning. And whilst the phrase may be reductive or an oversimplification of an incredibly complex disorder that is, *yes*, about control but also about self-esteem, expression, beauty standards, identity (and the list goes on), it is a core function of AN most commonly endorsed by patients according to research (Serpell et al., 2004). So what is this control all about?

> To let go of AN therefore means to let go of this sense of control and embrace the full catastrophe of life – a daunting (but worthwhile!) task.

Whilst affected individuals are engaged with their eating disorder (ED), a myopic focus on what their ED deems important develops. Food. Weight. Calories. Compared to the complex world of paying one's bills and managing relationships and changing the tires and remembering to take one's vitamins and attaining *Success!* (whatever that means), narrowing one's focal point to something as simple as *What did I eat, and how much do I weigh?* allows a sort of reprieve from life's impertinent demands. The previously complex task of living – with all its uncertainty and randomness and unknowns – suddenly becomes simple, black-and-white, *quantifiable* even. The ED will assure the affected person, *As long as you are restricting and losing weight, everything is okay, no matter what else is going on in the periphery.* To let go of AN therefore means to let go of this sense of control and embrace the full catastrophe of life – a daunting (but worthwhile!) task.

AN as a skill: As AN develops, the affected individual often experiences a sense of mastery and inner strength for having achieved something most other people cannot do – managing to adhere to a strict diet and achieve weight loss goals. As AN patients commonly suffer from low self-esteem, discovering something they know for a fact that they are good at (losing weight and restricting calories) may boost their confidence. Ironically, AN very much acts like a wrecking ball in other areas of their life, affecting work, grades, relationships, and so forth, yet the ED may assure the affected individual, *Got a bad grade on your essay? No worries! All you need to do is lose X more pounds and you'll feel better about yourself! Most people couldn't eat as little as you do!* To let go of AN therefore means to let go of this sense of mastery, and to let go of the notion that one's self-worth is somehow contingent upon external achievements (a foreign notion perhaps to ED and non-ED sufferers alike!).

AN as a confidence booster: This may sound similar to the previously addressed benefit, but applies specifically to feeling worthy of compliments and feeling more attractive as a result of a thinner appearance, which is often reinforced by positive feedback from others about one's appearance, particularly in the beginning phases of AN, when weight loss may be noticeable but not yet alarming. Interestingly, this particular benefit of AN is most commonly endorsed by patients who are *less* underweight (Gregertsen et al., 2018), perhaps indicative of our societal standards whereby females who are thin but not frighteningly so are still lauded by society as the pinnacles of attractiveness. To let go of AN therefore means to let go of this ingrained beauty ideal and the praise one might receive for having achieved something close to it, but most importantly, to let go of the notion that the number which appears at the bottom of one's feet when stepping on a scale might tell one something about one's worth. Because it won't.

AN as a red flag: Communicating distress can be difficult, and a sickly appearance and pathological behaviours may be a means to convey a feeling of distress that an individual with AN has been unable to express with words. As the individual becomes more and more sickly looking, family members and loved ones may finally take notice and acknowledge their duress, a duress which may have long preceded their frail appearance, but is only now being recognised as it manifests into something visible. In the words of Marya Hornbacher (1998), "all along, part of the point of disappearing was to disappear *visibly*" (p. 262). The concern, then, regarding recovery is this: *If I look healthy, everyone will think I'm okay when I'm not!* (Let's face it, no one becomes magically recovered the day they reach a BMI of 18.5.) To let go of AN therefore means to let go of this often very successful means of communicating one's distress, and to learn to say the words out loud: *I am not okay.*

OVERCOMING EGOSYNTONICITY

Having understood the nature of egosyntonicity and the benefits that the person with AN may perceive their illness is adding to their life, thereby decreasing motivation for recovery and engagement with treatment, the question then becomes: How do we address this in the therapeutic context?

Firstly, whilst the egosyntonic nature of AN can be considered a hallmark feature of the illness and thereby universal to most AN patients, how this egosyntonic nature

presents itself is specific and unique depending on the patient in question; therefore, uncovering this idiosyncratic nature within each patient is key. To this end, psychometric measures such as the Pros and Cons of Anorexia Scale (P-CAN; Serpell et al., 2004), as well as letter-writing tasks addressing the illness as both friend and enemy, may be utilised within the clinical context. Such activities can provide the therapist with an overview of which pros and cons of AN the patient endorses and does not endorse. As such, these tools and activities are helpful in finding healthy mechanisms to replace positive functions of AN, as well as in solidifying or elaborating upon negative perceptions already endorsed by the patient. To exemplify, if the patient identifies that AN allows them to escape from their emotions, the therapist may wish to teach distress tolerance strategies as a replacement for AN's impact on their distress. Further, if the patient identifies health risks as a negative aspect of AN, the therapist might offer to provide information on health risks associated with AN, to further strengthen this endorsement. In contrast, if health risks are not endorsed as a con, the therapist should avoid the temptation to bombard the patient with information regarding these risks, as this is likely to impair the therapeutic alliance and build resistance to change.

Whilst considering pros and cons, it may also be helpful to explore with the patient the short-term pros versus long-term cons; for example, AN may provide an immediate escape from current emotional stressors, but impact their life goals and health negatively when considered long-term. A task such as writing letters to a friend in an imagined five years time, one in which the person has recovered from AN and the other in which AN is still present (Schmidt, Wade & Treasure, 2014) can be an effective way to elucidate these differences. It is common for pros to be short-term or immediate whilst cons are often longer term. When this is the case, it can be helpful to discuss the way in which our behaviour tends to be more affected by immediate rewards and to teach techniques to keep longer term goals in mind.

Another important avenue to explore with the patient in order to tackle egosyntonicity is to consider personal values. Initially, the pros of AN that the patient endorses may seem aligned with their values (hence the illness's egosyntonicity!); however, upon further scrutiny, patient and therapist may come to the conclusion that they are in fact opposed. For example, a patient who expresses that AN fits with their religious beliefs in that they feel closer to God through purity and restraint may come to realise on further inspection that AN in fact limits their closeness with God due to obsession with weight or shape, leaving little room for spirituality. As such, through value-clarification and uncovering personally held values which are not compatible with AN behaviours, patients may discover how their overarching values are being compromised by their disorder, and how ultimately if they want to live a life truly aligned with their core values, recovery is a necessary pathway (Mulkerinn et al., 2016).

> …patient and therapist can work together in overcoming this detrimental illness in an environment where empathy and understanding is promoted, and this roadblock to recovery may finally be surmounted.

Lastly, it is also essential to consider how the egosyntonic nature of AN may lead to patients being perceived as less 'compliant' by clinicians, which can negatively impact the therapeutic alliance. A useful paper by Vitousek et al. (1998) on enhancing motivation for change emphasised the importance of appreciating the degree to which the desire for thinness and self-control is egosyntonic, pointing out the problematic nature of 'attaching surplus meaning to resistance' toward recovery. The clinical danger here is labelling patients as non-compliant (and therefore not suitable for treatment), when resistance is to be expected, considering patients often view their ED as a solution to their problems. By immediately emphasising the negatives of the ED, without acknowledging the patient's perceived benefits, the patient may be quick to label the therapist as 'the enemy'. After all, the therapist is proposing 'to take away the one thing in their life which they do not regard as broken', whilst failing to understand the unique function(s) of AN for the patient, and therefore the therapist's admonitions cannot be trusted. Conversely, by reframing resistance as a comprehensible response to threat, the patient and therapist are provided with an alternative narrative that may help enhance empathy and lessen conflict, allowing them to work collaboratively. Such a reframe may be achieved by therapists being aware of and acknowledging the functional role AN plays in the patient's life, using the aforementioned tools, as is often done in motivational interviewing. By fully acknowledging, understanding, and examining the egosyntonic nature of AN, patient and therapist can work together in overcoming this detrimental illness in an environment where empathy and understanding is promoted, and this roadblock to recovery may finally be surmounted.

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