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Caritas in Veritate

Benedict XVI released his third encyclical on 29 June 2009. Its Latin title is 'Caritas in Veritate;' its English title is 'On Integral Human Development in Charity and Truth.'[1] This article explores the significant teachings of this encyclical.

The Catholic Church has a long tradition of social teaching. The modern phase of this teaching began with Leo XIII's 1891 encyclical *Rerum Novarum (The Condition of Labor)*. Addressing the plight of workers after the Industrial Revolution, this groundbreaking statement insisted on the necessity of a living wage sufficient to support the worker and his or her family. It also supported trade unions, and did not exclude strike action in certain circumstances. Social teaching since then has included encyclicals by Pius XI, John XXIII, Paul VI and John Paul II, important speeches by Pius XII, documents from the Second Vatican Council and the Synod of Bishops, and statements from national bishops' conferences including the Australian Bishops' *Common Wealth for the Common Good* (1992).[2] In this tradition, Paul VI's 1967 encyclical *On the Development of Peoples (Populorum Progressio)*[3] is particularly significant. Whereas *Rerum Novarum* focussed on the plight of impoverished workers, *Populorum Progressio* recognised that "the social question has become worldwide." (*PP*, #3) It therefore focussed on the plight of the less developed nations, and reminded better-off nations of their duty to provide international aid, to rectify unjust trade conditions, and to practise universal charity. Finally, the last major international statement of Catholic social teaching was John Paul II's 1991 encyclical *On the Hundredth Anniversary of Rerum Novarum (Centesimus Annus)*.

After a lengthy eighteen-year hiatus, Benedict XVI's *Caritas in Veritate* is the next major international statement of Catholic social teaching. Originally planned to mark the fortieth anniversary of *Populorum Progressio*, the encyclical was eventually a bit delayed. As Phil Lawler notes, clearly Benedict "allowed the project to slip behind schedule" because he was "determined to wait until he had a document that satisfied him."[4] Recently, too, the encyclical was revised to address the Global Financial Crisis of the last few years. Dated 29 June 2009, *Caritas in Veritate* was released at a packed Vatican press conference on 7 July. One of the speakers at this conference was Stefano Zamagni, a consultant to the Pontifical Council for Justice and Peace, and a professor of economic policies at the Italian University of Bologna.[5] As Margaret Archer has noted, this indicates that the "sauce, substance and savour" of the encyclical was inspired by the ideas of Zamagni and other critical realists at Bologna. *Caritas in Veritate* is quite long. At just over thirty thousand words (including footnotes), it is almost two-and-a-half times as long as *Populorum Progressio*. This article does not attempt to summarise everything that the encyclical says about every topic, for that would be impossible in an article of this size. (For that, I recommend that you read *Caritas in Veritate*. While it is not an easy read, because it has so much to teach us, it is worth the effort. My advice is that you do not try to read more than one chapter at a sitting.) In this article, my aim is to discuss the most significant ideas in each of the encyclical's eight sections:

Introduction (#1-9)

The Introduction to *Caritas in Veritate* is a profound meditation on the place of charity and truth in our commitment to social justice. Obviously, it is charity or love which "leads people to opt for courageous and generous engagement in the field of justice and peace." (#1) If we do not have this love, even the Church's social teaching would remain for us nothing more than a dead letter. But this love must be directed by truth. Truth teaches us what will truly help other people. Without truth, the things we do may make us feel good, but they might not be truly helpful to others. Thus, Benedict explains that charity "needs to be understood, confirmed and practised in the light of truth…. Truth is the light that gives meaning and value to charity." (#2-3) He concludes, "Charity in truth… is the principal driving force behind the authentic development of every person and of all humanity…. *Caritas in veritate* is the principle around which the Church's social doctrine turns…" (#1, 6) The Introduction then meditates on the hidden depths of these deceptively simple ideas. For example, it notes that our

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very capacity to love in this way is ultimately given to us by God. It is "grace" whose "wellspring" is "the Father's love for the Son, in the Holy Spirit." (#5)

Chapter One (#10-20)

Towards the end of the Introduction, Benedict states, "I express my conviction that *Populorum Progressio* deserves to be considered 'the *Rerum Novarum* of the present age.'" (#9) In other words, Benedict challenges us to develop within ourselves *Populorum Progressio*'s global perspective on social justice. For example, as we consider the Global Financial Crisis, we should be aware not only of its effects on our superannuation accounts, but also its far more severe effects in the developing world. There, because of the Global Financial Crisis, "as many as 100 million people have been plunged back into the most acute hardship of living on less than $US1 a day, and more than a billion people are reported as undernourished."[6]

Chapter One of the encyclical is a re-examination of *Populorum Progressio*. As well as considering the encyclical in itself, Benedict explores its place within the Church's social doctrine, and its connections both with the Second Vatican Council and with the rest of Paul VI's teaching. Among other things, he is concerned to demonstrate the "dynamic faithfulness" of the tradition. (#12) In other words, he recognises that Catholic teaching is neither statically unchanging nor radically discontinuous, but rather involves "novelty in continuity" or both "fidelity and dynamism."[7] This is a common theme in Benedict's thought.

Above all, Benedict points to one of the most important themes from *Populorum Progressio*, that of integral human development. This vision of development insists that authentic development cannot be only economic. It must instead involve every dimension of the human person. It must be at once economic, social, political, cultural, religious, and so on. Also, authentic development cannot involve only one person or a small group in isolation. It must instead embrace all people – and even all peoples – together. As *Populorum Progressio* notes, integral human development "has to promote the good of every person and of the whole person." (*PP*, #14)

Benedict notes that *Populorum Progressio* recognises integral human development as "first and foremost a *vocation*." (#16) It is God who calls us to make something of ourselves. It is God's Spirit within us who calls us to grow and develop. From this insight, Benedict draws at least three important conclusions. First, integral human development cannot be fully understood except from a religious perspective. Again quoting *Populorum Progressio*, he states, "There is no true humanism but that which is open to the Absolute, and is conscious of a vocation which gives human life its true meaning." (#16) Second, authentic development cannot neglect the spiritual dimension of the human person. Indeed, "development must include not just material growth but also spiritual growth." (#76) Third, authentic development requires a religious perspective for its full flowering or completion. For example, globalisation can make us "neighbours," but it "does not make us brothers." Religious faith alone teaches us that we are all brothers and sisters in one human family. Religious faith alone teaches us the "fraternal charity" which causes us to genuinely care for those within our human family who live far away from us. (#19)

Chapter Two (#21-33)

This chapter of *Caritas in Veritate* explores the signs of the times – the significant changes which are currently taking place within the world. It considers economic changes including the Global Financial Crisis (#22-24), social changes (#25), and cultural changes (#26-29). Two of the cultural changes should be highlighted. Firstly, Benedict notes that in many countries there is now "deliberate promotion of religious indifference or practical atheism." He warns that this "deprives" people "of the moral and spiritual strength that is indispensable for attaining integral human development." (#29) Secondly, Benedict also notes the declining respect for human life in many countries. He points to contraception, abortion and euthanasia (#28), to *in vitro* fertilization, embryo research, "the possibility of manufacturing clones and human hybrids," and "the systematic eugenic programming of births." (#75) He warns:

> ***Openness to life is at the centre of true development*. When a society moves towards the denial or suppression of life, it ends up no longer finding the necessary motivation and energy to strive for man's true good. (#28)**

But above all, the "principal new feature" in the world today is "the explosion of worldwide interdependence, commonly known as globalization." (#33) This above all is why Benedict regards *Populorum Progressio* as "the *Rerum Novarum* of the present age," and why he calls us to its global perspective.

Benedict recognises that "if badly directed," globalization could "lead to an increase in poverty and inequality, and could even trigger a global crisis." (#42) Even so, he insists that "in itself it represents a great opportunity." (#33) "The processes of globalization, suitably understood and directed, open up the unprecedented possibility of large-scale redistribution of wealth on a world-wide scale." (#42) Benedict therefore calls the human family to manage globalization so that it will deliver good rather than bad outcomes.

Chapter Three (#34-42)

In this chapter, Benedict considers but then goes beyond what he calls the "exclusively binary model of market-plus-State." (#39) This binary model recognises only two structures within the economy. Firstly, it recognises the market. The market is about contracts or deals. For example, I contract to sell my labour for so many dollars an hour; or you contract to buy a car for so many thousands dollars. Contracts exist "in order to regulate relations of exchange between goods of equivalent value." (#37) The market is therefore governed by "the principle of the equivalence in value of exchanged

goods." (#35) Secondly, the binary model also recognises the State (i.e. the government). The State is "directed towards the pursuit of the common good." (#36) For example, for the common good, the State decrees that some actions are illegal, and it also collects money through taxation both for public works and for distribution to those in need through social welfare programmes. Significantly, then, this binary model recognises only two types of transaction: "giving in order to acquire (the logic of exchange) and giving through duty (the logic of public obligation, imposed by State law)." (#39)

Benedict no longer believes that justice will be achieved through these structures and transactions alone. Instead, he calls us to rediscover gift or gratuitousness or "the principle of gratuitousness and the logic of gift." (#36) Gift is anything good that we do, beyond what is strictly required by a contract or by State law. It is parents' care and nurture of their children. It is friends' solicitude for one another. It is a volunteer's contribution to a community organisation. It is the lawyer's pro bono work, the doctor's uncharged home visit, the nurse's unpaid overtime. It is the receptionist who is warm and friendly even when she doesn't really have to be. It is the organisation which perseveres with an under-performing employee as he or she goes through a time of personal crisis. It is our contributions in cash and in kind to charitable organisations. It is surely many other things besides. Above all, it is a "sign of God's presence in us, a sign of what he expects us to be." (#34)

Benedict calls for a rediscovery of gratuitousness both within the market and within the State. He writes, "The great challenge before us… is to demonstrate, in thinking and behaviour… that in commercial relationships the principle of gratuitousness and the logic of gift as an expression of fraternity can and must find their place within normal economic activity." (#36) Thus, for example, a firm might not charge top dollar when it is dealing with a client who is genuinely struggling, or it might do some extra things for free, or it may make some funds available to support community groups, and so on. Benedict adds that within the State too, "the aspect of fraternal reciprocity must be present." (#38)

For true justice to be achieved worldwide, Benedict argues that gratuitousness must be rediscovered within the market, within the ethos of businesses, within the State, and within each one of our own lives. Clifford Longley rightly calls this reflection on gratuitousness and gift "Benedict XVI's strikingly original contribution to the corpus of Catholic social teaching."[8]

Chapter Four (#43-52)

This chapter is about rights and duties. It begins with an introductory essay about the need to balance rights with duties. "Individual rights, when detached from a framework of duties… can run wild, leading to an escalation of demands which is effectively unlimited." (#43) It continues with a series of essays about rights and duties in various contexts. There is an essay on population growth which insists that governments must protect and not interfere with the rights of the family. (#44) There is an essay on ethics in business (#45-46). An essay on development programmes insists that "the people who benefit from them ought to be directly involved in their planning and implementation." (#47) There is a longer essay on our duties in relation to the environment. (#48-51) Let me pick up two important points:

Businesses are discussed both here in #46 and earlier in #38. In both places, Benedict recognises the diversity of business in today's world. There are, for example, public enterprises, for-profit companies, non-profit companies, charitable foundations sometimes associated with for-profit companies, mutual organisations such as building societies and credit unions, and so on. In both places, Benedict calls for interaction among these various types of organisations to form composites and partnerships which pursue the common good. These composites and partnerships might not "exclude profit," but "consider it a means for achieving human and social ends." (#46) Forming such partnerships is an important challenge for Catholic schools and universities, for Catholic hospitals and aged care services, for Catholic welfare agencies, and for Catholic parishes and dioceses.

In his essay on the environment, Benedict notes the connection between respect for human life and care of the environment. He writes:

> **If there is a lack of respect for the right to life and to a natural death, if human conception, gestation and birth are made artificial, if human embryos are sacrificed to research, the conscience of society ends up losing the concept of human ecology and, along with it, that of environmental ecology. (#51)**

If you want to care for the environment, respect human life. I believe that this is one of the great insights of this encyclical.

Chapter Five (#53-67)

Chapter Five is about building relationships between people internationally. Again, there is an introductory essay. (#53-54) This time, it reminds us that we are never simply isolated individuals, but instead that we grow and mature through our interpersonal relationships. A second essay notes that while Christianity encourages authentic human development, some other religious and cultural traditions may retard or even obstruct this. (#55) A third essay insists that "the Christian religion and other religions can offer their contribution to development only if God has a place in the public realm." (#56) Next, there are essays on the principle of subsidiarity and the principle of solidarity. (#57 & 58) There is then a series of essays on developing international relationships through inter-cultural dialogue (#59), international aid, (#60), education and international tourism (#61), migration (#62), trade unions (#63), international finance (#65), and consumers' associations including those that provide a market for goods from the developing world (#66). A final essay is on the United Nations and the

international economic and finance institutions. (#67) Again, let me take up two of these areas:

Firstly, the essay on finance is one place where the encyclical discusses the Global Financial Crisis. Benedict notes that the "misuse" of finance has "wreaked such havoc on the real economy." (#65) Elsewhere, he identifies this as one of the "pernicious effects of sin." (#34) Here, he calls the financial system back to its rightful purpose of "sustaining true development." He adds that "regulation of the financial sector… should be further explored and encouraged." (#65) And elsewhere, he suggests that "in the search for solutions to the current economic crisis, development aid for poor countries should be considered a valid means of creating wealth for all." (#60) He sees the crisis as "an opportunity for discernment, in which to shape a new vision for the future" - a vision focussed emphatically on developing nations, the environment, and the poor. (#21)

Secondly, Benedict calls for a "reform" of the United Nations and the international economic and finance institutions so that "the family of nations can acquire real teeth." Among other tasks, he wants this reformed organisation to manage the Global Financial Crisis, "to bring about disarmament, food security and peace," and "to guarantee protection of the environment." He adds this reformed organisation should be "regulated by law," observe "the principles of subsidiarity and solidarity," be "universally recognized," and be "vested with effective power to ensure security for all, regard for justice, and respect for rights." (#67) This somewhat radical hope for the United Nations is the common vision of Catholic social teaching.[9]

Chapter Six (#68-77)

The final chapter of *Caritas in Veritate* is about the use and abuse of technology. The introductory essay reminds us that technology is essentially a good thing. Indeed, it is "a response to God's command to till and to keep the land (cf Gen 2:15)." (#69) However, technology is abused "when too much attention is given to the 'how' questions, and not enough to the many 'why' questions." There is a "'technical' worldview" or ideology which is spreading worldwide and which ignores questions about the moral appropriateness of technological innovations. The chapter continues with essays on the need for an appropriate ethical framework in the fields of development and peace (#71-72), the mass media (#73), bioethics (#74-75), and the care of the human psyche (#76). The essay on bioethics merits special comment:

Benedict lists *in vitro* fertilization, embryo research, "the possibility of manufacturing clones and human hybrids," "the systematic eugenic programming of births," and "a pro-euthanasia mindset" as examples of the abuse of technology within bioethics. Indeed, he sees all this as the "clearest expression" of the abuse of technology. He warns that "these practices in turn foster a materialistic and mechanistic understanding of human life," and asks, "Who could measure the negative effects of this kind of mentality for development?" One consequence, he suggests, is that a developed world so focussed on absolute control might lose its capacity for compassion. He writes, "While the poor of the world continue knocking on the doors of the rich, the world of affluence runs the risk of no longer hearing those knocks..." (#75) Earlier, Benedict argued that if we want to care for the environment, we must respect human life. Here, he warns that if we truly want to care for the poor worldwide, we must again respect human life. Drawing on a famous image from Cardinal Joseph Bernardin, Neil Ormerod calls this the "new seamless garment of Catholic social teaching."[10]

Conclusion (#78-79)

The short Conclusion suggests that only religious faith can sustain us in the struggle for justice. "Only if we are aware of our calling... to be part of God's family... will we be able to generate a new vision and muster new energy in the service of a truly integral humanism." (#78) For this reason, those who work for justice must be people of prayer. "Development requires attention to the spiritual life.... if 'hearts of stone' are to be transformed into 'hearts of flesh' (Ezek 36:26)." (#79)

This, then, is a short summary of Benedict's latest encyclical. I hope it has whetted your appetite to read the full encyclical for yourself.

ENDNOTES

[1] Benedict XVI, *Caritas in Veritate*, Holy See, http://www.vatican.va/holy_father/benedict_xvi/encyclicals/documents/hf_ben-xvi_enc_20090629_caritas-in-veritate_en.html
[2] Australian Catholic Bishops' Conference, *Common Wealth for the Common Good* (Nth. Blackburn, VIC: Collins Dove, 1992).
[3] Paul VI, *Populorum Progressio*, Holy See, http:// www. vatican. va/holy_father/paul_vi/encyclicals/documents/hf_p-vi _enc_ 26031967_populorum_en.html
[4] Phil Lawler, "*Caritas in Veritate*: an awkward hybrid, an important breakthrough – or both?" CatholicCulture.org, http: //www.catholicculture.org/commentary/articles.cfm?ID=333
[5] Margaret Archer, "No man is an island," *The Tablet* 263, no. 8801 (18 July 2009): 10-11 at 10.
[6] Bruce Duncan, "Pope's worthy plea against market forces," The Age, http://www.theage.com.au/opinion/popes-worthy-plea-up-against-market-forces-20090713-diq4.html?page=-1
[7] Joseph A. Komonchak, "Novelty in continuity," *The Tablet* 263, no. 8778 (31 January 2009): 5-6 at 6. Komonchak is actually referring to Benedict's comments about the Second Vatican Council in his end-of-year talk to the Roman Curia on 22 December 2005. Then, Benedict suggested that the Council should be understood through a "hermeneutic of reform."
[8] Clifford Longley, "Gift means giving up the pursuit of every last morsel of profit," *The Tablet* 263, no. 8805 (15 August 2009): 5.
[9] The same vision is found in the Second Vatican Council's *Gaudium et Spes* #82, John XXIII's *Pacem in Terris* #145, Paul VI's *Populorum Progressio* #78, and #441 of the *Compendium of the Social Doctrine of the Church*.
[10] Neil Ormerod, "Pope's 'seamless garment' bares green credentials," Eureka Street, http://www.eurekastreet.com.au /article.aspx?aeid=15048

All on-line documents accessed 15 September 2009.

Kevin McGovern ✠

Eating Disorders

The prevalence of eating disorders is increasing. This article provides an overview of these disorders and explores the biological and social conditions that influence their development.

The time when the sole purpose of eating was sustenance, is long past. We no longer have to hunt or scavenge for food and mostly all that is required is a trip to the supermarket. Ironically even in this time of abundance nearly half the world's population is still suffering from food shortages - yet for the other half food has come to be associated with much more than just satisfying hunger. It is an integral part of the social, cultural and economic fabric of today's society. However, for some individuals the relationship with food and eating is complex and may manifest in the form of an eating disorder.

Eating disorders are characterized by severe disturbances in eating behaviour.[1] These include two distinct disorders; anorexia nervosa (AN) and bulimia nervosa (BN). Both disorders represent the most severe form of eating disorders with a symptom spectrum ranging from partial to full syndrome. DSM-IV-TR[i] recognises another entity, binge eating disorder (BED) which is characterized by repeated episodes of binge eating, but without the extreme measures of weight control, such as vomiting or purging as seen in BN.[2] The distinguishing factor in this disorder is the relative lack of concern for body weight and shape,[3] which is the most significant factor in the diagnosis of AN and BN. Yet another category of eating disorders is 'eating disorders not otherwise specified' (EDNOS). This is the most common type of eating disorder encountered in out-patient settings. It includes eating disorders of clinical severity that fail to meet the diagnostic criteria for AN and BN.[4]

Eating disorders predominantly affect adolescent and young adult women and are often driven by dissatisfaction with body shape and the desire to thinner. Large studies have shown that the lifetime prevalence of AN and BN is relatively low; it is estimated to range from 1% to 4% in white women.[5] The prevalence of BED is reported to be nearly 3%, while there are sparse data on the prevalence of EDNOS. A matter of concern is the lack of empirical classification of eating disorders, which adversely affects research in this area. Often the diagnostic criteria for the two established conditions AN and BN are also considered to be quite restrictive. This implies that the values quoted above may underestimate the prevalence of these disorders, as they may not take into account the full range of their manifestation. In spite of this, research now suggests that the prevalence of eating disorders is gradually increasing and the age of onset is decreasing.[6]

[i] Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision, is a manual published by the American Psychiatric Association that includes all currently recognized mental health disorders.

Anorexia Nervosa

Anorexia nervosa is characterised by psychological, behavioural and physical manifestations. The extent of the psychological disturbance determines the severity of the behavioural and physical symptoms.[7] The basis of the psychological distortion is an intense drive for thinness possibly associated with body image disturbance. Those who suffer from AN consider themselves to be overweight and consequently undesirable, despite being underweight. This belief translates into an acute fear of weight gain, and sufferers strive to remain far below what is normal for their height and age. Weight loss is considered to be an accomplishment in self-discipline, while weight gain is seen as a failure of self-control. Even their emaciated body seems 'fat' to them and they engage in various behaviours to cause drastic weight loss and to prevent subsequent weight gain. These practices include: extreme dietary restriction, self-inflicted vomiting, purging, laxative abuse and vigorous exercise/activity.[8] The fixation on body weight and shape manifests as obsessive habits which include: frequent weighing, measuring body parts, and looking in the mirror for perceived fat.[9]

DSM-IV-TR Diagnostic Criteria for AN:[10]

- **Refusal to maintain body weight at or above a minimally normal weight for age and height**
- **Intense fear of gaining weight or becoming fat, even though underweight.**
- **Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.**
- **Amenorrhea, i.e., the absence of at least three consecutive menstrual cycles.**

Researchers believe that the body image disorder in AN is more than a distortion of perception, and may represent the patient's beliefs, ideas, internal images and emotions related to their body.[11] The desire for thinness and body image disorder are the cornerstones of AN but a few auxiliary psychological traits have also been associated with AN. These include perfectionism, obsessive behaviour, depression, anxiety, emotional lability, a symbiotic association with the illness and lack of motivation for recovery.[12]

The extreme weight loss in anorexics has devastating and long term physical effects, resulting in significant morbidity as well as a high mortality rate. However, research has shown that a higher proportion of deaths

results from suicide, rather than causes directly related to the eating disorder.[13] This highlights the significance of the psychological component of the illness on the prognosis. The most significant physical symptoms of AN are a low body mass index (BMI) and amenorrhea or loss of menstruation. As mentioned above, amenorrhea is a DSM-IV-TR diagnostic criterion for AN, but there have been concerns regarding the use of this criterion due to certain limitations. These include: absence of amenorrhea in many patients who have all other symptoms of AN, the false sense of reduced severity of AN due to absence of amenorrhea, and the irrelevance of this diagnostic feature in males suffering from AN.[14] Studies have shown that presence of amenorrhea, though consistently correlated with low body weight, may not be an essential feature of AN.[15] Furthermore, it has been shown that amenorrhea is not a useful predictor of short-term treatment outcome and thus may be more useful as a reflection of nutritional status rather than a diagnostic criterion for AN. Some other physical sequelae of AN are electrolyte imbalance, cardiac dysfunction, infertility, reduced bone density and endocrine dysfunction.

The ambiguity of the diagnostic criteria and often highly heterogenous presentation makes the diagnosis of AN difficult. Another complicating factor is the lack of disease staging; some have described discreet stages while others have suggested the idea of conceptualizing disease presentations along a continuum. This has implications for disease identification, prognostic factors and development of treatments. Though conflicting evidence exists, some symptoms of AN have been associated with a poor prognostic outcome. These include: low BMI, vomiting, bingeing, purgative abuse, long duration of illness, social dysfunction and obsessive-compulsive symptoms. Effective treatment for AN requires a multidisciplinary approach involving psychiatrists, social workers, dieticians, and other health care professionals. There is no pharmacologic remedy for AN and the mainstay of treatment is cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT).[16] These are often required for a few years following weight restoration to prevent relapse. Since anorexic individuals rarely seek treatment on their own and are usually persuaded by family to get help, the success of therapy relies on family support and cooperation.

Bulimia Nervosa

Bulimia Nervosa is characterized by repeated episodes of binge eating followed by inappropriate compensatory behaviours such as self-induced vomiting; abuse of laxatives and diuretics; fasting; and excessive exercise.[17] Unlike the self-controlling tendencies of people with AN who often feel a sense of accomplishment by controlling their weight, those with BN are often ashamed of their behaviour and endeavour to keep it hidden from family and friends.[18] But like patients with AN, those with BN harbour an unusual fixation on the weight and shape of their bodies, as a basis for their self-worth.

DSM-IV-TR Diagnostic Criteria for BN:[19]

- **Recurrent episodes of binge eating.**
- **Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.**
- **The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.**
- **Self-evaluation is unduly influenced by body shape and weight.**

The typical patient of BN is a young adult woman of normal weight who reports binge eating and purging 5–10 times a week for some years. There are self-imposed attempts at severe dietary restriction in order to prevent weight gain. This restriction increases hunger and inevitably leads to loss of control resulting in binge eating. This is followed by an intense feeling of guilt driven by the fear of weight gain, which culminates in an episode of self-induced vomiting or laxative abuse. Such compensatory behaviour is a source of satisfaction in the beginning, as patients feel empowered that they are able to prevent weight gain despite bingeing. However, as the disease develops a vicious cycle ensues. The dietary restriction is increased causing heightened craving for food and subsequently larger binges, resulting in self-hate and more drastic purging. As the behaviour is established the frequency and intensity of the binging and purging episodes increase. These are often triggered by depression, anxiety, or a sense that too much food has been consumed in a normal meal.

A variety of factors have been implicated in the aetiology of BN including psychological, behavioural and genetic. Yet research has shown that the main factor predisposing to increased risk of BN is emotional dysregulation, which manifests as an inability to regulate, express and modulate emotions. Alexithymia is a type of emotional disturbance frequently associated with eating disorders, whereby sufferers experience difficulty identifying and describing feelings and are unable to distinguish emotions from physical sensations.[20] Another feature of BN is experiential avoidance – an unwillingness to remain in contact with unpleasant cognitive, physical and emotional processes.[21] As people with eating disorders have poor emotional regulation skills,[22] the excessive eating is an attempt at avoiding and shielding one's self from these negative feelings. Other negative states such as depression, anxiety, guilt, and self-loathing are also known to precipitate binges.[23]

Emotional intelligence (EI) is another psychiatric parameter that has been linked to eating disorders. It is defined as "the ability to perceive accurately, appraise and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and

intellectual growth."[24] High levels of EI give rise to positive attitudes, satisfaction and contentment, better coping mechanisms and a greater ability to adapt. On the other hand, those with low EI are more susceptible to negative emotional states such as loneliness, depression and stress, due to a reduced ability to cope. Although low levels of EI have been associated with eating disorders in general, there appears to be a stronger correlation of EI with BN. One study found that women with bulimic symptoms are more likely to have lower scores of EI, lower levels of adaptability, higher levels of alexithymia and more negative emotions compared to women with a less bulimic symptomatology. [25]

The treatment for BN reflects the complexity of aetiology and variable presentation of the disorder. As in AN, psychosocial treatment modalities such as cognitive behavioural therapy and individual as well as group psychotherapy are important. Those with serious physical disability, depression or suicide ideation may require hospitalization. Nutritional counselling has proved useful in minimizing the binge-purge activity and food restriction. Support groups may also provide another avenue of support but pharmacotherapy with anti-depressants has largely been unsuccessful.

Eating Disorder Not Otherwise Specified (EDNOS) and Binge Eating Disorder (BED)

Eating Disorder Not Otherwise Specified (EDNOS) is a term used to describe eating disorders that do not entirely fulfil the criteria for AN or BN, while Binge Eating Disorder (BED) has been defined as a separate entity. At least 50% of patients presenting with eating disorders are diagnosed with EDNOS, which highlights the complexity of diagnosing and subsequently treating eating disorders. Some instances where EDNOS has been diagnosed include examples where in a female, all the criteria for AN are met except amenorrhea or in the case of BN if there is regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food.[26]

EDNOS is the most common type of eating disorder seen in clinics, yet it is the most misunderstood. There are misconceptions that EDNOS cases are mild, unimportant and uncommon.[27] Consequently, very little research has been done regarding prevalence, aetiology and treatment. Studies have shown that EDNOS patients have a higher rate of recovery than AN or BN, and it has been suggested that EDNOS may constitute a transitory phase in people recovering from an eating disorder or during transition from one to another disorder.[28] This finding highlights the significance of EDNOS as a potential niche for therapeutic intervention, with an improved prognosis.

Binge Eating Disorder (BED) is characterized by recurrent episodes of binge eating. A binge is defined as eating, in a discrete period of time, an amount of food that is larger than most people would eat in a similar period of time under similar circumstances, along with a sense of lack of control over eating during the episode.[29] There is marked distress regarding the bingeing, but there are no associated compensatory behaviours such as induced vomiting, purging or excessive activity. Individuals suffering from BED are usually obese, and the bingeing behaviour is the aftermath of strict dietary restriction to lose weight. Bingeing involves eating more rapidly than normal, eating when not physically hungry, and/or eating until uncomfortably full. Those suffering from BED often eat alone as they are embarrassed by how much they are eating, and may feel disgust and guilt after bingeing.[30]

The diagnostic criteria for BED are quite controversial primarily due to the difficulty in defining a binge episode.[31] There are inconsistencies in determining what constitutes a large portion size, and how to differentiate between bingeing and over-eating. These inconsistencies make it difficult to determine the true number of binge episodes. Determining loss of control is also difficult mainly due to the subjective differences in definition.[32] As with other eating disorders, stress plays a major role in triggering binge episodes. High levels of perceived stress and increased incidence of life stressors have been associated with bingeing.[33] Furthermore, risk factors such as high levels of dietary restraint, emotional eating, and disinhibition; female sex; and obesity have been shown to exacerbate stress-induced eating.[34] It has also been hypothesized that strict dietary restriction and abstinence may increase the risk of bingeing, especially on highly palatable calorie-rich food, which has attendant risks.

Treatment for BED involves a three tiered approach using cognitive behavioural techniques, anti-depressant medication, and weight loss programs. Usually immediate improvements are seen in bingeing symptoms after treatment, however, most patients are unable to lose weight, which causes distress and can trigger a relapse. Traditional therapies for obesity such as dietary intervention, increased physical activity and behavioural modifications are also useful in BED. In those with morbid obesity (BMI >35), bariatric surgery may also be considered.

Aetiology of Eating Disorders

Although eating disorders are considered to be psychosomatic in origin, it is likely that socio-cultural stressors interact with a biological predisposition to cause these behavioural changes.[35] Eating disorders are almost exclusively seen in affluent societies where food is abundant and there is an excessive focus on body weight and shape. Here success in life is often attributed to one's physical appearance rather than personal qualities and achievements, especially for women. This fixation on physical appearance has trickled down from the affluent classes and has permeated the collective subconscious of present-day society. As a result women everywhere are striving to achieve the "ideal" appearance, which popular media has dictated to us to be that of a nearly emaciated, tall female, with a slender frame and hauntingly perfect facial features. As these ideals are hard to achieve, most of us suffer from some level of body dissatisfaction. For some, this dissatisfaction takes on a more severe form and

morphs into an obsession, and they undertake extreme measures to achieve their ideals. This has lead to a rise in the incidence of eating disorders, where the central dysfunction appears to be body dissatisfaction or body image disorder.

Despite the influence of the media in normalizing unhealthy body weight, it has been shown that children model their ideal appearance on parental attitudes and beliefs. Mothers who lay emphasis on thinness, weight control and dieting, and often have unhealthy eating habits themselves are more likely to impart this fixation to their daughters, increasing their risk of developing eating disorders. However, it can be argued that these mothers are also susceptible to the standards set by the media and society and often see no wrong in encouraging their daughters to achieve those standards, especially if they believe this would ensure success and prosperity. It can be claimed that in normalizing unhealthy body shapes, the media has all but glamorized eating disorders. It is well known that popular models, actors and public figures often suffer from eating disorders. They are not only victims of the same media culture but also often contribute to the propagation of those very ideals.

Although media today has great influence in people's lives, not all young women suffer from eating disorders. This brings forth the biological aspect of the aetiology of eating disorders. These disorders are known to have a genetic component, making some people more vulnerable to social stressors. There is also a psychological component, and these disorders have been linked to certain personality types. Another aspect may be the lack of fulfilment and spirituality. Many sufferers tend to relapse into AN and BN when going through a difficult phase in life. It is at times like these when faith gives us the courage to go on. In this day and age many lives are void of faith and too many people have lost touch with their spirituality, and often engage in adverse behaviours in an attempt to find fulfilment and contentment. This has lead to a rise in high risk behaviours such as drug abuse, alcoholism and possibly eating disorders.

Eating Disorders and Obesity

At first glance, obesity appears to embody all that is the opposite of eating disorders. One is a result of the obsession with food; the other is the consequence of depriving one's self of food. However, paradoxical as it may seem, obesity and eating disorders have a lot in common. Firstly, both disorders are heritable and tend to run in families. Secondly, obese individuals tend to suffer from body dissatisfaction increasing their likelihood of engaging in unhealthy eating behaviour which may develop into an eating disorder. They also have reduced coping mechanisms and less likely to be able to deal with distress as are those with eating disorders. Thirdly, both obesity and eating disorders show a propensity for the female gender and early sexual maturation is known to be a risk factor for both conditions.[36] Negative mood states such as depression, anxiety, low self-esteem, body dissatisfaction and internalising disorders all abound among the obese and those suffering from eating disorders. Both conditions also put individuals at greater risk of addiction and substance abuse. Sexual abuse is also reported to be a common risk factor for obesity and eating disorders.[37] On the other hand, these two conditions have some contrasting features as well. For instance, eating disorders are thought to arise from psychological dysfunction, whereas obesity often results in psychological complications. Socio-economic status is another distinguishing feature, whereby affluence is associated with eating disorders while higher rates of obesity occur in those of low socio-economic status. With the exponentially increasing incidence of obesity and rising prevalence of eating disorders, identifying the similarities and differences between these disorders may contribute to an improved management of both.

In conclusion, eating disorders present a classic illustration of the complex interactions of the biological, psychosocial and cultural realms, and provide testimony for the intricacies of disease aetiology. To understand the complex interactions of the psychological and physical domains with external stimuli and influences could help unravel the secrets of many a disease.

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Rida Usman Khalafzai ✠

Obstetric Fistula

Several readers have pointed out that as well as sponsoring fistula repair, the United Nations Population Fund pursues other agendas which are not pro-life. Donations for fistula repair are therefore best directed to the Hamlin Fistula Relief and Aid Fund (www.fistula.org), and the Worldwide Fistula Fund (www.wfmic.org). Donations can also be sent to MaterCare International (www.matercare.org), an association of Catholic Obstetricians and Gynaecologists dedicated to improving the lives and health of mothers and their children throughout the world.

Lessons From a Memoir

Well-known ABC presenter Caroline Jones has written a memoir about her father's death, and her own long and painful experience of grief afterwards. Titled 'Through a Glass Darkly',[1] her memoir has much to teach us about medical decision-making, chaplaincy and pastoral care, grief, and the search for meaning in life.

Caroline Jones's father Brian died at the age of ninety-three on 30 July 2000. His daughter's memoir was published just under nine years after his death. At a total of 368 pages, it is a big book. It is also a very honest, moving and at times harrowing account of surgery, Intensive Care, death, and then grief.

The book contains nine sections. Firstly, the Foreword (xiii-xiv) is written by noted bereavement counsellor Mal McKissock, who hopes that this book will teach "the normality of the prolonged nature of grief." (xiv) In the Introduction (xv-xix), Caroline reports, "I was unprepared for the intensity of my own grief and for the extent to which it disabled me…. In time it also made me grow, changing me into a different person who had to find a new perspective on life." (xv-xvi)

Part One (1-18) introduces us to Brian Newman James before his surgery. He enjoyed a happy life with Mary, his second wife. He was active, energetic, and a keen gardener. His daughter Caroline visited every other weekend. But he also suffered from severe angina.

Part Two (19-136) tells the story of Brian's surgery, hospitalisation, and death. After open-heart, coronary bypass surgery, Brian was six weeks in Intensive Care and another two weeks in a ward. Based on Caroline's

diary, the account is harrowing as Brian was taken back to theatre for more surgery; given an electric shock procedure for an irregular heartbeat, a feeding tube, lung-draining, kidney dialysis and a tracheotomy; and developed pneumonia, nausea and vomiting. He was worn down by it all, and confessed to Caroline, "I'm buggered… I'm not sure I can go on much longer." (121) Caroline too was distraught: she wrote, "I think we have entered into a nightmare." (29) Furthermore, in this crisis, God and her Christian faith were "not accessible" to her. (39)

After Brian's death, Part Three (137-266) recounts the multiple manifestations of grief in Caroline's life over the next two years from July 2000 to June 2002. She no longer had much control over her emotions, which had become both unpredictable and extreme. At times, she felt great distress, especially when she first woke up. At other times, she felt great sadness and cried uncontrollably. Sometimes, too, she felt very angry. She made herself continue to function, but most of the time her heart was not in it. Much of the time, she felt very tired with great feelings of lethargy and apathy. As the book's title records, she felt that she was on one side of a dark pane of glass while the rest of the world was on the other side. She observed the world "through a glass darkly." (cf xvi) Her faith too seemed to be "behind glass." She wrote, "I can remember having it but at present I cannot connect with the clarity of it that I used to know." (185) Caroline's memoir is harrowing even to read as she records episode after distressing episode of the many manifestations of grief. It must have been even more harrowing to have lived through these many disturbing experiences.

Part Four (267-302) is titled Seeds of Consolation. It records another two year period from December 2003 to January 2005. In it, Caroline questions the "prevailing view" that "people need to achieve something called 'closure' after a loss, so that they can 'move on.'"(240) She suggests instead that grief never completely goes away. More importantly, she notes that she has been transformed by her grief. She has gained some measure of control over the intrusions of grief. She writes that "deliberately now I choose a different thought: that horror is not happening now; it is finished; choose a positive thought." (271) She has "cultivated the habit of gratitude" so she is now "inclined to notice the positive aspects of a situation rather than the negative." (270) She finds that her experience has made her more open to others and more compassionate. She also has "a strong sense of the benevolent presence of [her] parents in [her] daily life." (272) Her image of God has matured. Rather than "demanding omnipotence" and expecting God to magically fix all her problems, she accepts God as a "faithful companion" who walks with us in the struggle. (218) She also accepts that faith in God and doubt can "co-exist" – "the contradictions not seeking reconciliation but each suffusing, permeating and giving meaning to the other." (274, 308)

The Epilogue (303-308) was written another two and a half years later on 1 August 2007. Caroline draws on other accounts of grief and struggle to offer a more universal message of encouragement and hope.

The eighth section of the book, Appendix One (311-329), is by psychologist Carmel Ross. The ninth section, Appendix Two (330-334), is by Brian's intensivist, Dr Ray Raper. They each offer their specialist commentary on Brian and Caroline's experience.

This short summary cannot capture the richness and detail of Caroline's memoir. For that above all, I recommend that you read the book. But what can we learn from this memoir about medical decision-making, chaplaincy and pastoral care, grief, and the search for meaning in life?

Medical Decision-Making

The Catholic Church recognises that we may legitimately refuse treatment - even life-sustaining treatment – which is either futile or too burdensome.[2] But how do we discern beforehand which treatments are futile or overly burdensome? This memoir offers four important insights:

Firstly, the memoir reminds us of the crucial significance of the initial decision either to accept or to refuse treatment. As Carmel Ross wrote, "[O]nce the surgery has happened… what happens next may become a roller-coaster ride of one organ in trouble after another…. As a result… choice vanishes because the juggernaut simply spins out of control, and saying 'No' is not really an option." (312) This memoir therefore reminds us that an initial decision to accept treatment may well lead to the myriad of complications which Brian experienced. Because of this, that initial decision about treatment must never be made lightly. To the contrary, that initial decision must be made deliberately and with serious consideration of its possible consequences.

Secondly, in many cases these decisions about accepting or refusing treatment always remain somewhat uncertain. They are uncertain before treatment. They remain uncertain even after treatment. At that time, while we know the consequences of one choice, we never know with absolute certainty where other choices may have led. Because of this, even after Brian's many complications and eventual death, Dr Ray Raper can still argue that "it is very likely that the best chance, statistically speaking, for [Brian] to be alive in five years was surgery. If he had not had surgery the alternative was for him to live with perhaps very significant symptoms for an uncertain time." (333) This memoir, then, reminds us of the lingering uncertainty about treatment decisions. We must accept this, and decisions still have to be made.

This memoir reminds us as well that we are also somewhat uncertain about how best to help patients with these decisions. Clinicians have a legal responsibility to warn patients of possible complications. This can extend even to warning about relatively rare complications. But Dr Ray Raper warns that all this "rather gloomy" detail might not help the patient. For one thing, the many details may be simply overwhelming. For another, "they may well increase fear and impede rather than assist sound

decision-making." (331, 332) Because of this, when treatment options are discussed with patients, some clinical judgment is required. Clinicians certainly must fulfil their legal obligations. Complete information must be available to each patient, perhaps in written form. Each patient must be given as much information as they want. But clinicians must also recognise that lengthy discussion about every possible complication may not be in the best interests of the patient.

Finally, this memoir encourages family involvement in these treatment decisions. Caroline was opposed to her father's surgery from the start. Even before the surgery, she wrote, "I… am very unhappy about my father's agreement to have it, at his doctor's suggestion….I wish that he had decided against it." (22-23) However, because the discussion about treatment options took place only between her father and his doctor, Caroline was not able to voice her concerns nor to contribute to the process of decision-making. Writing about a similar case, Robert Burt rightly observed that the current ethical framework tends to exclude everyone but the doctor and patient from these conferences. This is ethically indefensible. Further, it can and at times does lead to decisions which are less than wise. Burt proposes as a better alternative that "family participation should be understood as psychologically and morally desirable but not as a legal requirement – as a goal that should be urged though not forced" on patients and their families.[3] Caroline's input may not have changed the final decision about surgery. But when these decisions are serious and the family is close, it is surely wrong to exclude them.

Chaplaincy and Pastoral Care

The Catholic Church recognises that "suffering and illness have always been among the greatest problems that trouble the human spirit." It therefore encourages "ministry to the sick" as "the common responsibility of all Christians,"[4] both within its own healthcare institutions and elsewhere. *The Code of Ethical Standards*, for example, highlights the importance of pastoral care, which it sees as "integral to the healing process."[5]

Caroline's memoir reinforces the great importance of pastoral care. Just over a week into her father's ordeal, Caroline records "a welcome visit from Sr Monica," who is on the pastoral care team of another hospital and who "has come in response to my request for a chaplain." Caroline wrote, "I am very grateful for Sr Monica's visit, after feeling so alone this past week…. Sr Monica promises to visit us again and I could weep with gratitude." (52-53)

Caroline continued to record the faithful - even daily - visits of Sr Monica and of the Anglican chaplain Rev Ross Weaver. A visit by her friend Fr Robert Walsh SJ was a "wonderful surprise" which allowed her to give "the care of my father into the hand of God for the night" and therefore to "sleep soundly for the first time." (64-65) And even while her own faith was eclipsed, Caroline drew great comfort from the prayers of her pastoral visitors. (cf 60, 67) Indeed, fully nine months after her father's death, as she experienced a deep personal crisis of faith, she was still greatly consoled by her memories of the "chaplains who came." (218)

Do we fully grasp the great importance of pastoral care? Do we understand just how much it is integral to the healing process? Caroline's memoir is a cogent reminder.

Grief

Benedict Ashley and Kevin O'Rourke distinguish four dimensions of the human person. There is the biological dimension which is the bodily or physical part of us. There is the psychological dimension which includes our senses, drives and feelings. There is our social or ethical dimension which includes our social relations within society and the free human choices which we make. And there is our spiritual or creative dimension which is about meaning, commitment, creativity and relationship with God.[6]

Using this framework, we may use Caroline's memoir to make two comments about grief. Firstly, we should note that grief affects us at every dimension of our being. Thus, for example, Caroline noted that grief "dislocated me physically, mentally, psychologically and spiritually." (xvi) At the biological level, Caroline at one point reported a severe headache which was a physical manifestation of grief. (242) Other people have had more profound physical manifestations, including tight feelings in the throat and chest, breathlessness, muscular weakness, and even psychosomatic sicknesses. At the psychological level, Caroline reported loss of control over her emotions, and extreme feelings of sadness, distress, anger and lethargy. At the social level, Caroline noted both great difficulty in returning to her "normal routine" and refusing numerous speaking engagements. (147) Again, other people become even more socially isolated. And at the spiritual or creative level, Caroline reported that her "sense of meaning was shaken" (xvi), that the "purpose" of her life had "disappeared with [her] loved ones" (191), and that she experienced a great crisis of faith. Grief truly affects us at every dimension of our being.

Secondly, even though grief does affect us at all levels, it is nonetheless essentially a spiritual phenomenon. This point is made repeatedly throughout the book, but let me offer only a few examples. Carmel Ross suggests that we "miss the mark" when we regard grief "only as a psychological phenomenon." She continues, "[O]ften it is also a spiritual phenomenon... because it tears apart something of our fundamental belief systems about ourselves, others, life and God." (319) In this "spiritual wounding…. we personally are hit at the core…. This journey is one that enables transformation to take place deep within us… [W]e will never be the same person again because what has happened will challenge and change our life views on the big issues of life." (320-321) Thus, Caroline reflects that through her own experience of grief she "has gained a more profound perspective on life, a new depth of spiritual maturity and an altered

image of God." (308) She quotes Joan Chittister, who writes, "[H]ow are we to think of struggle?... It is a function of the spirit. It is an organic part of the adventure of development…. Struggle bores down into the deepest part of the human soul… bringing new life, contravening old truisms." (306) This perspective reminds us that we should not try simply to escape from grief. We should instead allow the experience of grief to transform us.

The Search for Meaning

In her professional life, Caroline Jones has done a great deal to explore and document the human search for meaning and purpose in life. Her own experience offers valuable lessons for this quest:

Her life reveals that both meaningful work and meaningful leisure pursuits are important. For example, when she returns to her work of facilitating twilight retreats, she notes that this "work which is purposeful and congruent with my gifts and experience" is "meaningful and rewarding." (292) Or again, one of Caroline's leisure pursuits is dancing. She reports putting "several months of concentrated preparation" into performing a complicated tango routine, and notes, "I put a lot into it and I was rewarded by feeling alive and happy." (249, 266)

Her life also shows the importance of family and friends in the search for meaning. And she affirms the importance of striving to be open to other people too, including strangers. She notes that helping others "usually helps me to feel better too." (270)

Caroline's life also bears witness to the importance of cultivating both a sense of gratitude and a sense of beauty. She notes that she cultivated the "habit of gratitude" so she was "inclined to notice the positive aspect of a situation rather than the negative." (270) In several places, she also writes about the importance of finding "solace" or "consolation" in beauty (170, 261, 287), and of the need to "try to do [this] more consciously." (170, cf 295)

Finally, Caroline's life indicates the need for a "meaningful response" to suffering (307) In part, this requires "someone who listens… providing a time and space for the wounded psyche to express its suffering and for that pain to be accepted as legitimate." (94, cf 324-327) However, Caroline finds this meaningful response to suffering above all in her Christian faith. She writes, "It was the cross of Christ crucified which first gave me a way to think about suffering, even to make some sense of it ….. with its claim of 'not only death but also new life'…. Since I first glimpsed its meaning… I have been able to discern that sometimes crisis does contain the seeds of opportunity…" (216-217) She notes too "the need for communal rituals to remind us of this and to see us through it…. I am steadied by the reiteration, in the Mass, of the journey on which we are all embarked…. I need to huddle together with others for shelter in the storm…" (238)

Caroline's honest, moving and insightful memoir has much to teach us. We grow both as healthcare professionals and as people through sharing the journey with her.

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