

Doing What Works -

**The Professionals' Guide to Treating Eating Disorders
*The "Nuts and Bolts" of Developing Skills and Techniques
for Specialized Eating Disorder Treatment***

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I have included here the beginning portions of Chapter One through Chapter Seven of the e-book, Doing What Works. I invite you to peruse the material presented and to contact me if you are interested in receiving any, or all, chapters in their entirety. You can reach me at anatenshon@empoweredparents.com with your order. I am also available for case consultation which will custom tailor your learning to meet your own and your client's needs. The fee for each chapter is \$15, to be mailed as a check or money order to Abigail Natenshon, 271 Hazel Ave. Highland Park, IL. 60035.

I believe you will find these materials invaluable in your professional practice. I would love to hear your feedback about this project.

Chapter One: The Meaning and Origins of Eating Disorders

What are eating disorders? More importantly, what are they *about*?

One of the most critical aspects of disease recognition is developing an understanding of how these diseases present, and of what they mean for the afflicted individual. Eating disorder recognition is never simple, as eating disorders are typically not easily apparent; these diseases present in ways that are unique, from one individual to the next. Anorexia is not about eating too little... bulimia and compulsive overeating are hardly about eating too much....

Bulimia Nervosa is an eating disorder marked by out of control eating followed by some form of purging. It typically accompanies a pathological fear of weight gain leading to food restriction, followed by the need to gorge in response to extreme hunger. The excessive caloric intake leads to the perceived need to purge. With bulimia, eating becomes disregulated and feels out of control.

Anorexia Nervosa is a disease marked by the pathological fear of weight gain leading to rapid or extreme weight loss. Victims with anorexia restrict or limit their intake of food, as well as their behaviors in life spheres beyond food and eating. As an example, an anorexic young adult refused to go to her roommate's wedding because the ceremony was to take place at precisely the moment when she would need to be eating dinner. She did not have the flexibility to diverge from her daily schedule; and so her life became severely compromised. Another anorexic woman ate the same limited number of foods every day of her life in the same order and in the same amounts; she felt compelled to wear the same few items of clothing as well.

Binge-eating disorder (BED) or compulsive overeating is the lesser-known eating disorder, following anorexia nervosa and bulimia nervosa. It is characterized by eating when one is not hungry or by continual eating without regard to physiological cues. Binge eaters typically eat to the point of feeling extreme discomfort or even pain. I have

worked with people whose bingeing behaviors are so severe as to be experienced as a form of self-mutilation; one 33 year old patient of mine describes eating so much food at a sitting that her skin hurts from being stretched. The patient will typically report frequent episodes of binge eating, with an inability to stop or to control the behavior. One in five young women today report this experience with food. Forty percent of binge-eating disorders occur in men and boys.

Activity disorders, or exercise disorders, which take the form of exercise compulsions, are a form of eating disorders. For many, formalized exercise becomes a chief source of stress relief and ultimately can camouflage underlying feelings, which are a source of self-knowledge, problem definition, and therefore, problem solution. With the release of endorphins that comes with formalized exercise, disordered individuals can become reliant on brain chemistry changes as a substitute for resolving problems, a dynamic that can be a precursor to addictions and eating disorders.

- You may be surprised to know that there is a purging type of anorexia, and that not all anorexics are emaciated or even thin; in actual fact, many are of normal weight. Anorexics *do* eat; there is commonly held misconception that if people eat at all, they cannot be sick.
- Many bulimics restrict food, as do anorexics. Some do not purge. Most people with bulimia are of normal weight. Bulimic purging may take different forms. Some bulimics purge through spitting masticated food. Others purge through over-exercise, abuse of laxatives, diet pills, diuretics, Ipecac. Most bulimics do not recognize these behaviors as being purge-related.
- For some, an eating disorder may represent a brief and fleeting, relatively benign coping glitch at a critical or troubled time; in other instances, it may represent a

life-long struggle with food, and may be indicative of an Axis II personality disturbance, of childhood abuses, and severe emotional disturbance and pain. Behaviors involved with bulimia may become a form of self-mutilation, like cutting; in these instances, the individual eats to the point where the skin becomes so stretched from overeating as to put the individual in excruciating pain.

- Eating disorders are *not* teenage diseases. Victims can be as young as age 5. It may also come as a surprise to many that increasing numbers of individuals in their late twenties, thirties, forties, and fifties are coming forward for treatment now, having carried unresolved issues of eating disorders into their adult years, perhaps hoping they would grow out of them. These people invariably live productive and typically successful lives; they are professionals, parents, and business people, highly accomplished and talented. Many have wrestled with disease for 20, 25, 30 years, living the “big lie,” fugitives or sorts, in pain and in hiding from friends, families, husbands, children.
- Eating disorders become the “third wheel” in marriages, the triangulating third party in the marital system. Whether conscious or subconscious, the partner invariably prefers his or her partner thin, feels comfortable “looking the other way,” or is equally as perfectionist and compulsive in lifestyle. People find each other for a reason. As a result, with recovery from these disorders, marital systems change and partnerships may be in danger of splitting up unless both parties undergo treatment and change simultaneously.

In short, anorexia, bulimia and compulsive overeating are the misuse of food to resolve emotional problems.

For those with eating disorders the extremism and the deregulation in eating behaviors and appetite spill over into other life spheres, beyond food. These diseases denote an entire personality organized around a dysfunctional set of attitudes and values, around

self-hate, ineffectual problem-solving, poor coping mechanisms, denial and fear, compulsivity and the need to be in control.

Myths and Misconceptions about eating disorders

The following are some examples of myths and misconceptions surrounding disease and treatment:

- *Eating disorders are incurable.
- *Eating disorders are about food and weight loss.
- *Anorexics are always thin and do not eat.
- *Fat-free eating is healthy eating.
- *Dieting is the best way to lose weight.
- *Eating disorders are caused by dysfunctional parenting, by the child's low self-esteem, by a bid for attention, or by the media or peer pressure.
- *Children don't want their eating disorder "secret" to be discovered.
- *Parents must not infringe on their child's privacy and independence by becoming involved in treatment and recovery.
- *An intervening parent is, by definition, an interfering parent.
- *Parents should never discuss food with their disordered child.
- *Therapists breach the child's confidentiality by talking with parents.

The most debilitating myth of all is that once children become adolescents, they no longer need their parents who are left no alternative but to step out of their children's lives. Eating disorders signify that there are important emotional and developmental tasks yet to be achieved, coping and problem-solving skills yet to be attained. This is

hardly the time for parents to bow out of the picture!

Statistics:

1. There are 11 million sufferers in the US today, 87% are under the age of twenty.
2. There are increasing numbers of men and boys with eating disorders today, though 10 times as many young women are afflicted. In the past decade, the number of males with eating disorders has doubled.
3. The most lethal of all the mental health diseases, 6 to 13 percent die or are maimed from eating disorders. What is more, people don't have to look emaciated to die. It is not atypical for bulimics with a normal appearance to develop electrolyte imbalances that can result in heart failure. These are the kids who go to bed one night feeling fine and just don't wake up in the morning.

One of the families who appeared on the Oprah Show with me had a teenage daughter who had been treated effectively for bulimia for years. Her family was apprised, activist, and supportive. She was an intelligent and responsible young woman who had gone through treatment programs, had participated willingly in outpatient treatment, and had experienced substantive recovery progress. This youngster went to sleep one night and never woke up again.

In another instance, a young woman who was a scholarship student at a prominent California university fell into a bulimic coma for three weeks from which she emerged with permanent and global brain damage. Never able to return to school again, this young woman was to spend the rest of her life in a facility for people with brain dysfunction.

4. Eating disorders are curable, in as many as 90% of cases where detected early and treated effectively. The eating disordered recovered will have learned more than how to eat healthfully; through treatment and recovery, they will have learned what it takes to face adversity and the self as effective problem solvers. Eating disorder recovery can be seen as an insurance policy for success in adult life. Invariably, recovered individuals say they have their life back, their personality

back... Parents invariably proclaim that they have their child back. The practitioner who treats eating disorders needs to keep this bigger picture in mind.

Early Warning Signs of Eating Disorders

Your patient may:

- Be preoccupied with the fear of becoming fat, or may “feel fat” even though she is not.
- Lose weight rapidly.
- Display idiosyncratic eating habits, such as limiting food choices, cutting food into small pieces, moving food around plate, chewing and spitting out food.
- Restrict food through dieting, skipping meals, becoming vegetarian.
- Display signs of anxiety such as compulsions, perfectionism, over-achieving
- Display signs of depression such as social withdrawal, irritability, and difficulty concentrating.
- Display low self-esteem, seeking approval, and concerned about her physical appearance
- Feel dizzy, faint, fatigued, or constantly cold
- Need to feel in control of all aspects of life, even beyond food and weight management
- Exercise compulsively
- Spend excessive amounts of time in the bathroom.
- Lose her menstrual period.

How do eating disorders develop?

Clinical eating disorders are, relatively speaking, rare, involving 5% of adolescents; *the attitudes and values that lead to them, however, are rampant, putting lots of kids at risk*. But that’s the good news, because *it is far easier to change disruptive attitudes than to dislodge ingrained habits and behaviors*. Consider this fact to be the parent’s and the professional’s call to action.

Eating disorder onset is a *process* that happens over time, gradually; a person doesn’t wake up one day with an eating disorder, as they would with a strep throat. Happily, this

offers fair warning to those who know enough to read the signals. Eating disorders develop along a continuum over time, emotional development and life experience.

5. Eating disorder etiology is a kind of “cocktail” that consists of dysfunctional *attitudes* about weight and eating that coincide with stressful *life transitions* (entrance into high school or college, parental divorce, reaching puberty at an early age); in response,) children may turn to *disordered eating and dieting behaviors* to give them a sense of well-being or self control. When these circumstances occur in the company of *genetic propensities* towards disease, (through temperament and/or hereditary addictions) dysfunctional eating patterns may eventually lead to clinical eating disorders.

Chapter One to be continued.....

Chapter Two: Recognizing Disease

Prerequisite to the treatment of eating disorders is recognizing their existence. **Disease recognition** is fraught with challenges.

- Eating disorders are secretive diseases. As professionals, as doctors, therapists, nutritionists and educators, in looking for the possibility of an eating disorder, we are attempting to see what is not apparent;
- Eating disorders are guarded and coveted by the individual who aspires to thinness, who finds through his/her tenacious grasp on the disease, a sense of power and control, of acceptance by peers, and appreciation by parents. Children with eating disorders rarely consider the syndrome to be a disease, and are not willing to risk having anyone take away from them what they consider to be their ticket to strength, beauty, popularity and self-esteem. In some cases, parents who want their child to be thin, and who see that happiness and popularity are a function of physical appearance, view their eating disordered child's behavior as a sign of self-discipline and will power, and to be enviable and inspirational.

Signs to look for

Keeping in mind that eating disorders are diseases that are firmly rooted in both emotions and behaviors, look for signs in either or both spheres.

Behaviorally, you may see:

1. Weight change
2. Food quirks, such as eating a limited number of foods, in a specific order, at a specific time of day; vegetarianism may be a significant red flag, as is carrying one's own food to social events, or cutting food into tiny pieces, pushing it around the plate and picking at it rather than eating.
3. Compulsive behaviors in other spheres of life aside from eating.

4. Perfectionism and extremes in behaviors in other spheres of life.
5. Bathroom behaviors, such as purging during and after meals, vomiting in the shower, etc.

Emotionally, you might see:

6. Emotional inflexibility
7. Depression
8. Anxiety
9. Irritability
10. Social withdrawal
11. Difficulty concentrating and learning
12. “Feels” fat, even when thin

Professional’s, Beware! Disease recognition is a pivotal task for health professionals who are in a premier position to respond and help. Don’t expect this problem to be neatly or voluntarily presented to you by your patient in your initial assessment, or even beyond. I suggest that you consider reframing within and for yourself what an eating disorder indicates about its host. Though self-destructive in nature, these diseases can be seen as a sign of the patient’s will to survive and determination to so with “life quality.” It takes great sacrifice and tenacity, self-discipline and intention, fear and anxiety to motivate these behaviors. That she will shield and protect the eating disorder and foster its continued existence can be seen as a sign of her will to live, to succeed, and to sustain herself in the best way that she can with the resources that are currently available to her. It is no wonder that she is ambivalent or resistant about confiding in you about its existence.

- These diseases are often not detected in the psychiatrist’s or psychotherapist’s office.

One of my patients began to work with me after spending seven years with a psychiatrist. She admitted to me that she purposefully chose not to tell her psychiatrist about her bulimia for fear he'd be "grossed out" and wouldn't want to work with her anymore, an attitude reflective of her tremendous shame. By the time she came to see me, this woman was purging up to 30 times a day.

- Eating disorders are typically not detected in the pediatrician or internist's office, either. Eating disorders are hard to see, and physicians cannot rely on the patient to initiate discussion of them. Eating disorders will not show up in lab tests, (blood and urine) either, until the latter-most stages of disease.
- There may be times when these diseases *do* present themselves and the doctor may be looking the other way or may be unable to decipher the clues being offered.

Consider the pediatrician treating a bulimic adolescent who prescribed diuretics in answer to the child's concern about avoiding "bloat during her period."

Consider the misinformed words of another doctor who told an excessive exerciser who had lost her period not to be concerned, as it is "not unusual for youngsters to have irregular periods till they are 21 years old." This statement is not true, but most unfortunately, by not responding to a blatant sign of disease, and by not following the lead presented by the patient, this doctor forfeited an ideal opportunity to make a life saving diagnosis.

- In some instances, symptoms can literally *scream out* at professionals who choose not to notice and recognize them.

At a local hospital, an anorexic young woman was admitted to a general psychiatry unit for depression. Deeply concerned about her severely restrictive

eating, her mother spoke to the head of the unit about her concern that her daughter was not eating any protein. This physician's response was, "Don't let that worry you. We'd all do better to eat less protein."

Might this doctor have had some personal issues of her own regarding food, blinding her to obvious call for help? Might she not have understood eating disorders and how they present? I think so. *What is unfortunate is that this doctor was unaware of what she did not know.*

- ***In some instances, problems may not be screaming out, but gently tugging at your sleeve.*** Practitioners may do well to actively "play detective" getting a feel for a patient's personality structure, insinuating the likelihood of an eating disorder presence, and then actively investigating the possibility of its existence. Practitioners may need to "read between the lines," to look and to see, through understanding and instinct, if not through their eyes and ears.

Emilia, a well put-together, highly functioning adult in her late twenties, came to me for treatment for depression. She described her past life at college, where she was overly controlled and controlling, obsessive, perfectionistic, and afraid to confront problems.

"You know," I said, "in listening to you, I wonder if you might have had eating issues when you were in college." Her response was immediate, shocked and grateful. "How did you know!?" she asked. "I never talk about those times." The next question out of my mouth could then be, "Do you ever revisit these behaviors now? May this become part of your goals for your treatment here?"

Remember that excessive exercise regimes may be an indicator of compulsivity, body image concerns and eating disorders. Activity disorders are a form of eating disorders. When activity and exercise becomes compulsive, when the exerciser has little choice but to engage in this activity at the risk of otherwise experiencing profound anxiety, if exercise takes on a life of its own, whether or not it feels good or

does good for the exerciser, we are perceiving an activity disorder. Gymnasts, dancers and equestrians are much more prone to developing eating disorders than is the population at large. Ballet dancers are reported to be six times more likely to develop and eating disorder than non-dancers.

Keep in mind that eating disorders are behavioral problems that originate in emotions; at the same time, they are emotional problems that reside in a behaviors. The two cannot be separated. Where there is one, the other cannot be too far afield.

Don't be misled by the notion that an eating disorder will disappear on its own once a victim has dealt with the underlying emotional issues driving the disease. This is not the case. Eating disorder symptoms take on a life of their own in the manner of addictions. All aspects of these integrative diseases must be recognized, addressed and resolved at once for treatment to be effective.

Remember not to overlook the possibility that eating disorders may appear in your male patients as well. Men will have a greater tendency to binge and purge, which is more socially acceptable for males than to starve themselves of have their salad dressing "on the side." Males typically use steroids and excessive exercise to develop larger bodies, rather than smaller ones, as woman attempt to achieve.

- **Remember that weight is NOT the standard for diagnosis.** Don't get hung up in this misconception! Thinness is not equivalent to having anorexia. Anorexia is not equivalent to being thin. Restoration of weight does not necessarily mark recovery, nor does starting to eat again, though these behaviors are prerequisite for recovery to occur. Weight gain can indicate the start of recovery when in conjunction with changing behaviors, thinking, and emotional versatility. Also keep in mind that it is a requirement for the malnourished body to be re-fed before it can fully benefit from psychotherapy.

Eating disorders are not solely about food or weight. They reside in every aspect of a personality and in the quality of emotional function. They are indicators of underlying problems that will need to be defined and resolved. In addition, they create problems in their own right simply by existing.

Chapter Two to be continued.....

Chapter Three

A Word about Parents in the Treatment of Childhood Eating Disorders

Though ideally positioned to prevent problems and intercede, when it comes to eating disorders, it is safe to assume that in many cases, parents are often the last to know that their child is struggling. By virtue of living alongside their sick child, despite their comfort level or personal preference, parents have little choice but to become meaningfully involved. The question is, what will be the *quality* of that participation?

The answer lies in the guidance they receive about effective intervention from health professionals. Parent and child both seek the same end...to see the child happy, healthy and fulfilled. Parents need to determine how best to support the child towards this common goal. It is for the child's therapist to offer parents the opportunity make their involvement constructive, effecting change positively and facilitating the intrinsically difficult task of recovery. Offering support that feels welcome and enriching is a continuously changing and challenging process as children make their way throughout the various stages of recovery.

Parents need to be present in their child's life.

- Parents are in the best position to become diagnosticians. Eating disorders are diseases that appear around the kitchen table or in the family bathroom more often than they do in the doctors' or therapist's office. Lab tests show nothing of eating disorders until their lattermost stages. It is parents who observe their child being the last to show up at the dinner table, and the first to leave. It is parents who watch as the child pushes food around the plate or picks at it, rather than eating it. It is parents who are on the front lines when it comes to experiencing the child's depression and irritability, particularly around mealtime. They experience their child avoiding celebrations and withdrawing from family gatherings, and finding a myriad of good excuses for missing meals (they ate with their friends, they will eat later, they are not hungry now, they had a big lunch.) Lastly, it is parents who

find the remnants of vomit on the sink, the tub, and the toilet and observe rapid weight fluctuations in their child in many instances.

- The recovery process too, happens at home, under parents' noses, particularly in this day of managed care, where limited insurance coverage translates to a limited number of treatment sessions with health professionals. Hospital inpatient programs have become almost non-existent. A psychotherapy session lasts for 45 minutes a week; the child spends the bulk of their remaining recovery time at home. It is for parents to get with the program. Like it or not, parents are implicated and involved by virtue of physical proximity, if not emotional connection. It is the *quality* of that emotional connection that can contribute significantly to the nature and rate of the child's recovery.

It is an ironic turn of events that in a majority of cases, there is an inverse correlation between the importance of the role that parents play, and the parent's lack of entitlement and confidence in fulfilling that role.

The Parents' dilemma

In all too many cases, parents.....

- Are afraid to intervene with their child for fear of being intrusive and overly controlling.
- Believe they are the cause of their child's problem and that by becoming involved, they would only make matters worse.
- Are reluctant to interfere with the child's privacy and budding independence.
- Are afraid to incur their child's wrath, causing possible rejection.
- Mistakenly believe that what their child eats is none of their business. The opposite is true. The malnourished child with a malnourished brain is incapable of accurate self-perception, sound judgment and self-care. This child needs her parents now more than ever.

- Harbor their own personal issues around food and eating.
 - Sheila is a 43-year-old mother of five, who admitted that her life is spent thinking about food and her inability to feel safe around it. She came to treatment as a result of her teenage daughter first beginning to experiment with symptoms of anorexia. Sheila “respects” her child’s “control” over food, particularly because she doesn’t feel she has that control herself. To this mother, it does not seem right to offer guidance to her child about healthy eating when she is so confused about what it is herself; because thoughts and words about food and eating come from “a part of her that is sick and obsessive,” by offering her child guidance from that place within herself, she fears she will be inflicting her own problems. In addition, she is concerned that her own painful secrets will emerge and her secret life will be uncovered.

Complicating matters for parents are **common misconceptions among therapists and health professionals** that seriously hamper the child’s and parents healing. Health practitioners treating eating disorders too frequently *mistakenly* believe that:

- Overly controlling parents *do* cause eating disorders as so the goal for treatment is to perform a “parentectomy.”
- Teenagers best achieve separation and individuation from their parents through “geographical” separation if you will, by creating artificial barriers. In actual fact, there is no better way to help a child separate from parents than to encourage healthy bonding through communication.
- Ethical and professional practice in the treatment of the individual child should *exclude* parents from the child’s psychotherapy. The belief here is that the child in therapy deserves privacy. And of course this is true. As a psychotherapist, I too, am a fierce protector of the patient’s rights; confidentiality issues are real and legitimate. I believe however, that confidentiality breaches, boundary crossing and manipulations can be avoided unconditionally when families can be brought together to communicate their concerns in the *family therapy milieu*. **Privacy and**

confidentiality issues all become non-issues when brought above board, when all relevant parties hear the same things at the same time and are offered the opportunity to respond. Family sessions may be diagnostic, on-going or ad hoc; in all instances, they are healing for everyone involved.

Research that has come out of the Maudsley Hospital in London, England has proven that family therapy in fact offers the *greatest* opportunity for successful recovery with children living at home who have suffered from anorexia for three years or less.

I believe that parents must remain advocates for their children, not in the sense of taking control over their child's life, *but by taking charge* in those instances where the child has lost the capacity to care for herself, and only until such time as the child is capable of resuming responsible self-care. This means that the strongest and most substantive presence for the parent needs to be at the start of treatment, until such time as the child has become personally engaged and invested in the treatment and recovery processes. Whereas support may take the form of providing and sharing meals and in some instances monitoring whether they get eaten, at another time in the child's treatment it may be seen in the parent allowing the child to independently determine her food choices and to simply trust that the child's relationship with food has become fully responsible.

One mother, early in her daughter's treatment for anorexia, left her work every day at lunchtime to go to her daughter's school and eat lunch together with her in the cafeteria. The external structure she provided was necessary to reinforce the child's lack of internal regulation at this point early on in the girl's treatment. As the child progressed in her treatment, her mother's advocacy changed in nature; she would show her support by simply having nutritiously dense lunch foods in the house for her daughter to use in making her own lunches, by trusting that her daughter would prepare a healthful lunch for herself, that she would remember to bring it to school, and that once there, she would take responsibility to eat it, consistently and fully. The "proof of the pudding, here, would be in the eating" ...in other words, the only external monitoring required at this

point would occur when the child stepped onto the scale periodically, either in her doctor's or nutritionist's office. The number would need to indicate that the weight was either stable or in a direction towards weight gain, not loss.

Chapter Three to be continued.....

Chapter Four

The Challenges of Effective Intervention

What to do first

First and foremost, the patient with an eating disorder needs to be evaluated by a medical doctor, to first rule out organic problems that may be the cause of the appetite or weight loss. It is unfortunate that in all too many cases where life-threatening medical problems have been overlooked and diagnoses missed, lives have been lost.

The earlier the intervention with the eating disordered individual, the more potent is the likelihood of a successful outcome. Intervention can take place at any place along a continuum of disease development and cure. The earliest and most effective intervention, called primary prevention, occurs within the context of the family. This type of intervention takes the form of parents providing and serving nutritious meals for the family, and role modeling for their child:

- A healthy eating lifestyle,
- A healthy exercise lifestyle
- Healthy attitudes about the body,
- The capacity to face feelings and resolve problems effectively.

The next level of intervention, known as *secondary prevention*, involves recognizing an eating disorder in its beginning stages and attempting to nip the disease in the bud by confronting the individual and the problem, and attending to them both in an effective manner. This task falls largely to parents, but at times, to the medical doctor, educators, youth leaders or health practitioners...to whatever person is in the position of noticing a problem that has yet to be diagnosed.

Providing treatment for a clinical eating disorder is called *tertiary prevention*. By intervening with treatment at any point in the disease process, the prevention that occurs involves minimizing the deleterious effects of disease and preventing death.

Psychotherapy for eating disorders addresses the dysfunctional eating behaviors as well as the emotional issues that underlie and drive those behaviors. Eating disorder therapy needs to be cognitive and behavioral in its bent, with a here and now “process” orientation and with a mind for the effects of the family system on the afflicted individual and on the effects of disease on the family system. Psychotherapy needs to be performed in the context of a deeply trusting and dynamic psychotherapeutic relationship.

As professionals, I urge you to use my book, [When Your Child Has an Eating Disorder: A Step-by-Step Workbook for Parents and Other Caregivers](#) creatively for your own purposes, as well as for your patients’. I invite you to use the workbook exercises with groups, with families, or individual patients, adapting their contents for weekly tasks or assignments that will provide incentives for parent/child interaction, self-awareness, self-acceptance, and the discovery and acknowledgment of personal issues.

In addition, www.empoweredparents.com and www.empoweredkidz.com are an important source of visitors’ information and initial consultation free of charge.

- www.empoweredparents.com offers upwards of 100 informative articles and mini-articles on the subject of eating disorders, body image concerns, and related topics.
- www.empoweredkidz.com is a wholesome alternative to the pro-anorexic sites that continue to proliferate across the web. This site contains 30 articles answering kids’ questions about healthy eating, healthy weight management, eating disorders and body image concerns. Here is a place where kids can ask for the help they need, even when they might feel too afraid or too embarrassed to seek guidance elsewhere.

Eating disorders create unique challenges for professional intervention;

1. There is nothing indirect or passive about any aspect of eating disorder intervention. It requires the therapist's *active use of self*, not just for diagnosis, but for treatment, and for the support of the eating disordered individual and his or her family through a most challenging recovery process.
2. In most instances, health practitioners will *recognize* a disease first, and then intervene. ***With eating disorders, some form of proactive intervention or use of self may be a prerequisite to recognizing or defining the problem at hand.***
3. Diagnostic intervention with eating disorders is about more than defining a problem. It is about bringing the individual to her *own* problem awareness and recognition, acceptance, and assistance. People with eating disorders are typically loath to admitting to themselves that they have a disease. In some instances, they feel and look better than ever, empowered and appreciated for their show of self-discipline and will power. In other instances they fear admitting to an eating disorder, under the misconception that an eating disorder "is forever"...that there is no cure, or that an eating disorder indicates mental illness or insanity.
4. Diagnosis with eating disorders is not a one-time process, but an on-going dynamic that takes place throughout the therapy process. Some element of diagnostic thinking and assessment needs to be part of the content of every therapy session. Through astute diagnostic listening, patients need to be assessed continually for changes made that represent progress towards recovery, as well as for the appropriateness of possible referral to alternative milieus such as hospital day programs or residential placement.
5. Even the act of therapeutic *listening* needs to be proactive. ***Active listening*** is listening in a way that allows the patient to know herself better. It is accomplished by responding to the patient's "feeling messages" that *underlie the content* of the communication.

In using an example that was cited in a previous chapter, the child who approaches a table full of dessert snacks at a youth group function, eyes a plate of donuts and remarks, “Nobody eats donuts.” Here is a comment that might deserve deeper, “diagnostic” listening on the part of the youth group leader, peers, or of anyone in earshot. This remark represents a clear statement about the child, her attitudes and her thinking...it is hardly about the food of which she speaks. In an effort to use this opportunity *to educate the child*, (and not judge or control her), the listener would do well to investigate further, having the youngster expand on the statement. “Tell me about what you mean...”

Going further with the questioning, the questioner might help the youngster to recognize where this notion comes from, if it represents a fear that she has about eating certain types of food, if she entertains worries about her weight, if she seeks to lose weight, and if so, how she might be setting about to do so, etc.

6. Whether the person intervening is a family member or health professional, one’s own **personal issues** around food, eating, weight, body image and the emotions underlying these subjects have implications not only for what that person sees, but also for if and how he or she may choose to respond. For the person who may be reluctant to engage in conflict or confrontation, the act of approaching a person who exhibits resistance to acknowledging an eating disorder can be stressful. The realities of these diseases and of the anger (resistance) that may surface in response to addressing them could possibly extinguish a person’s impulse or motivation to investigate further. It takes courage to persist in such an effort responsibly and effectively, in tune with the requirements and opportunities of the moment.

In considering the challenges of intervention, perhaps the most difficult of them all is separating out what, in our society, what is normal and what constitutes “pathology” when it comes to eating. There is a thin line between benign “quirky” eating, disordered eating, and the habits that

constitute a clinical eating disorder. With 40 to 50 percent of young women on college campuses today being disordered eaters, normal eating is no longer one and the same as healthy eating.

Chapter Four, To be continued.....

Chapter Five

The Unique Role of the Health Professional in Treating Eating Disorders

Eating disorder psychotherapy, counseling and medical modeling require a special use of the professional's self, special skill sets, and specialized knowledge.

1. The first challenge is that of recognizing disease, a topic that has been discussed at length in article #2 of this series. Recognition requires knowledge, the capacity to approximate and anticipate, commitment to the process in terms of taking initiative, and proactive intervention.
 - In seeking to identify an eating disorder, it is important to become aware of *how much evidence you need in order to know that an eating disorder exists*, or that it is in the process of forming. The most astute and effective practitioner is the one who has the clearest vision of the *potential* for disease onset, having the least amount of information to go by.

2. The second greatest challenge is that of *professional intervention*. As described in depth in Chapter Four, one of the more unique elements associated with eating disorder intervention includes:

The professional's use of self - *The use of self with eating disorder treatment becomes uniquely challenging* because the treating professional is required to deal with his or her *own* emotionally charged *personal issues* around food, eating, weight management and body image. The patient's issues could trigger a response in the unsuspecting professional that could hamper the quality of the treatment offered. Unless fully aware, cognizant and mindful of one's own poignant issues and concerns in these spheres, the professional is at risk succumb to an obstructed vision of the patient, the problem and his or her own role in managing these. Professionals are people, first, with all of humanity's foibles and

vulnerabilities. Professionals need not be immune to having problems of their own; nor should they presume to have all of the answers. What they do need to be is self-aware and versatile within themselves and in their responsiveness. The following are real life examples of professionals bringing personal issues to their work in a non-productive way.

- A patient worked with a therapist for over a year, yet chose not to discuss her bingeing/purging behaviors with her. When asked why, the patient explained that the therapist became weepy, “tearing up,” whenever she spoke of her struggle with food.
 - Another patient recovering from anorexia was struggling with the compulsion to over-exercise. Her concerned parents asked this young woman to discuss this problem with her therapist. Somewhat co-dependent herself and fearful of riling her patient, the therapist’s need to appease and reassure took the place of attending to the unresolved issues at hand. She gave the patient the official go-ahead to continue exercising. Being unable to set limits and provide the necessary reality testing for her patient, this therapist missed a golden opportunity to help this patient grow and heal. How much more productive the dialogue could have been with “Tell me what you are doing, how is it different from before? What makes you think, or fear, that it might be excessive? Have you tried to alter these behaviors? What worked? What didn’t work? What else might you try? How difficult is it for you to discuss this problem?”
3. A second major challenge for the professional is *the unique requirement for the therapist to seek out and collaborate with professionals in other disciplines in the context of the treatment team* - this team would hopefully be inclusive of parents and family. Typical objections of patients and parents to the idea of using the team approach to facilitate treatment are the prohibitive costs involved in working with multiple practitioners. Ironically, the efficacy

of this collaboration makes it the most economically feasible alternative in the long run.

- Successful collaboration requires a team-based congruence of skill sets, of treatment philosophy, and of the “family system” bias. Inpatient clinics provide the most viable and workable milieu for professionals who operate under the same roof, as well as an efficacious source of support for patients. Outpatient treatment networks can be just as effective, however, when composed of competent collaborative professionals with like treatment philosophies, depth of treatment experience, and commitment to the healing process. Professionals sharing cases need to collaborate on a regular basis in order to guarantee an enhanced experience for the patient and for himself or herself.
- Professional treatment teams create the inevitable challenge for professionals of dealing with a random mix of personalities, with differences in treatment philosophies, and with the potential power plays that tend to occur among and between professional individuals with different treatment styles and approaches.
- Professionals should anticipate an overlap of function between the various disciplines, though taking heed when there might be excessiveness in this regard.

Take for example the medical doctor who might attempt to micro-manage the therapist’s work, or the nutritionist whose focus might be too heavily weighted towards discussing the emotional aspects of food and eating to the exclusion of discussion about a food plan and the client’s adherence to it.

- The wide range of professionals involved with eating disorder intervention requires a deep commitment on the part of each practitioner to the process, to the client, to the details of the case and to a successful outcome. These tasks require availability for unpaid cumulative time spent in conversation on the telephone, with parents of youngsters living at home, with out-of-town parents whose child is living away at school, with other collaborating professionals, etc. Team members need to communicate frequently and conscientiously with each other about patients they share, be it over lunch, on the phone, via fax, or email.

One of the most important criteria for me in choosing to work together with a medical doctor on the treatment team is whether that doctor cares enough about the patient and the treatment process to call me to inquire about the patient's treatment progress prior to seeing the youngster, particularly if the visits are spaced far apart (every couple of months or so.)

4. The *unique nature of the disease* provides its own set of special challenges for the eating disorder professional.
 - Eating disorders are *integrative* diseases that require the professional's integration of knowledge about various aspects of the eating disordered individual's persona, psyche and physiology. The helping professional, no matter what specific aspect of the disease he or she addresses, will affect the entire disease system and the entire individual. There must be therapeutic attention paid to the gestalt... to the body, the psyche, the emotions, and the social and cognitive functions. This attention needs to be on-going and simultaneous.
 - Eating disorders, because of their nature, impair the emotional faculties that would ordinarily allow a person to heal. The malnourished brain has little or no access to feelings, accurate cognition and self-perceptions.

Problem solving, and most of all, the will or desire to recover, is impaired. The eating disordered individual's brain is further disabled by depression, anxiety, and a sense of hopelessness. Initially, the patient will be required to *approximate* healthful behaviors and responses, and eventually *to grow into them* through “leaps of faith” initiated, motivated, and guided by the strength of the therapist/patient connection.

Chapter Five to be continued.....

Chapter Six

Important Tips on Dealing with Parents and Families Of Children in Treatment for Eating Disorders Case Studies

1. Teach parents to become reality testers for their child.

A father explains, *“We are feeling very encouraged. K. has put on 4 pounds in the past 6 weeks. All she needs now is about 3 more pounds and she’ll be in the normal range.”*

He had ceased to be concerned about his anorexic daughter because she had eaten enough to gain what he considered to be a substantive amount of weight. Being in a normal weight range, however, does mean that an anorexic individual has become normal, or is no longer sick. K is a severely anorexic 18 year old who had been reluctant to let go of her disease. As she begins treatment, she considers it her “legal right” not to allow her parents to participate in her initial diagnostic sessions, though she left it to them to contact me to request bi-weekly, rather than weekly sessions, “in the interest of saving time” for her studies. For K, studying was a habit as compulsive as her restrictive eating behaviors.

K. had gained this weight through further compulsive requirements of herself fostered by the fear of having to leave school, not out of a relaxation of her fear of gaining weight. Furthermore, these parents needed to be more cautious than optimistic in light of the girls’ reluctance to engage in the emotional aspects of eating disorder treatment. It was for them to remind K that what she has been able to accomplish to date is invaluable and commendable, that it will keep her body healthy while she recovers from the emotional aspects of her disease. Having made a great beginning in her recovery, she has accomplished a small sliver of an “upload” on the continuum line of eating disorder recover. Parents and child both need to be brought up to speed on the reality of the situation, to be disabused of the myths and misconceptions of so many of the principles of eating disorder recovery.

It is critical for parents to remain reality testers for their children, even for those children who are hostile or reticent or ambivalent about embarking on the recovery process. In so doing, parents

need coaching. There is no better coach for the parents than the therapist who is working with the child.

About weight in eating disorder recovery

In coaching these parents, I made it clear that there is no such thing as a weight that would liberate their daughter from the grips of her disease. Weight is simply not an issue when it comes to measuring recovery from anorexia. A person can be underweight and anorexic, normal weight and anorexic or overweight and anorexic. The rapid loss of weight for anorexics indicates that behaviors around eating are erratic and potentially dangerous. The *process* and dynamic around eating, which ultimately affects a person's weight, is what is significant; the introduction of healthy eating can stave off what might otherwise have become dire health problems for the anorexic individual. Eating, for the starving individual can preserve both life and life quality, can protect the brain's capacity to learn and the body's capacity to grow and mature.

Weight restoration marks a person's ability to benefit most effectively from the therapy process. Weight restoration indicates that bone density will be maintained and the danger of dying is minimized. Recovery from an eating disorder lies in the person's thinking, way of life, freedom to eat without fear and guilt, capacity to live life fully and richly, solve problems effectively, make choices freely and moderate oneself. A body is not adequately fed and weight is not adequately restored until the female body has stored enough fat to sustain enough estrogen to support a monthly menstrual period, ultimately allowing the individual to bear children.

2. Teach parents to become limit setters, to create the “bottom line.”

Parent: *“She isn't anorexic, of that I am sure. She eats. You know? She'll take an apple to school and will pick at dinner.”*

E. is a quirky, picky eater. A junior in high school, she has recently lost 20 pounds and is painfully thin. Her mother and sister both had been obese eight months before and had lost weight on a Slim fast diet. Unclear about a healthy approach to food herself, she wanted to know where to set limits for her daughter, where to express the concerns she felt, to say “Eat,” when her

daughter was unable to feed herself...especially when her daughter does eat some things and is not “totally starving.” “Sometimes, to get her to eat, I’ll say, “Do it for me.””

The bottom line is what all people need to do to stay healthy. The human body must be fed and fueled in order to keep it alive and functioning. It needs to be fed nutritious food, on a regular basis in the form of meals. Meals should be varied and balanced and contain all of the food groups. Eating healthfully indicates that the person living inside that body cares enough about herself to stay alive and well and to be comfortable. How a person eats is an indicator of self-esteem and self-preservation.

It is essential that parents are mindful of bare minimum self-care behaviors, and that they should expect and demand these behaviors from their child. Needless to say, parents need to role model healthy care taking of the self, making healthy eating a priority and demonstrating wise decisions about food and eating. When these signs are not apparent in the child, it is up to the parent to take charge, to expect and require food intake for their child’s sustenance just as they would require insulin intake if their child were diabetic.

Rules for self-care:

1. The body is a machine that needs to be fueled in order to run properly and to keep it from breaking down. People need to eat three meals a day with snacks in between as optional. People get hungry and need sustenance approximately 6 times a day.
2. People need to get a goodly number of hours of sleep every night in order for the brain to be alert and to function optimally.
3. People need to tend to their daily hygiene, bathing, brushing teeth twice a day.
4. People need to attend to the tasks that sustain them in the world; for parents, that means work and the financial support of the family. The work of the child is learning and education.

How to handle the rebuttal, “*But you skip breakfast too?*”

It is important for parents to look seriously at their own issues with food, which will surely create the backdrop for their capacity to observe problems in their child and to respond to them appropriately. Parents, though not the cause of their child’s eating disorder, have a great deal to

do with the child's developing healthy or unhealthy attitudes about food and eating; unhealthy attitudes about food can ultimately translate into increasing the risk of a child developing an eating disorder. For their child's sake, but mainly for their own sake, parents too, need to recognize their issues about food and eating and confront them squarely and honestly. The parent who does not practice what he or she preaches is at a disadvantage in terms of legitimacy in asking the child to care for herself.

Parents need to learn eat breakfast as much as their child does. The benefits of sitting down at the breakfast table together to chat and share thoughts and concerns before everyone leaves for their day of school or work are immeasurable. This is a life lesson for the child that will benefit the parent equally.

Chapter Six to be continued.....

Chapter Seven The Professional Team: Who Does What

To be posted.....