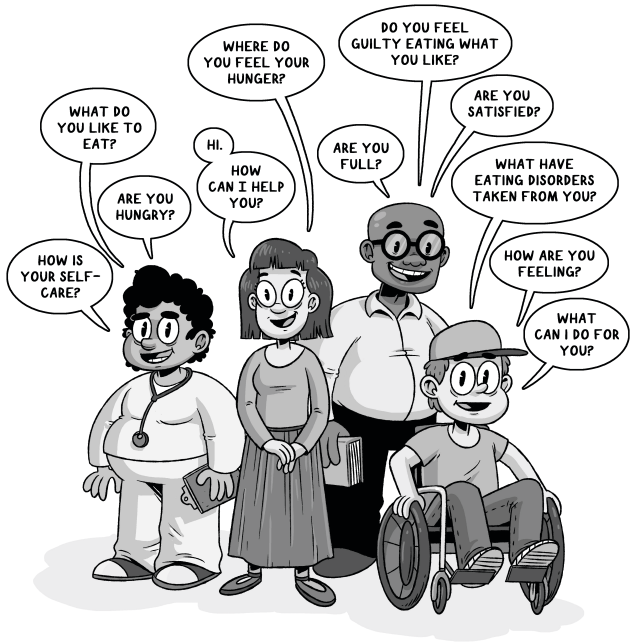
CHAPTER 2

CAN WE TALK? MAXIMIZING YOUR TIME WITH THOSE STRUGGLING WITH AN EATING DISORDER



We need to talk.

It is not you, it is us. All of us.

In the first chapter of this book, I offered a general overview of eating disorders, as well as the supporting statistics to demonstrate how serious and prevalent these diseases are within our society.

Eating disorders are not rare. I truly believe anyone would benefit from gaining a working knowledge of eating disorders. The reality is, if you do not run into people with eating disorders in your career, you

likely will in your personal life. Eating disorders impact about twenty million cisgender women and ten million cisgender men in the United States alone.[1] A survey of approximately three hundred thousand college students found that transgender college students had over four times greater risk of being diagnosed with anorexia nervosa or bulimia nervosa, and two times greater risk of eating disorder symptoms such as purging compared to their cisgender female peers.[2, 3] Regardless of age, gender, race, and sexual orientation, your child, your family member, your colleague, your boss, your neighbor, and your friend could all be affected and at risk.

Therefore, I urge all of you to familiarize yourself with the symptoms of eating disorders, and educate yourselves, so that you will be able to help people in need. In writing this chapter, I had in mind the primary professionals who usually come across this patient population—physicians, dietitians, and therapists. However, this information is also invaluable for dentists, physical therapists, personal trainers, coaches, educators, school counselors, religious leaders, family members, and friends. What category do you fall under? And how can you help? Contemplating the following questions is a great place to start.

How Much Time Do I Spend with People?

If you are a teacher, school principal, coach, or school nurse, think about how much time you spend with the students each day. It is likely that you spend more time with your students than you do with your own family members. For about eight hours a day and five days a week, you witness their mealtimes, social interactions, mood, and appearance. This probably makes you privy to more information than the parents, who may just see them for a few hours in the evening and on weekends. This puts you in a great position to notice any concerning signs or covert calls for help.

The same situation can hold true for others, whether they be trainers, religious leaders, or other helping professionals. Adults who live alone may only see their family members once every few months on holidays. Yet they may see their trainer several times a week, or attend religious services weekly. If one has their eyes open, these regular interactions can reveal concerning behaviors.

If your profession is one that involves being a regular fixture in another individual's life, you are a person of trust who has the opportunity to witness potential eating disorder signs or symptoms.

What Information Am I Learning about People?

Doctors, therapists, or registered dietitians are likely not spending large chunks of time with their patients or clients on a daily basis; however, the time they do spend with them is meaningful, telling, and one of high intensity.

Therapists often ask clients to share their deepest emotional struggles and vulnerabilities and process them in order to overcome them.

Doctors examine the individual's physical body in a way that untrained family or friends cannot. They have the opportunity to ask questions, assess well-being, and screen for health concerns with tests and other measurements.

The insight gained in these encounters is more telling than other ordinary encounters. This then places the clinician in a vital position for intervention. Prompt intervention at the earliest sign of an eating disorder is ideal. Is there significant weight loss? This is especially suspicious for an eating disorder when seen in children, adolescents, and young adults. Other causes of significant weight loss (such as cancer or diabetes) are usually easily discernible and are less common than eating disorders.[4, 5, 6]

Below are five simple questions that can be used as a screening tool to assess for need for a referral to an eating disorder specialist:

1. Do you have a poor relationship with food?
2. Do you feel guilty after eating certain foods?
3. Do you frequently compensate for eating too much or for eating a "forbidden" food?
4. Do you have a history of chronic dieting?

How much of the day do you spend thinking about food, eating, or your weight?

These questions are easy to ask even if you feel you have insufficient

training or time to address them. The initial screening does not necessarily mean the one asking will be the one offering the formal assessment or treatment. Its prime purpose is to determine if a referral for an in-depth assessment would be beneficial. The Academy for Eating Disorders[7] and the National Eating Disorders Association[8] websites are just two of the many online resources that will help a provider find a local eating disorder specialist.

Unfortunately, even glaring signs of eating disorders are often ignored. This oversight can be deadly. It is estimated that there is an average span of five years between the time of the first visit to the doctor and the time the diagnosis of an eating disorder is made. Also worrisome is that it could take months or years before treatment actually starts.

Meet Rae, a Dancer Who Thought They Were Not Small Enough

This is an example of a teenager I will call Rae, who struggled with anorexia nervosa.

The dance teacher notices Rae has lost a significant amount of weight quickly, and asks if there is something wrong. Rae admits that they want to be thin like the other dancers, so they have stopped eating very much. Rae's dance teacher voices her concerns to Rae's parents.

Rae's parents take them to the doctor. The doctor notes that Rae has had weight fluctuations since their last appointment, sensitivity to cold, dry skin, brittle hair, a low heart rate, mood changes, trouble sleeping, and complaints of fatigue. Recognizing these signs as worrisome, the doctor orders labs and refers Rae to a therapist.

Rae's therapist finds that, in addition to their physical symptoms, Rae speaks about food and their relationship to their body in a troubling way. They have a lot of shame and guilt with eating, and feels they still need to lose more weight. Rae's therapist acknowledges that she is well-educated but not well-trained in eating disorders and refers Rae to an eating disorder specialist.

The specialist finds Rae to be in need of a higher level of care, and facilitates getting Rae into an eating disorder–treatment program.

Rae's treatment team consists of a therapist, medical doctor, psychiatrist, and a dietitian. Rae receives the coordinated care they need to process the mental, emotional, and physical deterioration caused by their eating disorder. Rae's parents are also involved with the treatment team. They are updated on Rae's progress and goals, and are asked to attend family meetings.

Rae restores their weight, and is discharged from the eating disorder program. They have been connected to an outpatient treatment team, who will continue to support Rae through their healing process.

Consider the many instances in the above scenario where Rae could have fallen through the cracks. The dance teacher could have ignored or even validated Rae's weight loss, praising them for becoming thinner. The doctor could have just asked the family to come back in six months, and not referred Rae to a therapist. The therapist could have continued seeing Rae despite her lack of experience with eating disorders. The treatment center could have discharged Rae without coordinating care with an outpatient team.

The network of support created among these individuals worked well because they each had a working knowledge of eating disorders, and a desire to help Rae in the best way possible. That one person in Rae's life spoke up about a concerning behavior she noticed, leading to the domino effect of Rae's disorder being detected earlier. This allowed for Rae to receive the comprehensive care they needed to recover, before their disordered behaviors became engrained.

Beginning this domino effect is sometimes as simple as asking the question, "What is going on?" This can be particularly pivotal early on, when the eating disorder behaviors aren't as entrenched in the individual's identity. A simple "What is wrong?" can give them the exact opportunity they have been looking for to admit they are in trouble, scared, confused, and need support.

Yet it is not always that easy. Eating disorders, by nature, are secretive. If you are examining a patient and ask about a potential disordered behavior or symptom, there is always the chance they will flat out lie or

completely deny they have an issue. Even when working with a client with an admitted eating disorder, they may simply refuse to engage and you may reach a roadblock where things just "are not working."

Have You Identified Someone Who May Need Help? What Is the Next Step?

First and foremost, lead with compassion. These individuals are struggling with a mental illness that has hijacked their mind, body, and soul. They don't mean for their lies to hurt you; they are not being obstinate when they refuse to get help. They are simply clinging to a coping mechanism that they have found to be their best source of comfort at this time.

As professionals, we sometimes have to approach the individual like a puzzle box, attempting to reach them in varied ways until they open up or become interested in receiving help. If the direct question of "What is wrong?" does not work, try asking the following questions, which give the individual more power and agency:

- What are your goals for working with me?
- What needs can I help you fulfill?
- What are things that are important to you in your life?
- What can I do that would be helpful for you?

It can also help to ask indirect questions about their disorder or their behaviors, such as:

- If weight wasn't a concern for you, would you continue to eat in the way you are eating?
- What do you like to eat, not just what you have been told not to eat?
- Are you worried I may take away the only thing that has helped you feel better about yourself?

Imagine you have struggled with an eating disorder for a while. You have tried all sorts of treatments and coping skills, and you have been to more appointments and clinicians than you can count. Is it likely, then, that you may feel as hopeless and burned out as some of your clients or patients do? Reaching someone who has completely shut themselves

down to help is not easy, but it may help to start with what went wrong in their previous experiences. Finding out what didn't work in past encounters can help you move forward with your work. Some sample questions to ask in this regard are:

- What has worked for you in the past, and what has not?
- At what point did you feel things stopped working?
- Where do you think your therapist/treatment team went wrong?

These questions can also be helpful if you feel your treatment has come to a halt. You may have inadvertently said or done something that shut your client down. Being open and honest about what did not work for them can help repair any damage, improve the individual's view about treatment, and help treatment progress forward.

It is important to consider how your messages come across. Sometimes you have the right intentions, yet deliver the message in a way that turns the client off. For example, you may be excited to recommend they vacation in a city you visited on bicycle. If the client has any exercise resistance, or physical limitations, this may come across as insensitive.

Here are some of the best tips I can offer to help you communicate your messages more effectively:

Watch your language (both your body language and your words). Let your body show that you are interested and concerned. Show such expressions in your face, and with your tone. Be mindful of the words you choose and how they may be perceived. Be especially careful with language you use when addressing the body, appearance, food, and movement. Our society is permeated with diet culture language; it is important to ensure the things we say do not reinforce it. It is imperative to be nonjudgmental in discussions about appearance, exercise, and food. Conveying judgment in our statements can be harmful for anyone, but is particularly destructive to someone who struggles with an eating disorder.

Avoid self-disclosure. Yes, it is important that your clients and patients see you as human. After all, no one wants to be treated by a robot they do not know or understand. However, in these circumstances,

disclosing about your own eating or movement habits can sometimes cause more harm than good. The meeting is about them, not you. You might accidentally mention a restrictive behavior that to you seems harmless, but to someone with an eating disorder, generates another insecurity or "food rule." How an individual nourishes and fuels themselves is as unique to them as their bodies and their personalities; therefore, disclosing your own practices may not serve anyone and may promote comparison. In instances where the clinician has recovered from their own eating disorder, discretion can be practiced with regard to self-disclosure. In such cases, self-disclosure may actually be validating for the client.

Their body is not your business. Too many people make the mistake of believing a certain body weight, size, or shape is indicative of health, or lack thereof. Comments like, "You do not look like you have an eating disorder," "You do not look so bad," "You do need to lose some weight," or "You should exercise more," are incredibly destructive. They send the message that people with eating disorders need to look a certain way, and people who are "healthy" must look a certain way too.

The discussion of someone's body size, weight, or shape needs to be approached very carefully. When showing concern about potential eating-disordered behavior, discuss the behavior rather than appearances. For example, "I have noticed you have been eating less," or "I am worried that you stay in the bathroom for a while after every meal." Comments that involve assessment of appearance can be triggering for clients. For example, parents who see their loved one and say, "You look so much healthier," or "Wow, they fattened you up in no time," can be causing significant damage to treatment progress.

Do not envy their eating disorder. It is shocking that this even needs to be said. There are horrifying stories of clinicians telling patients, "I wish I had a little bit of what you have," or "I think I would lose weight if I did that," or "I understand why you do that, because I have to exercise a lot to get rid of this belly."

Eating disorders are incredibly traumatizing disorders that can lead to severe health problems and death. They are not something to be desired.

Do not push restriction. Patients are often told to "cut out carbs" or "cut down on dairy." Encouraging restriction can amplify the problems of patients who struggle with an eating disorder.

A former client told me the first time she purged was in response to her doctor telling her to cut more fat out of her diet. At that time, she had already been restricting and had cut everything she could think of out of her diet. So the only remaining option became purging. Having a working knowledge of eating disorders could have helped prevent this; the doctor would have known to not make triggering suggestions.

Set the Example

Becoming aware of the language used in your clients' environment can be a powerful way for you to support your client. Often, friends or family members are unaware of how their words or actions can impact their loved one. They may act as "food pushers," for example, simply trying to help their loved one feel better by offering them food. Or they may be routinely making positive comments about their loved one's appearance. All these actions are well-intentioned but misguided, and should be gently corrected.

Raising awareness about how such remarks affect your client will teach family members or friends how to better support the client. Pushing food can teach the client the habit of comforting emotions with food, even when not hungry. Commenting on appearances may make the client feel pressured to always look a certain way.

Helping individuals with eating disorders involves some learning as well as some unlearning. You will need to learn how to recognize the signs and symptoms of eating disorders, and how to best approach someone who may be struggling. You will need to "unlearn" language that diet culture has engrained in you and learn to speak in a way that deemphasizes body weight, size, shape, and appearance. Focus on the inner beauty of the person, their value system, and how recovery will bring out the best in them.

It is important to acknowledge the shortcomings of our training. Knowing a little about eating disorders does not make you qualified to treat them. As in Rae's story, the therapist knew her limitations and

referred Rae to someone who specialized in eating disorders. Take the ego out of the game. It is important to remember that we are all in this together to help the client. If we cannot treat them, the best way to help them is to find someone who can.

If you make the decision to refer this person to a therapist, eating disorder specialist, or treatment program, please do your due diligence first. Do not simply surf the web for treatment programs, but rather look for programs and clinicians who do not promote any form of restriction, dieting, or weight loss. There can be unclear messages when looking for a provider or program, and oftentimes they are disguised as an eating disorder–treatment program. Look for eating disorder–treatment programs that utilize a well-rounded team of professionals: therapists, doctors, psychiatrists, and dietitians.

The old saying "Sticks and stones can break my bones, but words cannot harm me" does not apply to eating disorders. In many cases, it is the words of others that instigate an eating disorder. The right words can be a powerful tool in opening the gates of communication with someone struggling with an eating disorder so healing can start. A meaningful interview process by a professional can make all the difference. I'll discuss that in the next chapter.

Chapter 2 Notes

1. "Statistics & Research on Eating Disorders," National Eating Disorders Association, accessed December 20, 2019, www.nationaleatingdisorders.org/statistics-research-eating-disorders.

2. "Statistics & Research on Eating Disorders," National Eating Disorders Association.

3. E. W. Diemer et al., "Gender Identity, Sexual Orientation, and Eating-Related Pathology in a National Sample of College Students," *Journal of Adolescent Health* 57, no. 2 (August 2015): 144–149.

4. E. Shinohara et al., "Esophageal cancer in a young woman with bulimia nervosa: a case report," *Journal of Medical Case Reports* 1, no. 160 (November 2007): 1–4.

5. F. Navab et al., "Bulimia nervosa complicated by Barrett's esophagus and esophageal cancer," *Gastrointestinal Endoscopy* 44, no. 4 (October 1996): 492–494.

6. S. Amiel et al., "Ketone lowers hormone responses to hypoglycaemia: evidence for acute cerebral utilization of a non-glucose fuel," *Clinical Science* 81 (August 1991): 189–194.

7. Academy for Eating Disorders, www.aedweb.org.

8. National Eating Disorders Association, www.nationaleatingdisorders.org.