



NATIONAL ASSOCIATION OF ANOREXIA NERVOSA AND ASSOCIATED DISORDERS

How to Help Someone with an Eating Disorder



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Worried about a friend?

Does he/she:

- Obsess about dieting and their body?
- Talk about calories, fat and carbs constantly?
- Get anxious around food?
- Panic if unable to work out?
- Skip meals regularly?



Don't be afraid to help!

**To learn more about how to help your friend and for information about FREE support groups, treatment centers and therapists in your area, call or email us:
630.577.1330 or anadhelp@anad.org**

ANAD



An estimated 11 percent of all college students are suffering from an eating disorder, and an ANAD study found that 86 percent reported onset of their illness by the age of twenty. Early detection has the potential to make an immense difference in the success of treatment. Informed students at schools can play a pivotal role in the early detection of eating disorders and in urging friends to seek treatment.

It is easy for students to slip through the cracks at college. Even very caring and attentive administration, professors and staff are often not around students enough to pick up the warning signs. Friends frequently take on the role of family in looking out for each other. This is why it is so vital that we educate students on how to recognize the signs of eating disorders and give them the tools to help a friend.

Included in this packet is a wonderful collection of materials geared toward helping college students concerned about a friend's eating behaviors, including:

- General information about eating disorders
- Signs and symptoms of eating disorders
- Strategies for planning an intervention/easy to follow "confront" plan
- Do's and Don'ts for interacting with your friend

The purpose of these materials is to raise awareness and understanding about eating disorders on your campus. This packet is a valuable resource for students and we hope that you will make copies available in dorms, counseling centers, health centers, workout facilities, or wherever else you think will offer easy access for students.

We hope that you will make use of these materials and find them helpful. Eating disorders are not going away any time soon and the worst thing to do is ignore the problem. Please contact us if we can help in any way.

You can make the difference in someone's life!

Information on Eating Disorders

Eating is controlled by many factors, including appetite, food availability, family, peer, cultural practices, and attempts at voluntary control. Dieting to a body weight leaner than needed for health is highly promoted by current fashion trends, sales campaigns for special foods, and in some activities and professions. Eating disorders involve serious disturbances in eating behavior, such as extreme and unhealthy reduction of food intake or severe overeating, as well as feelings of distress or extreme concern about body shape or weight. Researchers are investigating how and why initially voluntary behaviors, such as eating smaller or larger amounts of food than usual, at some point move beyond control in some people and develop into an eating disorder. Studies on the basic biology of appetite control and its alteration by prolonged overeating or starvation have uncovered enormous complexity, but in the long run have the potential to lead to new pharmacologic treatments for eating disorders.

Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which certain maladaptive patterns of eating take on a life of their own. The main types of eating disorders are anorexia nervosa and bulimia nervosa.¹ A third type, binge-eating disorder, has been suggested but has not yet been approved as a formal psychiatric diagnosis.² Eating disorders frequently develop during adolescence or early adulthood, but some reports indicate their onset can occur during childhood or later in adulthood.³

Eating disorders frequently co-occur with other psychiatric disorders such as depression, substance abuse, and anxiety disorders.⁴ In addition, people who suffer from eating disorders can experience a wide range of physical health complications, including serious heart conditions and kidney failure which may lead to death. Recognition of eating disorders as real and treatable diseases, therefore, is critically important.

¹ American Psychiatric Association Work Group on Eating Disorders. Practice guideline for the treatment of patients with eating disorders (revision). *American Journal of Psychiatry*, 2000; 157 (1 Suppl): 1-39.

² American Psychiatric Association. *Diagnostic and Statistical Manual for Mental Disorders*, fourth edition (DSM-IV). Washington, DC: American Psychiatric Press, 1994.

³ Besker AE, Grinspoon SK, Klibanski A, Herzog DB. Eating disorders. *New England Journal of Medicine*, 1999; 340(14): 1092-8.

⁴ Anderson AE. Eating disorders in males. In: Brownell KD, Fairburn CG, eds. *Eating disorders and obesity: a comprehensive handbook*. New York: Guilford Press, 1995; 177-87.

Both males and females develop eating disorders in our body and food conscious society. An estimated 5 to 15 percent of people with anorexia or bulimia⁵ and an estimated 35 percent of those with binge-eating disorder⁶ are male.

Anorexia Nervosa

An estimated 0.5 to 3.7 percent of females suffer from anorexia nervosa in their lifetime.⁷ The ratio of female to male sufferers is seven to one; however we suspect that anorexia nervosa is underreported in males. Symptoms of anorexia nervosa include:

- Resistance to maintaining 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
- Infrequent or absent menstrual periods (in females who have reached puberty)

People with this disorder see themselves as overweight even if they are dangerously thin. The process of eating becomes an obsession. Unusual eating habits develop, such as avoiding food and meals, picking out a few foods and eating them in small quantities, or carefully weighing and portioning food. People with anorexia may repeatedly check their body weight and many engage in other techniques to control their weight, such as intense and compulsive exercise, or purging by means of vomiting and abuse of laxatives, enemas, and diuretics. Menstrual periods may cease or be delayed in females.

The course and outcome of anorexia nervosa varies across individuals: some fully recover after a single episode; some have a fluctuating pattern of weight gain and relapse; and others experience a chronically deteriorating course of illness over many years. The mortality rate among people with anorexia has been estimated at

⁵ Spitzer RL, Yanovski S, Wadden T, Wing R, Marcus MD, Stunkard A, Delvin M, Mitchell J, Hasin D, Horne RL. Binge eating disorder: its further validation in a multisite study. *International Journal of Eating Disorders*, 1993; 13(2): 137-53.

⁶ Sullivan PF. Mortality in anorexia nervosa. *American Journal of Psychiatry*, 1995; 152(7):1073-4.

⁷ Bruce B, Agras WS. Binge eating in females: a population-based investigation. *International Journal of Eating Disorders*, 1992; 12:365-73.

approximately 5.6 percent per decade, which is about 12 times higher than the annual death rate due to all causes of death among females 15-24 years old.⁸ The most common causes of death are complications of the disorder, such as cardiac arrest or electrolyte imbalance, and suicide.

Bulimia Nervosa

An estimated 1.1 percent to 4.2 percent of females have bulimia nervosa in their lifetime.⁹ As with anorexia, bulimia nervosa is underreported in males. Symptoms of bulimia nervosa include:

- Recurrent episodes of binge eating, characterized by eating an excessive amount of food within a discrete period of time and by a sense of lack of control over eating during the episode
- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting or misuse of laxatives, diuretics, enemas, or other medications (purging); fasting; or excessive exercise
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months
- Self-evaluation is unduly influenced by body shape and weight

Because purging or other compensatory behavior follows the binge-eating episodes, people with bulimia usually weigh within or above the normal range for their age and height. However, like individuals with anorexia, they may fear gaining weight, desire to lose weight, and feel intensely dissatisfied with their bodies. People with bulimia often perform the behaviors in secrecy, feeling disgusted and ashamed when they binge, yet relieved once they purge.

Binge-Eating Disorder

Community surveys have estimated that between 2 percent and 5 percent of Americans experience binge-eating disorder in a 6-month period.¹⁰ Symptoms of binge-eating disorder include:

⁸ Agras WS. Pharmacotherapy of bulimia nervosa and binge eating disorder: longer-term outcomes. *Psychopharmacology Bulletin*, 1997; 33(3): 433-6.

⁹ Wilfley DE, Cohen LR. Psychological treatment of bulimia nervosa and binge eating disorder. *Psychopharmacology Bulletin*, 1997; 33(3): 437-54.

¹⁰ Apple RF, Agras WS. Overcoming eating disorders. A cognitive-behavioral treatment for bulimia and binge-eating disorder. San Antonio: Harcourt Brace & Company, 1997.

- Recurrent episodes of binge eating, characterized by eating an excessive amount of food within a discrete period of time and by a sense of lack of control over eating during the episode
- The binge-eating episodes are associated with at least 3 of the following: eating much more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not feeling physically hungry; eating alone because of being embarrassed by how much one is eating; feeling disgusted with oneself, depressed, or very guilty after overeating
- Marked distress about the binge-eating behavior
- The binge eating occurs, on average, at least 2 days a week for 6 months
- The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise)

People with binge-eating disorder experience frequent episodes of out-of-control eating, with the same binge-eating symptoms as those with bulimia. The main difference is that individuals with binge-eating disorder do not purge their bodies of excess calories. Therefore, many with the disorder are overweight with this illness for their age and height. Feelings of self-disgust and shame associated with this illness can lead to bingeing again, creating a cycle of binge eating.

Treatment Strategies

Eating disorders can be treated and a healthy weight restored. The sooner these disorders are diagnosed and treated, the better the outcomes are likely to be. Because of their complexity, eating disorders require a comprehensive treatment plan involving medical care and monitoring, psychosocial interventions, nutritional counseling and, when appropriate, medication management. At the time of diagnosis, the clinician must determine whether the person is in immediate danger and requires hospitalization.

Treatment of anorexia calls for a specific program that involves three main phases:

- (1) Restoring weight lost to severe dieting and purging
 - (2) Treating psychological disturbances such as distortion of body image, low self-esteem, and interpersonal conflicts
 - (3) Achieving long-term remission and rehabilitation, or full recovery. Early diagnosis and treatment increases the treatment success rate.
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Use of psychotropic medication in people with anorexia is helpful for obsessive compulsive, depressed, anxious and thought disordered symptoms, but may not be able to take full effect until weight gain and normalized eating are established. Certain selective serotonin reuptake inhibitors (SSRIs) have been shown to be helpful for weight maintenance and for resolving mood and anxiety symptoms associated with anorexia.

The acute management of severe weight loss is usually provided in an inpatient hospital setting, where feeding plans address the person's medical and nutritional needs. In some cases, intravenous feeding is recommended. Once malnutrition has been corrected and weight gain has begun, psychotherapy (often cognitive-behavioral or interpersonal psychotherapy) can help people with anorexia overcome low self-esteem and address distorted thought and behavior patterns. Families are sometimes included in the therapeutic process.

The primary goal of treatment for bulimia is to reduce or eliminate binge-eating and purging behavior. To this end, nutritional rehabilitation, psychosocial intervention, and medication management strategies are often employed. Establishment of a pattern of regular, non-binge meals, improvement of attitudes related to the eating disorder, encouragement of healthy but not excessive exercise, and resolution of co-occurring conditions such as mood or anxiety disorders are among the specific aims of these strategies. Individual psychotherapy (especially cognitive-behavioral or interpersonal psychotherapy), group psychotherapy that uses a cognitive-behavioral approach, and family or marital therapy have been reported to be effective.

Psychotropic medications, primarily antidepressants such as the selective serotonin reuptake inhibitors (SSRIs), have been found helpful for people with bulimia, particularly those with significant symptoms of depression or anxiety, or those who have not responded adequately to psychosocial treatment alone. These medications also may help prevent relapse. The treatment goals and strategies for binge-eating disorder are similar to those for bulimia, and studies are currently evaluating the effectiveness of various interventions.

People with eating disorders often do not recognize or admit that they are ill. As a result, they may strongly resist getting and staying in treatment. Family members or other trusted individuals can be helpful in ensuring that the person with an eating disorder receives needed care and rehabilitation. For some people, treatment may be long term.

(National Institute of Mental Health)

Symptoms of Eating Disorders

Anorexia Nervosa

- Preoccupation with food, weight, and body
- Deliberate self-starvation
- Unrelenting fear of gaining weight
- Refusal to eat except for tiny portions
- Dehydration
- Denial of hunger
- Compulsive exercise
- Excessive fine hair on face and body
- Distorted body image
- Abnormal weight loss
- Sensitivity to cold
- Absent menstruation
- Hair loss
- Constipation

Bulimia Nervosa

- Preoccupation with food, weight, and body
- Binge eating (consuming more than a normal person would during the same period of time), usually in secret
- Vomiting after bingeing
- Abuse of laxatives, diuretics, diet pills, or emetics
- Compulsive exercising
- Swollen parotid glands
- Broken blood vessels in eyes
- Dehydration
- Constipation
- Irregular menstruation

Binge-Eating Disorder

- Preoccupation with food, weight, and body
- Rapid consumption of a large amount of food
- Consumes large amounts of food in secret
- Consumes food when not hungry
- Consumes large amounts of food until very uncomfortable
- Loss of control over eating
- Constipation
- Only 50% may be overweight

Psychological Repercussions from Eating Disorders

- Depression
- Shame and guilt
- Mood swings
- Low self-esteem
- Withdrawal

- Impaired family and social relationships
- Negative thought patterns (“all or nothing”)
- Perfectionism

Step-by-Step Plan for an Intervention

1.) Pick the intervention team

- The team should consist of meaningful people in the sufferer’s life. (Friends, parents, boyfriend/girlfriend/partner, coaches, professors, Deans, advisors, siblings)
- Try and narrow it down to 3-5 people. Too many can cause confusion and weaken the intervention.
- Contact the people and find out if they are willing to participate.
- If you wish to use a professional interventionist contact ANAD for references if one is available in the area.

2.) Prepare

- Each person should make a list of specific behaviors/incidents that concern them
 - Keep them honest, explicit, and straightforward.
 - Try not to make them sound accusatory.
 - “I worry that you aren’t getting enough to eat when I see you picking at your lunch and dinner.”
 - “Last Wednesday you were in the bathroom for a long time right after dinner and when you came out I noticed that your eyes seemed all red and puffy.”
 - “Three times last week you spent over three hours at the gym. You seem to be spending more and more time there.”
- Look into treatment options and have the information ready for the person.
 - Find out what the counseling center offers on your campus and get the number they should call for an appointment.
 - Call ANAD at 630-577-1330 (www.anad.org) for information on therapists, treatment centers, and free support groups near you.

3.) Practice

- Choose a leader who can be counted on to maintain order and keep the intervention moving along smoothly.

- Each person should go through what they have prepared to say.
- Determine the order group members will speak in and write it down.
- You may have the group members take turns playing the role of the person with the eating disorder.
- Decide on responses for possible excuses, refutation, and denials the sufferer may offer.
 - Don't make ultimatums or threats such as:
 - "If you don't stop this, I won't be your friend anymore!"
 - "I'm not talking to you until you start eating again!"
 - Don't offer simple solutions:
 - "Just eat!"
 - "Stop hurting yourself!"

4.) Plan the actual intervention

- When: choose a time and date that is convenient for everyone.
- Where: select a location that is private and non-threatening
- Who: designate someone to remind the group of the time and place and someone to ensure the person with the ED will be there.

5.) Help yourself

- Remember that you are not ultimately responsible for the recovery of the person with the ED. They have to be ready to get better.
 - Even if the person does not accept treatment, an intervention can break through denial and urge the person to seek help.
 - When planned carefully and executed correctly, there is no such thing as failed intervention.
- Know your own limits and respect them.
 - Don't overextend yourself or you risk burn out and rendering yourself incapable of offering long term support for the person.
 - Don't let the person with the eating disorder manipulate you.
- Find support for yourself.
 - You may wish to see a counselor or therapist yourself to help sort through the emotions you're feeling toward your friend.
 - ANAD (630-577-1330) can put you in contact with resource people who have either had an eating disorder themselves or have experience through a loved one and want to talk about it.
 - You may find it helpful to read books for friends and family of persons with eating disorders.

Adapted from:

Johnson, Vernon E. Intervention, how to help someone who doesn't want help.
Minneapolis: Johnson Institute Books, 1986.

Intervention Q&A's

Why intervene now?

The sooner the eating disorder is recognized, the easier it is to treat. In addition, the person with an eating disorder is frequently in a lot of emotional and sometimes physical distress. An intervention is the first step in getting him/her on the road to recovery.

Why should I be the one to do it?

Because you care. If you are reading this, then there is someone in your life for whose wellbeing you are concerned. You don't have to be a parent or relative to intervene; friends often play an important role in recovery. But if you are able to include family members your intervention may be more effective. Family are usually able to provide the additional support needed to find a treatment center that meets with their needs and resources.

Why intervene?

Intervention is important because it breaks down the walls of denial and secrecy surrounding the eating disorder and allows the person to accept help. Eating disorders are not about the food. There are underlying issues. The eating disorder is the symptom, not the problem itself.

What if the person gets mad at me for meddling with their personal life?

It is quite likely that the person will respond with anger and/or denial. Expect this sort of reaction, but don't let it deter you. The person's health is at stake, and this is ultimately more important than he/she being upset with you. Underneath it all they are probably relieved to have it out in the open.

Why does the intervention need to be a group effort?

The goal of the intervention is to break down the defenses and denial of the person suffering from the eating disorder. A small group of the person's most trusted friends and family are good resources for reaching out to someone suffering from

and eating disorder. Reassure what your intentions are and why. Remember: some people want help and will be very glad that you offered. Others may need some time understand how much people care and how severe their disorder is.

What if it doesn't work?

Don't give up. No intervention is a failure. At the very least you have planted the seed in the person's mind. The sufferer knows that others are aware of his/her problem and want to help. Also, those concerned about the person know that they are not the only one worrying. They can discuss their concerns and offer each other support in dealing with the sufferer. Recovery ultimately depends on whether or not the sufferer is ready to get better. Intervention is one of the best ways to urge them along.

The Serious Physical Consequences of Eating Disorders

Death rates: Young women with anorexia nervosa are 12 times more likely to die prematurely than all other women of the same age. Eating disorders have the highest mortality rate of all mental illnesses.

Mental Functioning:

- Feeling dull, listless
- Difficulty concentrating or focusing
- Difficulty regulating mood
- Associated mental disorders: depression, anxiety disorders, obsessive-compulsive disorder, substance abuse

Cardiovascular (Heart):

- Slow irregular, pulse
- Low blood pressure
- Dizziness or faintness
- Shortness of breath
- Chest pain
- Decreased potassium levels may result in life threatening cardiac arrhythmias or arrest
- Electrolyte imbalances may lead to life threatening cardiac arrhythmias or arrest

Mouth:

- Enamel erosion, loss of teeth

- Gum disease
- Swollen salivary glands from vomiting
- Sore throat because of induced vomiting

Esophagus:

- Painful burning in throat or chest
- May vomit blood from small tear(s) in esophagus
- Rupture of the esophagus, may lead to circulatory collapse and death

Endocrine System:

- Thyroid abnormalities
- Low energy or fatigue
- Cold intolerance
- Low body temperature
- Hair becomes thin and may fall out
- Development of fine body hair as the body's attempt to keep warm

Stomach:

- Stomach may swell following eating or binging (causes discomfort and bloating)
- Gastric rupture due to severe binge eating (gastric rupture has an 80% fatality rate)
- Vomiting causes severe electrolyte imbalance which can lead to sudden cardiac arrest

Intestines:

- Normal movement in intestinal tract often slow down with very restricted eating and severe weight loss
- Frequent constipation
- Chronic irregular bowel movements

Reproductive System:

- Amenorrhea (absence of menstruation)
- Infertility
- Increased risk of miscarriage, low-birth weight, or premature birth
- Inadequate weight gain, starvation, or binge/purge behaviors during pregnancy may increase risk of complications (e.g. low birth weight or premature delivery)

Complications Associated with Laxative Abuse:

- Kidney complications

- “Cathartic colon,” refers to the colon’s inability to function normally without the use of large doses of laxatives due to the destruction of the nerves in the colon that control elimination.
- Electrolyte imbalance (for example, potassium depletion)
- Dehydration
- Laxatives are habit forming

“CONFRONT”

The plan for confronting someone you feel has an eating disorder

When confronting a person with an eating disorder, it is important to have a plan. A confrontation can be difficult due to denial seen in those with the problem. However, if a person does deny the problem, the initial seed has been planted. At some point in the future, the problem will be recognized and admitted. The following scheme is helpful to use when doing a confrontation.



CONCERN The reason you are doing the confronting. You care about the mental, physical, and nutritional needs of the person.

ORGANIZE Decide WHO is involved, WHAT everyone is going to say, WHERE to confront, WHY concerned, HOW to talk, WHEN is a convenient time?

NEEDS What will he/she need after the confrontation? Locate several options in the way of professional help and/or support groups and have the information ready. On college campuses, find the number for the counseling center.

FACE The actual confrontation. Be empathetic but direct, and offer specific examples of the behavior that concerns you. Expect denial and possibly anger, but do not back down. Don’t get angry at them. Stick with “I” statements rather than “you” statements to avoid being accusatory. Keep emphasizing that you are coming from a place of love and compassion.

RESPOND By listening carefully.

OFFER Help, suggestions, support. Find information on where he/she can go for professional help and even ask if they would like you to accompany them. You may want to encourage them to contact you when he/she needs someone to talk to, but don’t play therapist. Remember, there is only so much that you can do.

NEGOTIATE Another time to talk and a time span to seek professional help. Follow up and be gentle but firm.

TIME Recovery takes time and patience, from both you and him/her. Remind him/her how much he/she has to gain by that process, and also, how much he/she stands to lose if he/she chooses to remain in these behaviors.

REMEMBER: If you think he/she is in immediate danger, contact help immediately

How to Help a Friend with an Eating Disorder

DO

- Talk openly and honestly about concerns
- Be gentle but firm
- Try to make yourself available when he/she needs someone
- Be honest about your own fears, struggles, and frustration
- Take time to listen, even though the talk may seem trivial or insignificant to you
- Express your love and support
- Remember that an eating disorder is not about the food
- Understand that he/she is terrified of gaining weight and being fat (regardless of how he/she actually looks to you)
- Focus on personality and positive character qualities
- Encourage him/her to accept support and express her feelings
- Keep in mind that he/she is separate from his/her eating disorder
- Avoid conflicts and battles of will
- Be patient; recovery can be a long process
- Know your limits and respect them
- Gently encourage him/her to eat properly
- Realize that while he/she needs help in recovery, he/she has to want it for him/herself

DON'T

- Try to be his/her therapist; enlist professional help
- Be afraid to upset them; communicate
- Ignore him/her; they need support
- Offer simple solutions (“why don’t you just eat?!”)
- Comment on their weight (if you say “you look too thin”, he/she may take it as a compliment; if you say “you look healthy” he/she may take it as an insult)
- Let him/her feel like he/she is the only one with a problem
- Blame him/her, make him/her feel ashamed or guilty for having an eating disorder
- Threaten (“if you don’t eat...”)
- Gossip about him/her
- Use “you” statements; they sound accusatory

- Expect an instant recovery
- Try to force him/her to eat or stop exercising
- Focus on food, weight, or appearance
- Pretend it will just go away

How You Can Help Your Friend: Advice from a Recovering Individual

The best thing that you can do for a friend you're concerned about is just be there for them; even if they are having a really tough time and appear to be pushing you away, try to stick by them. Try to encourage them to go to the doctor or at least share their thoughts with somebody so that they can try to get some help before things get really bad. I think if people get help sooner it wouldn't take so long to recover. It's been a part of my life for such a long time and I definitely feel that my problems have become bigger because there wasn't any help at school. It has helped me so much to have somebody to talk to, though, and thankfully, with that help I am slowly getting better.

-Jo is 23 years old and has been dealing with eating issues since age 15