



Offering support, practical advice and understanding so you
can help your loved one recover from an eating disorder



CARER PACK

Dear Caregiver

EDANZ (Eating Disorder Association of New Zealand) is run by a small group of parents who have had a child or young person fully recover from an eating disorder. We are here to help you understand your loved one's illness, support you in helping them get the appropriate treatment and to provide you with valuable information to help them recover and thrive.

We strongly believe families play a vital role throughout the recovery process. We believe in full recovery. We believe information is power and good treatment saves lives. No two families have the same needs or path, but we know what information and skills can help them become resilient and powerful as they support their loved one to strong and lasting recovery.

We also know that eating disorders can make carers feel isolated and overwhelmed. We hope to ease that. EDANZ offer an 0800 helpline that you can call or email anytime. We endeavour to respond to all messages within 24 hours. We are here to listen to you, to provide you with the latest knowledge and information on the treatment of eating disorders, and to empower you. We do not have medical qualifications, we are not therapists or clinicians, but we do have lived experience and understand the challenges of supporting a child with an eating disorder. Many people find strength in having the opportunity to talk with others who have had or are currently experiencing challenges similar to your own.

So, in addition to our helpline, we run Support Group Meetings. These meetings provide an opportunity for EDANZ volunteers and carers of individuals with an eating disorder to come together over a cup of coffee and talk, listen and learn from one another. Our EDANZ website has details of upcoming meetings which you are welcome to attend: www.ed.org.nz/parent-carer-support-groups

EDANZ also produce a regular newsletter with information about the latest research and articles about eating disorders, and to tell you what our volunteers have been up to, advise about conferences, and other educational events of interest locally and around the world. If you would like to receive this newsletter, please email us at info@ed.org.nz

The pack you are holding contains articles and resources that others who are supporting someone with an eating disorder have found informative and relevant. Be assured that the information we share has been carefully researched and collated. **It is to be used in conjunction with, and to support, the specialist eating disorder treatment your loved one is receiving.** The information enclosed is evidence based, current, has practical application and is geared specifically to you, the carer. We encourage you to read and learn all you can – *Knowledge is Power* – the more you know about eating disorders and the latest knowledge in treatment, the better you will be able to support your loved one to full and lasting recovery.

In the battle to regain their health, your loved one needs you to provide the hope, comfort, compassion and understanding essential to their recovery. EDANZ is here to support you so you can best support them. We encourage you to call or email at any time. Please trust that you are stronger, smarter and more resilient and resourceful than any eating disorder, and you have one of the most important assets that the eating disorder does not have – love.

Sending our very best wishes to you
EDANZ Volunteer Team



CARER PACK

CONTENTS

Articles

1. Introduction to F.E.A.S.T.
(Families Empowered & Supporting Treatment for eating disorders)
2. 'Family Matters – Tips for families from families' by the Victorian Centre of Excellence in Eating Disorders, Australia
3. 'Getting Your Child with an Eating Disorder to Eat' by Eva Musby
4. 'Why Your Teen Probably Won't Want to do FBT, and Why You Should Feel Free to do it Anyway' by Lauren Muhlheim, PsyD
5. 'My Daughter Does Not Want to Recover From Her Eating Disorder' by Laura Collins
6. 'After Weight Restoration: Anosognosia and the Role of Insight' by Dr Sarah Ravin
7. 'Trouble Shooting Common Difficulties for Adolescents with Anorexia', Workshop Handout from The Royal Children's Hospital, Melbourne
8. 'Why Full Anorexia Recovery Is Crucial for Brain Health' by Lauren Muhlheim, PsyD
9. 'ANGI (Anorexia Nervosa Genetics Initiative) Study: What the ANGI results mean for Patients, Families, and Clinicians today' by Cynthia Bulik, PhD
10. 'Dear Mum & Dad, Thank You For Saving My Life' by Kinsey Ouellette
11. EDANZ Recommended Booklist

F.E.A.S.T Booklets

- The Neurobiology of Eating Disorders
- Coming to Terms with a Loved One's Eating Disorder Diagnosis
- The Importance of Nutrition for Understanding and Treating Eating Disorders

F.E.A.S.T.

Families Empowered & Supporting Treatment (for **eating disorders**)

Parents and Carers

Online Peer Support

www.aroundthedinnersupport.org



"Around the Dinner Table" Group for Caregivers

For ED Caregivers on Facebook as a supplement to F.E.A.S.T.'s ATDT Forum.
Visit the ATDT Forum at: www.aroundthedinnersupport.org

facebook.com/groups/ATDTcarersupportgroup

International, 24/7, peer-support for anyone caring for someone with an eating disorder.
Shared experience, freely available, anytime, anyplace.

F.E.A.S.T. believes:

- Eating disorders are biologically based and fully treatable
- Parents do not cause eating disorders, and patients do not choose them
- Parents and caregivers can be a powerful support for a loved one's recovery
- Patients should receive evidence-based treatment, when available.
- Families should be supported in seeking the most appropriate treatment in the least restrictive environment possible.
- Food is medicine: all treatment should include urgent and ongoing nutritional rehabilitation.
- When the family is supported, the patient is supported.
- Siblings and parents are affected by a family member's illness; their needs deserve full attention too.
- Parents have a unique capacity to help other parents with support, information, and the wisdom of experience.

F.E.A.S.T. is committed to a coalition-building model of advocacy work that requires mutual respect among caregivers, professionals, and patients.



www.feast-ed.org

The following is taken from a post on the Around The Dinner Table forum (previous page), giving a perspective on the fundamentals of refeeding vs "normal" parenting:

*"I believe it is also critically important to **re-frame the re-feeding process as a medical protocol**. Your daughter is very ill with a life-threatening disease, and just like a cancer patient, she needs a treatment plan that will deliver the right medicine in the right quantities to beat the disease.*

*In the case of ED **the medicine is food, and the quality and quantity of the medicine needs to be non-negotiable**. (high calorie, adequate fats and proteins are the prescription)*

*Just like a cancer patient, your daughter needs **a safe environment** for this treatment where nothing is more important than getting her well. This means structuring your life and her life in a way where eating is the first priority, and **not eating is not an option**.*

***Think of your home as an extension of a hospital** where your daughter will be fed regularly, watched carefully, kept safe from ED behaviors, and looked after in a calm, caring manner.*

Re-feeding is not normal eating, and is not normal parenting.

*In normal eating, food sustains the body and the brain. **In re-feeding, food heals the body and the brain** first through weight restoration, then catch-up growth, and finally re-balancing brain chemistry that will lead to new healthy thought patterns and behaviors.*

*Normal parenting involves helping to guide our children towards independence, while easing their pain along the way. **Parenting during re-feeding requires a more clinical approach** and an understanding that your daughter will suffer physically and mentally as her body and brain adjust to eating again.*

*It requires **taking over all the decisions about food**, rather than guiding the child to make good choices, because a brain taken over by ED is unable to make good food choices.*

It takes a lot of food and a lot of time and a lot of dedication, tools which determined families with good support can provide 24 hours a day, 7 days a week and 365 days a year. No professional can offer that kind of dedication to your daughter, but the best ones will support that kind of dedication in the family.

*So, gather your confidence, get your support in place, make a plan for the preparing and serving of the food, consequences for resistance, supplements to replace thrown food, and **know that you are doing the right thing to help your daughter** even though it will be incredibly painful for you and her. The only way out of the pain is through the pain, but a life worth living is the reward."*



Family Matters – Tips for families from families

Getting started and making a plan

Refeeding is a necessary part of recovery from an eating disorder and keeping your child safe from the effects of an eating disorder (and not a punishment, as it may feel like to your child). The way in which the parents go about this difficult but delicate task of refeeding does not differ much in terms of the key principles and steps that a competent inpatient nursing team would follow.

It may be helpful to re-frame the re-feeding process as a **medical protocol**. Your daughter/son is very ill with a life-threatening disease, and just like a cancer patient, she/he needs a treatment plan that will deliver the right medicine in the right quantities to beat the disease.

So how do we set up our home and routines to manage the care of our child at home? Each family and child is different but there are some key things you need to incorporate in a plan which everyone in the household/s understand and adhere to.

The easiest thing to remember in what you are about to undertake is that ‘Life Stops Unless You Eat (or stop exercising or purging)’. And that means life. Nothing trumps eating, weight restoration and reduction of compensatory behaviours - not school, not family commitments, not formals, not Year 12 exams, not anything. **ALL** of these are possible and encouraged as long as child is eating, and not exercising or purging.

Food/eating

For EDs, the **medicine is food**, and the quality and quantity of the medicine needs to **be non-negotiable**.

You need to be prepared to provide at least 3 generous meals & 2 / 3 snacks (including nourishing drinks at each meal & snack).

Eating at predictable times is helpful in the beginning and ensuring no more than 3-4 hours between any meal/snack.

The child is not involved in **any** choice or preparation of food. His/her only job is to turn up to meal table and eat. While it feels paradoxical, this reduces anxiety significantly. Keep him/her out of the kitchen.

Present food in dishes or containers so calorie information not available e.g. yoghurt tipped into bowl.

Plastic crockery can be handy if going to get thrown.

Make sure you have extra food at hand before meal to replace any food disposed of by child.

You will need a **back-up plan** for food refusal that everyone understands. This may vary from family to family and from service to service. You need to discuss your specific local options with your clinical team but the end goal is to make eating at home non-negotiable, in the same way it would be in the inpatient setting.

During meals, your child will require you to sit with them and **support or distract them**. Don't debate the eating disorder, rather games, light-hearted conversation, television, friends can all be useful distraction once child eating. You can even use pause button on TV/Video or next game move dependent on mouthfuls being taken.

Support outside of meals

Your child is going to be **very** unhappy as the eating disorder is challenged and eating required. Prepare a range of activities to distract them or soothe them when not eating (and that are relatively sedentary). They may also appreciate hot water bottles, warm blankets, baths (also helpful for soothing stomach discomfort), and massages to calm down their anxiety. This may also be the last thing they want! It is important to remember this process is distressing but **the only way out is through**. You may not be able to do much to alleviate distress.

Preventing exercising and purging

If exercise compulsion or purging is a component of your child's illness, additional boundaries need to be set up in your home.

You may need to provide 24/7 supervision of your child, including overnight while asleep. You can sleep with your child or they can sleep on mattress in your bedroom. At the minimum, supervision for an hour after meals is helpful as this can be when the urge to compensate for eating is the strongest.

Bathroom visits may need to be supervised, including door open. While embarrassing for all involved, it is important for the behaviour that can occur in bathrooms, whether purging or exercising, to be interrupted.

If any behaviour cannot be interrupted e.g. constantly standing, leg jiggling, food intake needs to be increased to make up for the calories burnt. Once your child realises he/she can't circumvent your attempts to ensure weight gain, many of the behaviours decrease.

Some other tips at the start

The distress is high and may lead to self-harm. Consider sources of harm in your house and remove e.g. lock up knives, sharp implements, medications.

You may need to do a regular check of your child's room for laxatives and evidence of purging. This is keeping them safe, not an invasion of their privacy. Locks to bedrooms should be removed.

Clothing can become an issue as they gain weight. For this gaining weight period, loose and stretchy clothing can be helpful. While at home and not at school, lounging around in comfortable clothing and even pyjamas is best, and would be what they would be wearing if in hospital. You will need to totally remove all clothing that fitted when at their lower weights.

Try to work out ways and means for each parent or family member to get a break from providing the care and supervision as you can get overwhelmed. Once overwhelmed it becomes more difficult to insist on the boundaries required.

The greater your belief that you are stronger, smarter, and have more staying power than the ED; the greater the chance your child will come to believe that too

Developed by Belinda Caldwell – CEED Carer Consultant, and the mother of a daughter with anorexia nervosa.

Tips collated from the lived experience and wisdoms of parents on the FEAST website (www.feast-ed.org) and other sources.





Family Matters – tips from families for families

At the meal table

Restoration of full nutrition is the first and most necessary step in recovery. But how do you do it? Following on from the first tip sheet, in this one we explore in more detail the ins and out of supporting our child to eat.

To achieve full weight restoration as efficiently as possible, you will need to feed your child a high calorie diet, ensure he/she eats everything you provide (no mean feat!) and prevent any compensatory behaviours (will be covered in a later tip sheet).

What to feed your child?

One of the key challenges for parents is working out how much to feed someone in order to gain weight. Common pitfalls for families is finding the volume of food required as 'too much', not being aware of which foods provide more calories, being used to cooking in ways which minimise fat content and having fixed ideas of what is 'healthy'. In many ways feeding someone with Anorexia Nervosa runs counter to all of our society's traditional norms on healthy eating. The key to success is minimising the 'footprint' of the food our children are required to eat. In order to do this, you will need to change the food you serve to include full fat products, plenty of fats and oils, foods rich in proteins and carbohydrates. Vegetables may become an optional extra for a while! You may also need to change your food preparation style e.g. sausages may now be fried in oil rather than grilled.

Families differ in terms of how they work out what to feed their child – some families are naturally very good upping the calorie density and portions by intuition. Other families may need to take a more structured approach. However, any measurement of food or calorie counting must not be done in view of the child.

Ideas for high calorie meals and food options can be found at <http://atdthalloffame.feast-ed.org/home>, <http://www.bookemon.com/read-book/320399>, <http://www.maudsleyparents.org/learnmore.html> or on websites supporting nutrition of children with cystic fibrosis or cancer.

How do we make them eat?

Many parents have found the term "Magic Plate" helpful in enabling them to conceptualise what they have to do. Magic Plate means that caregivers/parents make all decisions about food and nutrition until the sufferer is able to eat safely and appropriately him/herself. You plan the meals and snacks, you do the shopping, you do the preparation, you decide the amounts, you

put it on the plate and the sufferer must eat it. The only job for the child in all this for now is to eat what you give him/her. Most parents honour historical dislikes, but strive to reintroduce foods that were previously accepted but became "hated" or feared during the course of the disease.

Typically parents see fireworks at first, but this subsides once the ED works out your daughter/son has no choice in the matter. Counterintuitively, being relieved of the choice of what, when and how much to eat ultimately eases the sufferer's anxiety and they are able to eat what is presented.

Encouraging versus requiring

A key challenge for parents is to understand the difference between **encouraging** the child to eat and **requiring** him/her to eat. Understanding the difference can make all the difference

With **encouraging**, you leave the eating up to the sufferer. Dish up her food (not too much! you don't want her to freak out!) and hope she eats; try to say exactly the right thing that will support her in exactly the right way (not too pushy, mind you!). The truth is nothing you can say will overcome the loud voice of ED in her head that is stridently telling her NOT to eat. She has a loaded gun pressed to her temple telling her not to eat. Your words are not going to win that battle.

With **requiring**, you take the choice away from the sufferer. You dish up the food she needs and do not give her a choice about eating it. Food is her medicine; it's very important that the medicine be taken. **Sit with her until it is 100% gone.** Plan on *long* meals at first. Bring a book if you need to and settle in at the dining room table for a few hours. No phones get answered, no tv's get turned on...all other activities cease.

Research tells us that meals are more effective when families have a behavioural focus on eating (verbal and physical prompting) rather than trying to 'convince' the child to eat or provide child with choices. Verbal prompts may be 'keep eating', 'pick it up and eat it', 'you need to eat all the xxx'. Non-verbal prompts can be pushing plate towards child, putting spoon into hand etc.

Useful things to say

Many parents have found the following mantras useful to say:

"We love you too much to let you starve."

"Food is your medicine; if you are too sick to take your medicine, you are too sick to ____" (fill in the blank: go to school, go to work, watch TV, text, listen to her iPod, etc).

"Eating is not a choice. You can eat here at home or you can eat at the hospital; but eating is not a choice."

Every meal that goes in moves your child closer to recovery; every meal that he/she misses, or every food group that she cuts from her diet, makes her sicker.



Getting Your Child with an Eating Disorder to Eat

Make it Possible For Your Child to Eat

Many parents are desperate for answers to the life-or-death question, “How can we get our anorexic child to eat?”. For some, whose children can only bear a limited range of foods or are locked into a rigid meal plan, the pressing question is, “How can we help our child to eat normally?” With my own daughter I was frustrated with the lack of answers, so once she was well I compiled strategies in a book for parents of children and teenagers, based on the small amount of published research, on our experience and on the know-how of other parents, of recovered people and of therapists.

The ability to get our children to eat is crucial, because both nutrition and the formation of new habits get their brain working normally again.

Whatever our child’s age we all have a lot in common, so you should be able to adapt at least some of the following tips to suit your situation.

Are You Nudging or Taking Charge?

First, be clear about your role. How determined should you be to get your son or daughter to eat – and to eat well? Should you be a gentle guide who assists when your child is willing to receive your help? Or should you assume control and persist in spite of extreme resistance? For many treatment providers, the answer depends on the patient’s age. Yet surely it depends on how the illness is affecting the person: has it removed their willingness to eat? And even when a person is generally willing, does their resolve abandon them at mealtimes?

For people suffering from anorexia aged 18 or under, the best evidence is that parents should initially take charge of their child’s eating, after which the youngster is assisted to regain an age-appropriate level of autonomy. This is the essence of family-based treatment¹ (FBT is also called ‘The Maudsley Method’).

Therapists guide parents to:

- prevent behaviours driven by the eating-disorder (such as purging, exercising or bingeing)
- get their children to eat what they need at regular intervals
- rapidly bring them up to a healthy weight if they are underweight.

With this treatment we are not waiting for our children to engage with the process and we don’t need them to have motivation. We are carrying them to good health whether they like it or not. If we can’t do it (because no single approach works for everyone) then hospitalization will bring them back to safety, after which we will be in charge again.

Youngsters suffering from bulimia are more likely to have motivation and the ability to engage with treatment. Family-based treatment for bulimia offers more teamwork than for anorexia, but parents remain mostly in charge.

For young adults with anorexia (age 17-25), family-based treatment is currently being adapted² so that parents are hands-on but there is some level of buy-in from the patient.

Traditionally, over-18s suffering from any eating disorder are expected to engage in individual therapy and to take responsibility for their treatment. There is no research to indicate what contribution parents should make. In general parents are either not involved, or are offered skills to give gentle support (as in ‘The New Maudsley Approach’), nudging their loved one towards safety.

This is fine if gentle guidance is all it takes for your child to eat, and during the later phases of treatment it's appropriate to be increasingly hands-off. But in the early stages, restrictive eating disorders put up a tremendous fight when there's food on the plate. Which means if all you plan to do is 'nudge', you may back off at the very moment your barefoot child needs to be carried over the burning sands. Some parents see that their son or daughter is too consumed by the eating disorder to engage with treatment. Rather than wait for admission to an inpatient unit they attempt to take charge of food just as they would with a teenager.

Whether you take charge or just guide, you can do so with a supportive, compassionate, non-punitive approach, which you can adapt to age and circumstances. This is what I'll talk about here.

It's Not that Our Children Won't Eat, it's that They Can't

To be effective you need to try and understand your child's internal world. You should assume he or she finds it near-impossible to eat because eating – even just the thought of eating – doesn't 'just' create a feeling of disgust, it doesn't 'just' create discomfort in the belly, it actually triggers fear. You might reason there's nothing to fear about food but then you don't have a brain disorder that responds to food with a flood of anxiety-producing chemicals, and that responds to hunger with feel-good hormones. Given that anorexia creates a state of near-constant anxiety, it makes sense that a sufferer should avoid eating with all their might, even if it means fighting you, lying, and giving up on everything they used to value.

Fear is not just abstract for some people with an eating disorder. Sometimes they have an internal bully, a critical voice which feels as real as a hijacker holding a gun to their head: if they collaborate with efforts to eat, they will pay dearly for it. If we keep this image in mind we are more likely to be compassionate towards our children and not take their hostile reactions personally, and indeed family therapists teach us to separate the child from the eating disorder³.

With our compassionate support, our children's fear levels tend to be lower. But we don't wait for that to happen. We put food on the table and support them to eat in spite of how horrible it is for them.

Compassion is the Guiding Principle

Family-based treatment doesn't tell us how to get food into our children. It gives us one important principle, though: we should aim to give unconditional acceptance. That means we try not to judge, blame, or criticize our children even when we hate their behaviour. With parents who are very hostile and critical, outcomes are poor. It doesn't mean we parents have to be perfect – every single one of us has bad days and our children still recover.

The Main Tools to Help Your Child to Eat

How have you helped your children cope with injections? How did you support them to go to school when anxiety gave them a 'sore tummy'? And how would you like to be supported if you had to take a bungee jump?

The same principles apply when you're helping your child to eat in spite of fear. I'll outline a few here:

- You can remove wiggle-room and indecision, making eating a non-negotiable requirement (many children later reveal what a relief it was that their parents took the decision to eat away from them).
- You can make all the food-related decisions: you plan, shop and cook without your child and plate up the food you require him or her to eat.
- You can show calm confidence, compassion, patience, non-judgement – and as it takes practice to manage that⁴ even some of the time, fake it till you make it.
- You can exude competence and know-how so that your child trusts you.
- You can be unrelentingly persistent, determined and focused.
- You can put across hope and a vision of good things to come.

- You can give eating prompts over and over again: end most of your sentences with “Have a bite now”, “Please eat the potatoes now”, or “Keep going”. This is one of the few strategies for which we have some evidence⁵.
- You and your partner can work as a team and show you’re united on what and how much your child must eat.
- You can validate your child’s unpleasant feelings as perfectly normal, harmless and short-lasting.
- You can address your child’s resistance (hostility, hysterics, tears) with compassionate communication⁶. It’s common for our children to react to anything we say, but silent empathy can work wonders.
- You can offer distractions (before, during and after the meal) in the form of games, movies, non-food-related chat, and friends.
- You can track subtle signs of what’s going on for your child in order to steer each moment as skilfully as you can: this will help you guess when it’s useful to keep encouraging, to wait, to comment on progress, or be silent.
- You can step back after a meal and review what support you need to keep going.

There are also a whole lot of things we parents learn to stop doing while we’re supporting a meal.

- Most of us find that while food is on the plate it’s best to avoid using logical arguments or lecturing on nutrition⁷. We refuse to discuss calories, quantities, weights.
- We avoid giving choices or serving alternative foods until our children are more able to cope with decision-making.
- Some of us find it helps our children to know in advance what will be served, and some of us find the exact opposite.
- We avoid making deals that we’ll have to backtrack on next time.
- We avoid shouting and blaming, and we excuse ourselves and leave the room before we lose control.
- When we think our child can’t eat any more, we try one more thing.
- We don’t let our fear or our child’s fear stop us from supporting our child to eat.

Examples

In case the above is too abstract, let me give you a flavour of what I mean with some examples. If my form of words doesn’t work for you, don’t give up – either you need more context to understand how to shape your responses, or you need more tools, and there’s lots more on my website, in my book, and in parents’ forums (I like FEAST⁸ and EDPS⁹).

Your child: “I’m not eating this.”

You: “I understand. That’s a really normal reaction. I’m going to help you. Please start.”

Your child: “I’m too fat. You’re making me fat.”

You: “That must be such a horrible thought. No wonder you’re feeling so rotten with a thought like that. I’m sorry about what you’re going through. Would you make a start please.”

Your child: “I’ve been sitting all day. I don’t need all these calories.”

You: “Trust me. What’s on your plate is what you need to be well and feel good. Go ahead darling.”

Your child: “I’m not hungry.”

You: “I can see that makes it hard. You know food is the medicine you need right now? Please start.”

Your child: “Did you put cream in this? / How many calories is this?”

You: “For now, sweetheart, I’d like you to leave food stuff to me and Dad.”

Your child: “Do I have to eat this?”

You: “Yes, love. Let me tell you this crazy thing the dog did this morning.”

Your child: "I hate you!" [Tips half of the plate onto the floor, gets up]

You: "Please don't do that – I find it so boring to clean up. I'm guessing you're doing that because this is really hard for you, right? Scary? Hmm. That's a really normal feeling. It will pass. I'll get you a new plate, and meanwhile why don't you fire up the TV?"

Your child: "If I eat this, then next time you'll be putting a whole pot of cream in."

You: "What matters is right now. I'm guessing it's really hard for you right now?"

Your child: [tears]

You: "May I give you a hug? No? OK, so I just want you to know it's normal this is hard. It will pass. It will get easier. I love you. I have learned loads about eating disorders and we're doing all the right things for you to get your happiness back. Now have a bite. So I was telling you about the dog..."

Any of the responses above could lead to food being eaten. After a while your child might need just one reminder that eating is required. But at the early stages most of us need to be persistent. Accept that resistance is a sign you're doing exactly what's needed to carry your child out of the eating-disorder whirlpool.

Normal Life on Hold

In order to support our child to eat one meal after another (and perhaps to stop exercising, purging, or self-harm), most of us have to make changes to our life for a few weeks or months. The risk with this is that we end up with so many unmet needs that we lose touch with our inner power and our compassion. If we're going to support meals, we parents must make it a priority to source practical and emotional support for ourselves.

Our child's normal life can be on hold too for a few weeks or months. When my daughter was well enough to go to school but weight gain was a priority, breakfast was non-negotiable. This meant that sometimes she was late to school and sometimes she didn't make it at all because I wouldn't let her go on an empty stomach.

Have a Plan B

Think ahead what you will do when in spite of your best efforts, your child doesn't eat some or all of the meal. This will give you the courage to re-feed boldly and fast. Have what some parents call a 'Plan B'.

Depending on risks, on what you need to achieve, and on your resources, your Plan B might be about:

- medical safety: you'll insist on rest and you'll cancel activities; you'll take your child to the hospital.
- getting the required calories in: you'll provide an alternative food or an energy drink; you'll make up for lost calories at the next meal.
- showing the eating disorder that resistance from now on is pointless because you are consistent in requiring 100% nutrition: some parents use reward and punishment, some are ready to stay at the table for many hours, while some (including myself) persist with steadfast compassion; if this doesn't work you need to move to another Plan B item.
- marking the end of the meal while maintaining your position of trustworthy, compassionate leader or guide.

Regarding this last point, here are ways it might work for you:

- you find a way to end the meal without blame and without looking defeated
- you have someone ready to take over before completely losing your temper and making things harder for next time
- if most of the food is eaten or if this meal is about tackling a fear food (more than about nutrition), you choose to end on success and an acknowledgment of the courage it took.

Learn More

I hope this gets you started and that you experience successes you can build on. Give yourself kindness for the heroic work you are doing, take stock of the support you need, and ready yourself for the next meal.

We parents are very good at guilt, so if the tips outlined in this brief article don't work for you and you blame yourself, I have two suggestions for you.

First, you could recognize that for some people at a particular phase of the illness, treatment requires an entire specialized team. If your child is being fed in the hospital right now, use the time to recover your energy and learn as much as you can, so you can take over again when your child is better.

Next, you could learn more. This article only provides an overview of what is at times an extremely difficult job. An FBT/Maudsley therapist will guide you through a family meal during your second session. If you get multi-family therapy there will be meals too. To get more learning and support, make use of these additional sources:

- Your clinicians (additional mealtime coaching helped us turn the illness around).
- Parents' forums, in particular the FEAST forum, and the FEAST or EDPS Facebook groups. Read their resource files or discover a diverse range of approaches by following conversations. (Remember that while parents are understandably passionate about the precise thing that worked for them, there is no single validated way of feeding your child).
- My book 'Anorexia and other eating disorders: how to help your child eat well and be well'¹⁰ goes into a lot more depth, with chapters on helping your child to eat, on exposure and desensitization, on compassionate communication, with many tips, examples and scenarios.
- 'Help your teenager beat an eating disorder'¹¹ by Lock and Le Grange, who developed and continue to research and improve Family-Based Treatment (FBT/Maudsley) takes parents through the approach. Their 'Treatment manual for anorexia nervosa'¹² is a must for clinicians.

About The Author:

This article was written by Eva Musby, a respected author on eating disorders, whose daughter suffered from anorexia.

¹ <https://www.mirror-mirror.org/family-based-treatment-for-anorexia.htm>

² <https://www.mirror-mirror.org/treatment-for-young-adults-with-anorexia.htm>

³ <https://www.kartiniclinic.com/blog/post/telling-your-kid-apart-from-ed>

⁴ <https://youtu.be/kRFz6rB8bHE>

⁵ <http://eatingdisordertherapyla.com/parental-direction-works-but-dont-expect-your-kid-to-be-happy-about-it-research-on-the-family-meal-in-fbt/>

⁶ <http://anorexiafamily.com/emotional-support-parents-anorexia/>

⁷ <https://youtu.be/2O9nZAWCkLc>

⁸ <http://www.feast-ed.org/>

⁹ <https://www.facebook.com/groups/EatingDisorderParentSupport.E/>

¹⁰ <http://anorexiafamily.com/order/>

¹¹ <http://amzn.to/1PsuGAz>

¹² <http://amzn.to/1PsulZc>

Why your teen probably won't want to do FBT, and why you should feel free to do it anyway



Lauren Muhlheim, Psy.D., FAED, CEDS-S

Editor's note: Family Based Treatment (FBT) is one of many effective, evidence-based treatments for eating disorders. Treatment is not a one-size-fits-all approach; it should be tailored to the individual and will vary according to both the severities of the disorder and the patient's particular problems, needs, and strengths.

When I consult with parents who are considering treatment for their teen with an eating disorder, I advise that there are many things to consider. There are several different types of treatments. Family-based treatment (FBT) is an evidence-based treatment, with the best research support for the treatment of teens, and it requires parents to play an active role. I recognize that FBT is a big commitment for families, and I don't judge parents who do not feel up for the challenge.

I am an FBT enthusiast. I love doing FBT with families. At the same time, I fully admit that FBT is not for every family. It requires a degree of time commitment, active management, and capacity to tolerate distress that may not be practical for every family.

The weakest reason I get for rejecting FBT is that the teen does not want to do it. In my opinion, the child's perspective should have no bearing on whether you decide to use an effective, research-supported treatment to help them.

Imagine that your child had cancer and the most successful treatment for that cancer was a course of chemotherapy that would make the child uncomfortable and sick. If your child told you he didn't want to have that treatment, wouldn't you insist anyway? There are child decisions and adult decisions, and I believe that choosing the treatment your child receives for a life-threatening illness is an adult decision.

When I work with families, informed consent dictates that at the beginning of treatment I lay out what FBT will entail. When I describe that all meals must be supervised; that you should go to school to have lunches with your child; that sports should be curtailed; that sleepovers and other outings with friends will need to wait; that your child may require supervision between meals and in the bathroom as well; and that weight gain should be one to two pounds per week until your teen returns to their recovery weight—your teen (and their eating disorder) hears me.

Their eating disorder is understandably extremely threatened by the description of this approach and may dig in and resist. Further, no teen is excited by this level of supervision; barely any are willing to sign on to such a program! And why would they want to? Teens prize their independence and privacy. Most don't see their eating disorder as a life-threatening illness, which is a symptom of

the eating disorder. This blinds the teen to the very existence of the disease. I don't expect any teen to ever willingly agree to FBT. You shouldn't expect them to either—but that should not stop you from undertaking a treatment that is in their best interest.

I hear people say that it's cruel, unusual, or controlling to insist that a starving child eat and to firmly steer them through the healing process. I reject this opinion. Administering medicine in the form of food to your starving child is an act of love and compassion. Choosing to not do FBT is choosing to not take the strongest possible stance and assert your role as a key member of your child's treatment team.

Here's a common response from the family's perspective. The mother (not a patient of mine) commented:

Of course, she didn't want to do FBT—she was a 99% independent 17-year old with a car and a job and a college acceptance letter. Luckily, our paediatrician was emphatic that this was life or death and that FBT was the treatment with the most evidence for its effectiveness. It was a huge switch in parenting style for me, and while it was terrifying at times, it worked, and I got my feisty, fierce, full-of-life girl back.

From the teen (now a young adult):

I don't really remember a lot from the beginning of FBT because I was badly malnourished and what I do know is that there is just no way I could have chosen to eat; it had to be my parents taking charge because I couldn't. I am so grateful they did what they had to and gave me my future back.

As you decide which type of treatment to pursue for your child, I encourage you to consider what you think is in the best interest of your teen and their future health. That is your job as the parent. Fortunately, FBT is a treatment that you can pursue without their agreement. The alternatives are often less effective.

Lauren Muhlheim, Psy.D., FAED, CEDS is a psychologist and eating disorder specialist who provides evidence-based treatment for eating disorders in the outpatient setting. She directs Eating Disorder Therapy LA¹ in Los Angeles and is able to provide teletherapy in California and New York. She is active in several professional organizations and presents nationally to parents, professionals, and trainees. She is the author of 'When your Teen Has an Eating Disorder: Practical Strategies to Help Your Teen Overcome Anorexia, Bulimia, and Binge Eating'², published by New Harbinger Publications in September 2018.

¹ <https://www.eatingdisordertherapyla.com/>

² https://www.amazon.com/When-Your-Teen-Eating-Disorder/dp/1684030439/ref=sr_1_1?ie=UTF8&qid=1536616027&sr=8-1&keywords=muhlheim

My Daughter Does Not Want To Recover From Her Eating Disorder

By Laura Collins

One of the strangest, and most dangerous, symptoms of an eating disorder¹ is "not wanting to recover." Parents panic or get understandably angry when their child denies being ill, hides the eating disorder behaviours, and lashes out at anyone trying to help. We see a horrible illness that is sapping the life and personality from a beloved child – yet they seem to embrace it. What can parents do when a son or daughter says, "I'm not ill and I don't want to get better?"

First Step: We Have to Change Our Response

The first thing to do is to change how WE think of the illness², and of their resistance. When I hear that a patient with anorexia or bulimia or other eating disorder "doesn't want to recover," I don't hear "denial," I hear "anosognosia." This means "brain-based lack of insight into the seriousness or existence of a medical condition." Anosognosia is also a symptom of other organic or traumatic brain damage, and common in bipolar illness and schizophrenia (*Impaired Awareness of Illness (Anosognosia): A Major Problem for Individuals with Bipolar Disorder*³). The difference with eating disorders is that the anosognosia abates as the patient recovers.

Malnourishment causes damage to the brain and often a temporary blindness to certain sensations and insights. This isn't under the control the person and no amount of anger or logic on our part helps them "see" what we do if they are in certain stages of the illness. In addition, because some of the symptoms of eating disorders are ones society seems to value – like the pursuit of thinness and self-control – the patient is often encouraged in these symptoms or they are mistaken for healthy impulses.

Seeing Resistance to Eating Disorder Recovery as a "Can't" vs. a "Won't"

I find it very helpful to see these thoughts and this lack of motivation as a "can't" and not a "won't." Instead of being angry or frightened by a loved one's lack of insight we can choose to think of this as a symptom and something that they can't do YET. We can hold the optimism and the seriousness in our thoughts and actions until they can.

Parents usually find that anger doesn't work. Logic and pleading and punishment don't help. Compassion, commitment, and firm response can help a lot, however. We can insist on restoring the brain, keeping the loved one going to treatment appointments, and providing an environment where recovery is the goal and optimism is the mood – even when they cannot.

We can connect on an emotional level, instead of a logical one, by being unconditionally loving regardless of what the ill person does in response. We have to believe in the real person, the well person inside, and not allow ourselves to become embittered or defensive even when our loved one is irritable or combative. This is very, very hard. We are connected to our children and not used to separating them from their thoughts and behaviours – but we must try.

Brave Parenting: Not Needing Their Love

We can do the bravest thing of all for many parents: not need love or friendship or agreement from our children. They don't have to agree with or understand what we are doing in response to their illness. They don't have to like it or like us. Our responsibility is to "do the thinking for both of us" on behalf of the real person inside – until they can.

Motivation to recover is not required for the early stages of eating disorder recovery⁴. In fact, whether a patient is voluntarily or involuntarily brought into care has little impact on the success of treatment and does not mean the patient will permanently resent us .

I speak with former patients all the time who are grateful to those who listened to their needs and not their words, and those who were silently rooting for those who refused to listen to what they said aloud. I speak with parents who are amazed to discover that when they stop arguing and stand firm that their ill loved one becomes compliant instead of more combative. Parents often find their child feels safer and less anxious when the parent is firm and direct.

Eating disorders have been looked at as a form of self-expression for a long time, and so it follows that we have seen motivation to recover as a necessary factor in recovery. I agree: but the motivation is often a sign of recovery and need not be the price of admission.

It is our job as parents to "want recovery" until our dear children can.

APA Reference

Collins, L. (2010, May 12). My Daughter Does Not Want to Recover From Her Eating Disorder, HealthyPlace. Retrieved on 2019, July 31 from <https://www.healthyplace.com/blogs/eatingdisorderrecovery/2010/05/my-daughter-does-not-want-to-recover-from-her-eating-disorder>

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³ <https://www.healthyplace.com/bipolar-disorder/medication-noncompliance/impaired-awareness-of-illness-anosognosia/>

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After Weight Restoration: The Role of Insight

One of the hallmark symptoms of Anorexia Nervosa (AN) is anosognosia¹, or a brain-based inability to recognize that one is sick. For this reason, most patients have little or no insight when they first present for treatment. Even months into effective treatment, most patients with AN continue to demonstrate anosognosia from time to time, if not consistently. The irony here is that most patients with AN do not believe they are sick until after they have gotten well.

I am outspoken in my belief that insight² is unnecessary, not to mention unlikely, in early recovery from Anorexia Nervosa (AN). I do not expect my patients to have any insight whatsoever early on in their treatment with me. I expect kids with AN to present in my office denying that they have a problem. Their lack of insight does not delay or undermine treatment one bit.

In Family-Based Treatment (FBT)³, the patient is not required to demonstrate any insight at all during Phase I (Re-feeding and weight restoration). Phase II (returning control of eating to the adolescent)⁴ and even Phase III⁵ (establishing a healthy adolescent identity) can be successfully completed with a relatively small amount of insight on the patient's part.

The re-feeding and weight-restoration components of treatment can be achieved without the patient's consent or compliance. Through FBT and similar family-centred approaches, parents can feed their children complete, balanced nutrition and ensure that they maintain a healthy weight for as long as necessary. In theory, a patient could exist in an externally-maintained state of physical health forever, which would be far better than suffering the long-term medical and psychological consequences of AN. But this is not recovery.

Children and younger teens tend to lack the maturity to develop good insight even after their AN has been in remission for quite some time. Lack of insight is completely normal at this stage of development, even for kids who have never had a brain disorder. It is not necessarily problematic for recovering adolescents to lack insight as long as they are living safely under their parents' roof.

For older adolescents and young adults, however, there comes a point later in recovery, after physical health is restored and most mental symptoms have subsided, when a patient does need to develop some insight about their illness and "own their recovery." Patients do not need insight to get well, but they certainly do need insight in order to live a healthy, fulfilling, independent life.

As a side note here, the type of insight I am referring to here has nothing to do with "discovering the root cause" or "learning to love yourself" or "finding your voice" or any of the other talking points commonly referenced in ED recovery circles. The important insights to gain, in my opinion, are the following:

1. Acknowledging and accepting that you have (or had) an eating disorder, which is a biologically-based brain illness that you did not choose to have and your parents did not cause
2. Acknowledging and accepting the possibility of relapse
3. Ability to recognize eating disordered thoughts, feelings, and behaviours in yourself

4. Understanding the necessity of maintaining full nutrition, every day, for life
5. Accepting the necessity of maintaining your ideal body weight in order to reduce the risk of relapse

How do you help a person who is recovering from AN to develop insight? It's tricky, and it varies considerably based upon the patient's own unique experience of having AN. Unlike full nutrition and weight restoration, insight cannot be thrust upon someone against their will. The patient must be an active participant in the process.

I find it helpful, as a therapist, to have frank conversations with patients and their parents about the biological basis of AN⁶, potential triggers, vulnerability to relapse⁷, and the importance of practicing good self-care. A single conversation at the start of treatment is rarely sufficient. Instead, I integrate these conversations into most of our sessions to help the patient absorb and internalize this information. For the first few months of treatment, these discussions are primarily for the benefit of the parents, as most kids are too malnourished and shut-down to process this information. However, after weight restoration and brain healing, these discussions can have a powerful impact on recovering kids.

Parents often have these insight-building conversations with their recovering teens at home. Often, teens will get defensive, shut down, or lash out when parents bring up these topics. But sometimes kids actually listen!

Many weight-restored patients go through a phase of romanticizing their AN, longing to return to the days of extreme thinness, perpetual motion, and hyper-focus on academics and athletics. While these feelings are understandable and typical at a certain stage of recovery, they need to be counterbalanced with conversations about the negative impact AN had on their bodies, their minds, and their lives. Otherwise, it is all too easy for recovering people to view AN through "rose-coloured glasses."

Bear in mind that the development of insight can take years. Recovered teens who initially presented for treatment at age 13-14 (the typical age of onset) will often show a blossoming of insight around age 17-18, just as they are preparing to leave home for college. This newfound insight is often the result of a variety of factors, including consistent full nutrition, brain healing, normal adolescent developmental processes, maturity, frontal lobe development, and successful therapy. I have worked with many adolescents for whom this happens beautifully, organically, and right on time. These kids go off to college in other states and thrive.

In other cases, however, the timing may be far less convenient. Those who develop AN at 16 or 17 years of age may not be sufficiently recovered to develop the insight needed to manage their illness independently at that magical age of 18. Similarly, who relapse during their junior or senior year of high school may have a setback in the process of insight development and thus may not be ready for independence right after high school.

In some cases, kids are diagnosed in childhood or early adolescence but don't receive effective treatment until late adolescence. In these cases, it may take even longer for insight to develop if the illness has become entrenched and emotional maturity lags far behind chronological age.

Further, teens who have suffered through months or years of ineffective treatment⁸ may have built up an arsenal of bogus myth-based insight that has nothing to do with the reality of their illness. For example:

- “I developed AN as a way to cope with feeling out of control in life.”
- “I have to want to get better on my own. I have to do this for myself.”
- “Re-feeding doesn’t help us discover the root cause of your illness.”
- “I am enmeshed with my parents and this is keeping me sick. I need to become more independent.”

These myth-based “insights”⁹ very often result in parental alienation and protracted illness.

As you can see, all insight is not equal. The insights worth having are those that are based in empirical science, those that empower parents to help their offspring recover, and those that serve to help patients achieve and maintain their physical and mental health while living a full and meaningful life.

Written by Dr Sarah Ravin



Welcome to my professional blog¹⁰. I am a Florida Licensed Psychologist and trained scientist-practitioner. In 2008, I received my Ph.D. in clinical psychology. A major component of my professional identity is staying informed about recent developments in the field so that I may provide my clients with scientifically sound information and evidence-based treatment. There is a plethora of information on the internet about Eating Disorders, Depression, Anxiety, Psychotherapy. Unfortunately, much of this information is unsubstantiated and some of it is patently false. It is my hope that by sharing my thoughts and opinions on psychological issues, with scientific research and clinical experience sprinkled in for good measure, I can help to bridge the gap between research and treatment.

¹ <http://www.treatmentadvocacycenter.org/problem/anosognosia>

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³ <http://psychcentral.com/news/2010/10/06/family-based-treatment-best-for-anorexia/19248.html>

⁴ <http://www.blog.drsarahravin.com/eating-disorders/navigating-phase-ii/>

⁵ <http://www.blog.drsarahravin.com/eating-disorders/navigating-phase-iii/>

⁶ <http://www.blog.drsarahravin.com/eating-disorders/expanding-our-minds-towards-a-biologically-based-understanding-of-eating-disorders/>

⁷ <http://feast-ed.org/TheFacts/RelapsePreventionContract.aspx>

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⁹ <http://www.blog.drsarahravin.com/eating-disorders/why-psychodynamic-therapy-is-harmful-for-eating-disorder-patients/>

¹⁰ <http://www.blog.drsarahravin.com/>



At Home with Eating Disorders Conference – Melbourne 2015

Trouble Shooting Common Difficulties for Adolescents with Anorexia – Workshop Handout

DIFFICULTY	UNDERSTANDING THIS BEHAVIOUR	YOUR RESPONSE	YOUR INTERNAL DIALOGUE/MANTRA
MY CHILD WILL NOT EAT Major difficulty for parents is getting their child to eat sufficient food for weight gain required for health Most adolescents are usually willing to eat what they consider “healthy food” – usually their version of healthy food is low in calories	Fear of gaining weight and getting fat Fear that she won't be able to stop eating Fear that he will lose control as anorexia makes them feel in control Fear what others will think of them if she gains weight Fear of losing identity STARVED BRAIN FUNCTIONS IRRATIONALLY	Love and compassion Calm, firm, and confident manner – your firmness and confidence provides a containing boundary that makes your child feel safe A supportive manner despite displays of aggression and rejection towards you Non critical manner – try to avoid blame and criticism Need to show your child that you know what you are doing and that you have control of situation. This creates safety and also relief that they don't need to make a decision. Focus on the immediate task and one mouthful at a time	She is scared and can't make appropriate decisions. It's not my child saying that to me, it's the anorexia He needs to eat to get healthy. This is the only way to get my child back She needs us to help her. She can't fight anorexia on her own. The body needs fats to be healthy. It's the anorexia stopping him from eating food he likes. My child's brain is under nourished and is in need of food.

Note: These are common difficulties and solutions observed during Family Based Treatment for adolescents with anorexia. We recommend you use this handout within the context of FBT treatment.

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DIFFICULTY	UNDERSTANDING THIS BEHAVIOUR	YOUR RESPONSE	YOUR INTERNAL DIALOGUE/MANTRA
MY CHILD IS DISTRESSED Helping your child and trying to defeat anorexia 'head on' will inevitably bring on challenges Many parents struggle when they see their child so distressed and feel that they are creating further stress when they try and push refeeding This can create high levels of distress within family environments Parents often feel distressed and exhausted themselves	Child becomes overwhelmed with above fears Child struggles to regulate their emotions Child can either internalise or externalise their distress	Connect with your child's distress Be prepared to sit with your child and your own distress Remain Calm, Consistent & Compassionate Distraction, distraction, distraction... Develop a distress action plan Remain focused on food and nutrition Take some time out to recharge your batteries	Food is the only thing that will get rid of her distress Getting him healthy is the only way to get rid of his distress Her aggressive behaviour is a cry for my help. Anorexia is tormenting her, all I have to do is feed her.

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DIFFICULTY	UNDERSTANDING THIS BEHAVIOUR	YOUR RESPONSE	YOUR INTERNAL DIALOGUE/MANTRA
PARENTS STRUGGLING TO WORK TOGETHER Parents can find themselves struggling to work in unified and consistent approach Parents need to make many joint decisions about their child's treatment and recovery which can create tension and conflict	All parents have different personalities and roles in a family A distressed child raises parental anxiety and helplessness Anorexia will find the tiniest gap in your armour to split parents apart making it difficult to help your child Anorexia thrives on disunity between parents The demands on parents to get their child well and continue to run a family home (including looking after siblings) is very challenging	Knowledge is strength – understand an ED and impact on your child. Be clear what you both expect from your child, what you will tolerate from your child. Have a clear plan how you will respond to your child's distress/eating etc. Team tag if you feel that you are getting angry & frustrated, but don't not let your child feel this is their fault. Don't make your child feel guilty as they are not doing this on purpose Be prepared to ask for support from extended family etc.	My child needs us/me to get through this We need to make her feel that we understand so have to give her the same message We are going to get through this one meal, one day at a time United we stand, divided we fall I/we need to find a way to problem solve our difficulties (refer to attached problem solving wheel)

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DIFFICULTY	UNDERSTANDING THIS BEHAVIOUR	YOUR RESPONSE	YOUR INTERNAL DIALOGUE/MANTRA
MY CHILD IS NOT COPING WITH ANOREXIA THOUGHTS Parents are often puzzled by their child's lack of insight and anorexia thoughts eg. I'm not thin, I'm not unhealthy, I don't need to get better etc Parents get frustrated and helpless when the anorexia thoughts dominate their child's mindset and behavior Parents feel concerned with the mental struggle their child is facing when weight gain is occurring	Your child's thinking becomes more rigid and inflexible when the brain is malnourished Pre-existing (before the eating disorder) personality traits may also influential eg. perfectionist, rigid, anxious temperament etc The longer this type of anorexia thinking and behavior exists, the more entrenched it can become	'Food is the medicine' – gives the best chance to repair the brain trauma of malnourishment and anorexia thinking patterns Try not to debate anorexia's thoughts and remain focused on eating adequate food as the solution Focus on distraction activities to give your child's mind a break from anorexia Tune into your child's 'healthy thinking' eg. <i>'Good to hear you want to have more energy', 'Great you want to get back to having fun and sport with your friends'</i> When physical health and eating has started to improve, get them slowly re-engaged in adolescent life - friendships, hobbies, safe risk taking and autonomy	More food= better brain functioning, thinking + better emotional health Direct prompting to eat food is better than debating anorexia I/we will build our child's character and personality to fight the anorexia's focus on 'thinness' What activities and interests can we get her back involved in to distract from anorexia's thoughts?

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FURTHER TIPS TO MANAGE YOUR CHILD

CHILD WILL NOT EAT

Best to include variety and fear foods right from the start of refeeding, otherwise when you do introduce fear foods it will like starting all over.

Don't get caught in the trap that "healthy food" will get your child better. Anorexia is basically fear of food and in particular high density foods. You will know your child has recovered when she can eat everything without fear and a good sign of recovery is when she can eat everything she ate prior to AN.

At meal times don't get in the habit of negotiating, convincing, lecturing, using logic, it is likely to fail and it's a good AN tactic to waste/avoid refeeding time. Instead, stick to direct prompting (over and over again) to eat the food you provide your child at meal times as this will wear the anorexia down.

Don't fall into the trap of giving her what you think she will accept (this is accommodating your fear), give her what she needs to get healthy.

Don't get your child involved in food preparation, planning, calorie counting with them, shopping or any decisions involving food as their current focus will be on the reduction of calories and eliminating fear foods. Just put meal in front of your child and provide support.

Make sure you know how much your child needs to eat to gain weight and foods that will achieve good weight gain. Whilst parents are usually very good at knowing what to feed a healthy child, they need to learn quickly how much to feed a starving child.

Don't expect that your child will be able to make decisions about what to eat, his thinking is too compromised to do this and he will feel guilty whichever decision he makes. He is in a "no win" situation and will be relieved that someone has made the decision for him.

Try not to talk about healthy eating, but talk about normal eating. Normal eating is what the average healthy adolescent does – variety, regular, flexible and eating with enjoyment without fear.

Be prepared for resistance/battle with Anorexia. There will be a battle until your child gets the message/believes that you are stronger than the anorexia and will not budge because you will not let anything happen to them. The strength of the battle will vary with every family depending on: the strength of the anorexia, your child's personality and characteristics, family dynamics that arise and co-morbidity (other mental health issues). The strength of your persistence needs to match the severity of the illness and your child will find it containing. Learn to be decisive against the anorexia.

Try and stop all the anorexia behaviours at meal times as quickly as possible, eg breaking food into small pieces, eating with a teaspoon, etc as they strengthen the anorexia. Every time you push your child past her fear boundary it will get easier (it's like exposure therapy).

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CHILD IS DISTRESSED

Try to connect with your child's distress by showing that you understand how hard this is for them while at the same time not wallowing in their distress – if you are drowning you want someone to pull you out not drown with you.

Know what your child likes and have distractions ready to give her a breather or take her mind off the situation. – parents have used playing games, favourite tv shows, YouTube funniest videos, humour, there are a lot of sites on the internet eg Pinterest where you get ideas of how to help distract your child.

Following meals when adolescent feels disgusted in what they have eaten, get your child interested in a low calorie activity. For adolescents that love art Zentangle exercises are brilliant, musical adolescents – music, Good site for relaxing music is PANDORA.

Regular deep breathing exercises and mindfulness for young people (smiling mind) can help to better manage anxiety

PARENTS ARE STRUGGLING TO WORK TOGETHER

Make a clear and detailed plan that you both agreed to regarding what your child needs and try to stick to it. It's containing and gives the anorexia very little room to split you. Use the problem solving wheel attached.

If you feel out of control – leave the situation and get your partner to take over with the same approach. It is important to remain unified and consistent in approach.

Be aware of self-care needs. You can't help your child if you are not fully functional.

Constantly remind yourselves that you will get through this. Many parents initially feel they can't see the light at the end of the tunnel. Focus on a meal at a time and a day at a time it won't seem so daunting.

Complement each other of every little success and celebrate the successes together.

Note: These are common difficulties and solutions observed during Family Based Treatment for adolescents with anorexia. We recommend you use this handout within the context of FBT treatment.

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CHILD NOT COPING WITH ANOREXIA THOUGHTS

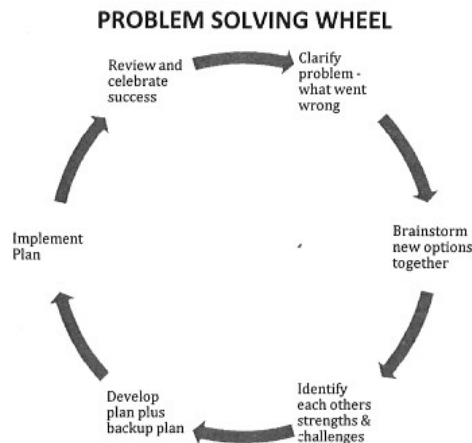
Don't get caught up in a debate with anorexia thoughts - about weight and shape, dress sizes, how good they look as this will only increase anxiety.

Get rid of scales, mirrors, tight clothes as she gets healthier, these are only reminders pulling her back.

Keep him focused on the future and the positive goals he wants to achieve.

Again, use the same distraction activities outline above that give your child a break from anorexia thoughts

When eating and physical health has improved, get them back to their activities and interests or introduce new ones. This helps them focus their minds on building their character, qualities and skills, which is essential in adolescent development.



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Why Full Anorexia Recovery is Crucial for Brain Health

By Lauren Muhlheim, PsyD, CEDS¹

Anorexia nervosa² (AN) is an illness defined by restriction of food, often resulting in malnutrition. Malnutrition affects every system of the body, and the brain rarely escapes malnutrition's impact.

Brain Changes

AN is accompanied by changes in mood and thinking. Patients frequently have symptoms of anxiety and depression that do not predate the eating disorder or are exacerbated by the AN. Ancel Keys' Minnesota Study documented that anxiety and depression were among the symptoms that presented in healthy men put on a semi-starvation diet. Additionally, individuals with AN often withdraw socially, become more rigid and fixated in their thinking, and frequently have little insight into their illness. One parent described her daughter, "As if the physical decline was not scary enough, she became a different and frightening person. She would lie and manipulate in order to get out of eating and get her workouts in. She would lie and manipulate to explain away the increasing isolation from friends. When I did attempt to 'just get her to eat,' my report to my husband about how it went would be, 'Her head spun around three times Exorcist-style and venom began to spew from her mouth.'"

Research

There is a general agreement that recovery from AN requires weight restoration and nutritional rehabilitation³. This must be prioritized over insight-focused therapeutic work. Three recent studies on the brain serve to illustrate why this is so important.

A study⁴ by Roberto and colleagues (2010) used MRI imaging techniques to study the brains of 32 adult women with AN before and after weight restoration (to 90% of their ideal body weight) and compared them to the brains of 21 women who did not have AN. The results showed:

- Underweight individuals with AN had significant deficits in brain grey matter volume compared to healthy controls.
- These deficits in grey matter volume improved with short-term weight restoration but did not fully normalize over the course of the 51-week study.
- Researchers concluded: "The correlation between BMI and volume changes suggests that starvation plays a central role in brain deficits among patients with AN, although the mechanism through which starvation impacts brain volume remains unclear."

A study⁵ by Wagner and colleagues (2005) performed MRI brain scans on 40 women in long-term recovery from eating disorders (subjects included patients with both AN and bulimia nervosa). Their

length of recovery ranged from 29 to 40 months (much longer than the Roberto study). Results showed:

- All brain structures in the recovered women were normal in volume and similar to those of control subjects.
- This study suggests that structural brain abnormalities are reversible with *long-term* recovery.

A study⁶ by Chui and colleagues (2008) evaluated 66 adult women with a history of adolescent-onset AN and compared them to 42 healthy female women. The participants received an MRI and a cognitive evaluation. The results showed:

- Participants with AN who remained at low weight had abnormal MRI scans.
- Weight recovered patients had normal brain volumes.
- Participants who currently had lost their menstrual cycles or had irregular menses showed significant deficits across a broad range of many cognitive domains including verbal ability, cognitive efficiency, reading, math, and delayed verbal recall (even if the structural brain changes had resolved).

Brain Recovery

Taken together, these studies suggest a complex interplay between weight status, brain structure, and optimal brain functioning. Brain matter actually shrinks during AN and takes time to recover. Six months after full weight restoration the brain often is not yet structurally back to normal. Yet with enough time at a healthy weight, the brain seems to *fully* recover. The research suggests that by three years after achieving weight recovery, most individuals' brains will likely appear normal physically.

However, even though a brain post weight restoration may look normal, normal brain functioning may not yet have returned. It seems that menstrual function may be a mediator and a better predictor of cognitive recovery than weight (for females) and that full cognitive functioning may not return until menstruation has been maintained for at least six months. This is one reason why the return of and continued menses is such an important marker of recovery⁷.

Parents of patients with anorexia report a range of time, from six months to two plus years for full "brain healing" to occur. What parents usually mean when they report brain healing is that they notice an improved state, "like the patient is coming out of a fog."⁸ Furthermore, parents report that brain healing brings around changes in mood and behaviours such that patients seem more stable in their recovery and "back to their former (pre-illness) selves." One book for parents is even entitled, "My kid is back."

It is important to recognize the catch-22 of AN recovery. Individuals with AN are typically cognitively impaired and require sustained time at a healthy weight for cognitive impairments to fully improve.

Yet, it is partly the cognitive symptoms of AN that make sufferers believe there is “nothing wrong” with them and thus reject treatment, which is a condition called “anosognosia⁹.”

Implications for Patients and Families

The upshot of this research, according to Dr. Ovidio Bermudez¹⁰, MD, Chief Clinical Officer and Medical Director of Child & Adolescent Services at Eating Recovery Center in Denver, is that that parents and treatment professionals cannot afford to compromise on weight gain (Updates in Refeeding Practices for Adolescents with Anorexia in the Inpatient Setting, Eating Recovery Center Professional Development Series). Dr. Bermudez lectures that ill underweight patients need a “brain rescue” so that “psychotherapy and behaviour change can make a difference.”

This is likely one reason that family-based treatment¹¹ (FBT) is often more successful than individual therapy for younger patients. Parents often need to do the heavy lifting for their children who are malnourished. It also illustrates the challenge of treatment for older patients with anorexia who may be trying to achieve recovery with a starved brain. Research supports that only with full and sustained weight restoration are individuals fully able to maintain their own recovery.

¹ <https://www.verywellmind.com/lauren-muhlheim-psy-d-ceeds-1138027>

² <https://www.verywellmind.com/symptoms-warning-signs-of-anorexia-nervosa-1138239>

³ <https://www.verywellmind.com/restoring-nutritional-health-in-anorexia-nervosa-recovery-4115081>

⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816503/>

⁵ <https://www.ncbi.nlm.nih.gov/pubmed/16139807>

⁶ <https://www.ncbi.nlm.nih.gov/pubmed/18676530>

⁷ https://www.verywellmind.com/eating-disorders-periods-and-bone-health-3994438?_ga=2.23910522.1592028168.1530100917-1998032573.1517947540

⁸ <https://www.youtube.com/watch?v=jzylaVomqJg>

⁹ <https://www.verywellmind.com/anosognosia-and-anorexia-3573545>

¹⁰ <https://www.eatingrecoverycenter.com/about-us/leadership/executive-leadership/ovidio-bermudez>

¹¹ <https://www.verywellmind.com/what-is-family-based-treatment-fbt-for-eating-disorders-4052371>

Personal Reflections and What the ANGI Results Mean for Patients, Families, and Clinicians Today: Part 4

By Cynthia M. Bulik PhD

This is the fourth in a series of blog posts about recent results from the Anorexia Nervosa Genetics Initiative study published in Nature Genetics¹. Part 1² details our results, Part 2³ the process, and Part 3⁴ is an interview with Dr. Patrick Sullivan about the future of eating disorders genetics research.

Recently Dr. June Alexander asked me in an interview how I felt when we started ANGI and how I am feeling about the results today. I responded that six years ago, when we started ANGI, I was both daunted and determined. Some people doubted we could obtain blood samples from 13,000 individuals with anorexia nervosa, but to be honest I never doubted that we would. My certainty came from working in this field since 1982! Having worked with people with anorexia nervosa and their families on three continents and across 4 decades, I had a pretty solid sense of how desperate they were for answers and how unsatisfied they were with our current understanding of and treatment of this devastating illness. In addition, I also knew in my heart that the compassion I had seen in so many patients (often before they could recognize it in themselves) would drive their willingness to participate and give back in the hope that others would not have to ensure the suffering that they had. My intuition proved to be correct. I think in our next stages when we expand our sample size and open up recruitment to bulimia nervosa and binge-eating disorder things will go even better because we no longer need blood samples! Technology has advanced in the past six years such that a simple saliva sample will allow us to do the same analyses that we needed blood for in ANGI.

A new explanatory framework. Our results and our conclusion that anorexia nervosa may best be conceptualized as a metabo-psychiatric illness are meaningful to patients and families in that they provide a new explanatory framework for understanding the illness. From my earliest days in this field, the purely sociocultural explanations for anorexia nervosa just never rang true. Sure, dieting to achieve a thin ideal might start the process in some cases, but it sure didn't explain why if we were all exposed to that thin ideal, why we didn't all develop anorexia. Nor did it explain why individuals with anorexia nervosa lost weight far beyond any societal ideal that might show up on the cover of a glossy magazine. Something was missing. So often parents would describe these incredible transformations in their children that marked their descent into anorexia and their relief during recovery when they could see glimmers of their pre-illness child again. Patients described wanting to eat and wanting to be well, but not being able to push through an impenetrable barrier that would allow them to eat and gain weight. I guess you could say that my career has been a quest to find an explanation that actually fit and accurately accounted for the most perplexing aspects of anorexia nervosa.

Some of the most perplexing aspects are: How do people with this illness actually reach and maintain such low weights? Why is negative energy balance (expending more calories than one

consumes) reinforcing for them? Why do their bodies drop weight so quickly even after medically-supervised renourishment? Why does physical activity seem to be more reinforcing than food? Why do they go through a hypermetabolic period during renourishment in which they burn through calories in ways that our equations simply cannot predict? So many unanswered questions. In retrospect, it is crystal clear that all speak directly to a metabolic component to the illness.

The importance of renourishment. Our results do not yet tell us the nature of the metabolic component, in fact, that is an important follow-on topic to be researched. But they do offer some important suggestions about treatment. For example, many of our interventions focus on the importance of restoring and maintaining a healthy weight as a cornerstone of recovery. Family-based treatment⁵ (FBT), specialist supportive clinical management⁶ (SSCM), cognitive-behavioral therapy-enhanced⁷ (CBT-E), and clinical guidelines all focus on the importance of weight restoration and normalization of eating. Yet for one reason or another, many treatments might stop short of these goals—partial weight restoration and partial normalization of eating. Although this is speculative, our results raise the question of whether these partial attempts may inevitably lead to treatment failure or relapse because they do not give the metabolism an opportunity to equilibrate or reset. If a patient is prematurely discharged from an inpatient renourishment program due to insurance coverage, chances are good that they will end up back on the unit at a low weight in the near future, ultimately costing more money and creating more distress for both patient and family.

Avoiding negative energy balance. Similarly, I have always warned patients and families to avoid negative energy balance even after long-term recovery. This recommendation was always just based on clinical observation. Too many times I had seen someone go through a stressful period when they skipped meals, or overseas travel disrupted their eating schedule leading to a full-blown relapse (even after years of recovery). Now, perhaps the explanation lies in our results. Maybe negative energy balance is the switch that engages whatever metabolic process it is that begins the descent into anorexia nervosa. If anything, I feel more confident in that recommendation now given our findings. Basically, anorexia nervosa becomes part of your health legacy. That does not mean that you cannot recover, but it does mean that you need to be vigilant. I draw an analogy to my own back injury. Three bones in my back were broken in 1978 when some drunken fans picked me up and passed me up in the stands at a Notre Dame football game...then dropped me. Those bones healed completely, but I have had to do back-strengthening exercises every day since and be mindful of positions or activities that could place me at risk for a back relapse. The thrill seeker in me would have loved to try bungee jumping, but the risk was too high. That event is part of my health legacy that I need to respect. Likewise, if you had anorexia nervosa, you need to be vigilant for and avoid negative energy balance, because the risk is just too high.

What about genetic risk? Another question that our work raises in people who have had anorexia nervosa is what this means for their next generation. The most important thing to remember is that genetics is not destiny! Anorexia nervosa is a classic complex trait, influenced by hundreds if not thousands of genes of small to moderate effect as well as environmental factors. In fact, you can look at your (and your offspring's) risk as a combination of four factors: genetic risk factors, genetic buffering factors, environmental risk factors, and environmental buffering factors. To increase complexity even more, you can throw in epigenetic factors. In the past, we were limited in being able only to identify environmental risk and buffering factors. Now we can add to that mix the ability

to at least quantify genetic risk (and our confidence in doing that will increase with increasing sample size). We still do not have a handle on genetic buffering factors. It is entirely possible that someone with high genetic risk for anorexia nervosa never develops the illness—due to the presence of genetic and/or environmental buffering factors. Likewise, someone with low genetic risk for anorexia nervosa could develop the illness in the presence of overwhelmingly risky environmental factors. So, neither genetics nor environment is destiny. Parents with histories of eating disorders who are struggling to figure out what the appropriate level of vigilance is as they watch their children traverse the ages of risk for eating disorders are encouraged to visit a genetic counselor. In the past genetic counselors focused primarily on diseases like Huntington’s where the probabilities of transmission were clear. They are now skilled in dealing with more complex diseases like anorexia nervosa and can aid families in understanding and apprising risk. In general, we encourage parents to aim for a gentle balance between being hypervigilant versus blind to emerging signs of an eating disorder. If you are concerned about your child, the best option is to schedule an evaluation and speak with your provider about your concerns and how best to address them. This is an active area of research in the field and we hope to provide additional tools and guidance for parents in the near future.

Once again, we are grateful for all patients, family members, clinicians, advocates, and researchers who participated in ANGI. This has been a remarkable journey and we look forward to teaming up with you again when we roll out our next study, the Eating Disorders Genetics Initiative (EDGI). Stay tuned!

July 15, 2019 · by [cbulik](#) · in <https://uncexchanges.org/author/cbulik/>

¹ <https://www.nature.com/articles/s41588-019-0439-2>

² <https://uncexchanges.org/2019/07/15/anorexia-nervosa-genetics-initiative-angi-part-1-the-results/>

³ <https://uncexchanges.org/2019/07/15/anorexia-nervosa-genetics-initiative-angi-part-2-the-process/>

⁴ <https://uncexchanges.org/2019/07/15/the-future-of-genetic-research-on-eating-disorders-angi-part-3-an-interview-with-patrick-sullivan-md-franzcp/>

⁵ <https://onlinelibrary-wiley-com.libproxy.lib.unc.edu/doi/abs/10.1002/eat.20122>

⁶ <https://www.ncbi.nlm.nih.gov/pubmed/16937382>

⁷ <https://www.ncbi.nlm.nih.gov/pubmed/23084515>

DEAR MUM AND DAD, THANK YOU FOR SAVING MY LIFE

MAY 2, 2019 THE VOICES OF THOSE WHO HAVE HAD EATING DISORDERS

To my parents and all the parents of children with eating disorders:

Dear Mum and Dad, Thank you for saving my life. Thank you for never giving up. Thank you for loving me enough to allow me to hate you. Thank you for fighting my battle when I couldn't or just didn't want to. Thank you for choosing recovery for me before I could choose it for myself.

To all the parents out there who are in this fight with their child, don't give up! Don't wait for your child to choose or want their own recovery because let's just be honest: it's not going to happen, and if it eventually does, it might be too late. Don't let the fear of losing or damaging your child's love for you keep you from fighting— the love will come back deeper and stronger when they are healthy, alive, and in recovery. It is not your child that hates you; it is the illness that has taken them hostage. Think of their disorder as a person; when your child is yelling, screaming, throwing things, refusing to eat, negotiating meals, whatever it may be, you are not witnessing or dealing with your actual child, you are face-to face with the personification of their disorder. This hate comes from a losing eating disorder so just remember that the more hate you feel, the better job you are doing. Be more worried when your child likes you because ED must be happy about something. Stand strong and unwavering when you are confronted with the demons and struggles you and your child face every day, every meal.

It is so important to remember that your sick child is not your child. When I was sick, I was not me. Anorexia turned me into a lifeless, vacant, unpleasant, and unloving version of myself. It must be the scariest thing for a parent to look at their child but not actually see them; to just see them disappearing more and more each day, both mind and body. It's crazy to hear people talk about the way they saw me slowly coming back to life through my weight restoration journey. They tell me how they could see it in my eyes, how they once appeared soulless and empty, but were finally full of the life and personality they always loved again. Keep fighting so you too can experience this with your child.

I always say that my parents have probably put in just as much work for my recovery as I have, especially at the beginning. Recovery is one of the hardest things a person can do, and just simply choosing recovery is even harder. This is why family based treatment and parent involvement is so crucial in a successful recovery. Just as my parents did, you have to want their recovery before they can want it for themselves, you have to choose their recovery for them before they can choose it for themselves, and you have to be their motivation before they find their own. Recovery is not a simple, linear, or easy journey but it is worth it.

Sincerely, Kinsey Ouellette

EDANZ BOOKLIST

Recommended by other parents. Includes links to Amazon, some are also available from Book Depository who provide free shipping (www.bookdepository.com).

Visit our website at <https://www.ed.org.nz/resources/booklist/> for live links.

Supporting Families Embarking On Family Based Treatment (FBT):

"Survive FBT" Maria Ganci. A skills manual for parents undertaking Family Based Therapy Treatment for child and adolescent Anorexia Nervosa.

<http://www.amazon.com/Survive-FBT-Undertaking-Treatment-Adolescent/dp/0994474601>

"When Your Teen has an Eating Disorder: Practical strategies to help your teen recover from Anorexia, Bulimia and Binge Eating" Lauren Muhlheim

An outstanding resource for parents, offering practical strategies to employ while engaged in FBT.

<https://www.amazon.com/When-Your-Teen-Eating-Disorder/dp/1684030439>

"Throwing Starfish Across the Sea" Laura Collins & Charlotte Bevan

In this little pocket sized book, two very experienced mothers share information and support with other parents/carers with honest humour and a very direct reassuring manner as they would share over the kitchen table.

http://www.amazon.com/Throwing-Starfish-Across-Sea-pocket-sized/dp/1494307146/ref=la_B001IOFFCA_1_2?s=books&ie=UTF8&qid=1425874153&sr=1-2

"Anorexia and other eating disorders: how to help your child eat well and be well" Eva Musby

Practical solutions, compassionate communication tools and emotional support for parents of children and teenagers

<http://evamusby.co.uk>

"ED Says U Said" June Alexander

This book aims to improve communication between someone with an eating disorder and their friends and family by revealing the eating disorder mind set and decoding language choices. Using examples of real-life, everyday conversations, it translates the highly charged language of anorexia, bulimia and binge eating disorder and unravels the emotional chaos that can surround sufferers and those who care for them.

<http://www.amazon.com/Ed-Says-Said-Disorder-Translator/dp/1849053316>

Books Written by Clinicians / Therapists:

"Help Your Teenager Beat an Eating Disorder" Lock and Le Grange

A great book that encourages you and your family to step in and take action to help your teenage daughter/son eat their way back to health.

<http://www.amazon.com/Teenager-Eating-Disorder-First-Edition/dp/1572309083>

"Decoding Anorexia – How Breakthroughs in Science Offer Hope for Eating Disorders" Carrie Arnold.

Based on the "adapted to flee famine" theory. Arnold has a PhD in science, is a science writer, and has herself suffered lifelong anorexia. Well researched, the scientific information is really compelling, but presented in a very readable way.

<http://www.amazon.com/Decoding-Anorexia-Breakthroughs-Science-Disorders/dp/0415898676>

Bulimia / Binge Eating:

“Overcoming Binge Eating” Christopher Fairburn

Written by an international leading clinician Fairburn offers practical strategies on how to overcome the destructive cycle of bulimia and binge eating using Cognitive Behaviour Treatment (CBT) strategies. Also useful for families.

<http://www.amazon.com/Overcoming-Binge-Eating-Second-Edition/dp/1572305614>

“Getting Better Bit(e) by Bit(e): A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders” Schmidt & Treasure

A practical hands-on guide written by international leading clinicians

<http://www.amazon.com/Getting-Better-Bit-Sufferers-Disorders/dp/0863773222>

“Crave – Why you Binge and How to Stop” Cynthia Bulik

<http://www.amazon.com/Crave-Why-You-Binge-Stop/dp/B002VPE7NS>

“Binge Control” Cynthia Bulik

A compact guide to understanding binge eating disorder (BED) and a companion to *Crave* It is designed to help people who have BED better understand their condition and their treatment options and to help family members and friends of individuals with BED provide understanding and support to their loved ones during recovery. The most important message in this handbook is that BED is treatable and many effective therapies and medications exist.

<http://www.cynthiabulik.com/books/binge-control/>

“Brain Over Binge: Why I was Bulimic, why conventional therapy didn’t work, and how I recovered for good” Kathryn Hansen

A powerful book that provides an insightful and gripping personal account and an informative scientific perspective on bulimia and binge eating disorder, and how to recover.

<https://www.amazon.com/Brain-over-Binge-Conventional-Recovered/dp/0984481702>

“The Brain Over Binge Recovery Guide: A simple and personalised plan for ending Bulimia and Binge Eating Disorder” Kathryn Hansen

A much-requested follow-up to ‘Brain Over Binge’, this book is a valuable resource that provides clear and comprehensive guidance in recovery.

<https://www.amazon.com/Brain-over-Binge-Recovery-Guide-ebook/dp/B01AZQJ1D0>

Books to Help Adult Individuals with an Eating Disorder (and families):

“Rehabilitate, Rewire, Recover! Anorexia Recovery for the Determined Adult” Tabitha Farrar

Tabitha had anorexia for 12 years and was unique in her recovery in that she re-fed herself, gaining an insight into why an eating disorder is ‘switched on’ and what is needed to switch it off. Her knowledge and understanding of ED’s is vast, and she now works as an ED coach and is an advocate of full recovery being absolutely possible, at any age and any stage. Her website and podcast are worth following.

<https://www.amazon.com/Rehabilitate-Rewire-Recover-Anorexia-determined-ebook/dp/B07B8SYKJ4>

“Neural Rewiring for Eating Disorder Recovery: For real and meaningful mental freedom” Tabitha Farrar

<https://www.amazon.com/Neural-Rewiring-Eating-Disorder-Recovery-ebook/dp/B07SC58CP9>

Books Written by Mothers:

"Brave Girl Eating" Harriet Brown

A moving account of a family's battle to save a daughter's life from anorexia. Also provides useful statistics and information about eating disorders.

Please Note: hear Harriet Brown interviewed by link (EDANZ website)

http://www.amazon.com/Brave-Girl-Eating-Struggle-Anorexia/dp/0061725471/ref=sr_1_1?s=books&ie=UTF8&qid=1279463361&sr=1-1

"My Kid Is Back" June Alexander and Le Grange

10 families tell their family stories of helping their children overcome eating disorders. Includes Sydney families.

<http://www.amazon.com/My-Kid-Back-Empowering-Anorexia/dp/041558115X>

"Eating With Your Anorexic" A Mothers Memoir, Laura Collins

Laura recounts her family's battle to save her daughter's life

http://www.amazon.com/Eating-Your-Anorexic-Mothers-Memoir/dp/0692329951/ref=la_B001IOFFCA_1_1?s=books&ie=UTF8&qid=1425874153&sr=1-1

Books for Families with Boys:

"The Boy who Loved Apples" Amanda Webster

<http://www.amazon.com/The-Boy-Who-Loved-Apples-ebook/dp/B007MOU93U>

"Boys Get Anorexia Too", Jenny Langley

<http://www.amazon.com/Boys-Get-Anorexia-Too-Disorders/dp/1412920221>

"Skinny Boy" Gary Grahl

A young man's battle and triumph over anorexia

<http://www.amazon.com/Skinny-Boy-Battle-Triumph-Anorexia/dp/0976154749>

"Making Weight" Andersen, Cohn and Holbrook

<http://www.amazon.com/Making-Weight-Healing-Conflicts-Shape/dp/0936077352>

Mother and Daughter Stories:

"Alice Through the Looking Glass" Jo and Alice Kingsley

<http://www.amazon.co.uk/Alice-The-Looking-Glass-experience/dp/0749926902>

Diabetes and Bulimia

"Diabulmia, Towards Understanding, Recognition and Healing" Aarti Esther Sharma

In this book, the author fuses her unique perspective as a former diabulimia patient with her medical training to expound upon all aspects of the condition.

http://www.amazon.com/Diabulimia-Towards-Understanding-Recognition-Healing/dp/149238478X/ref=sr_1_1?s=books&ie=UTF8&qid=1401578415&sr=1-1&keywords=diabulimia+sharma