

DENISON UNIVERSITY



**EATING DISORDER INTERVENTION TEAM
GUIDELINES**

2011



Denison University Health and Counseling Services

Eating Disorder Intervention Team Guidelines 2011

This document has been produced by the Eating Disorder Intervention Team (EDIT), which is an interdisciplinary team of professionals who work with Denison students with eating disorders. It is provided as a guide to faculty, staff, administrators, and students.

I. Purpose and Mission

The purpose of the Eating Disorder Intervention Team (EDIT) is to provide a comprehensive approach to the coordination of support services for Denison University students who exhibit disordered eating and related behaviors.

The mission of EDIT is to:

- A. Provide consultation and recommendations to any Denison community member concerned about a student with an eating disorder.
- B. To support and educate faculty, administrators and staff in working with eating disordered students and to promote a greater understanding of the biologic, sociologic, and emotional components of eating disorders.
- C. To provide eating disordered students with a community in which dignity, self-determination, and service are present.

II. Procedural Guidelines

The following procedural guidelines will allow for consistent actions when assisting students with eating disorders who may or may not be seeking care. These guidelines will also allow for communication between departments that have expertise in the identification, coordination, and management of these disorders and to support appropriate interventions.

These guidelines may be used when compelling information is present that a student may be exhibiting symptoms of an eating disorder. Eating disorders can be harmful, even fatal, if not handled appropriately and in a timely manner. At the same time, these guidelines reflect an understanding that eating disorders are complex, difficult, and generally long-term problems that require a long-term approach by all professionals involved. For this reason, EDIT plays an integrally consultative and educative role in its relationship with staff, faculty, students, and parents concerned about Denison University students.

A. INITIAL IDENTIFICATION OF STUDENTS WITH EATING DISORDERS

1. IF IDENTIFIED BY RESIDENTIAL LIFE

- ❖ If a potential problem with a student's health as related to an eating disordered behavior becomes a concern to a residence hall staff member, he/she is to report the concern to any Assistant/Associate Director (AD). **If the concern is of an urgent or immediate nature, contact the on-call professional staff member.**
- ❖ The AD or on-call administrator will initiate an in-person assessment to determine the urgency of the reported concern. If the student is determined to exhibit behaviors of concern such as bingeing, purging, severely restricted eating, or over-exercising, a referral to Health and Counseling Services may be strongly suggested. The need for referral is based upon the gravity of the student's behavior and its impact on the community in which the student lives.
- ❖ If the student appears to be a danger to themselves and or highly disruptive in the residential community, the AD will inform the Dean of Students so that he/she can require the student to be evaluated by a primary care clinician at Health and Counseling Services or be taken to the ER if uncooperative.
- ❖ The AD or on-call administrator is responsible for making the referral to Health and Counseling Services and ensuring that the student has initiated the assessment.
- ❖ If a student who is mandated by the Dean of Students to be evaluated at Health and Counseling Services is deemed to be at grave medical risk, appropriate actions will be taken by the Dean's Office to ensure that the student is safe.
- ❖ Students who are not medically at risk but are having a significant negative impact on roommates or other residents of the Denison community must follow mandated actions as deemed by the Dean of Students. These mandates may include weekly evaluations and/or the student may be asked to take a medical leave of absence. If the student does not comply he/she may be administratively withdrawn. Please refer to the Administrative Leave Policy noted in the Student Handbook.

Possible signs and symptoms of an eating disorder include:

- Pattern of vomiting
- Excessive exercise or exercising at unusual times
- Noticeable sudden change in weight
- Restricting food intake

2. IF IDENTIFIED BY HEALTH SERVICES

- ❖ If a potential problem with a student's health as related to an eating disordered behavior becomes a concern to a Health Services' staff member, he/she is to conduct an initial health assessment.
- ❖ Refer student to Counseling Services for psychosocial evaluation.
- ❖ Determine if the student is a varsity athlete. If so, notify and refer remainder of care services to the Team Physician. If the student-athlete is deemed medically at risk during the initial assessment, the Team Physician will be notified immediately. The student's sports participation may be suspended until cleared by the Team Physician.
- ❖ Obtain written releases to appropriate sources so that referral and follow-up can be accomplished. At minimum, a limited release is necessary to confirm that the referral has been completed.
- ❖ Encourage the student to develop a team of professionals for treatment. The initial team on campus will include medical (if athlete, team physician and athletic trainers), and counseling professionals. Additional team members may include medical specialists, psychiatrists, outside therapists, and/or inpatient hospitalization.
- ❖ Notification of the above referrals will be initiated by Health Services after obtaining a release of information for members of the professional team.
- ❖ Follow up will be completed by Health Services to ensure that the student has been seen at the referral sites.
- ❖ If the student is unwilling or unable to cooperate with an agreed upon treatment plan as determined appropriate by the team of professionals or if the student is at medical risk, the Medical Director of Health Services will refer the student to the Dean of Students. The student must follow mandated actions as deemed by the Dean of Students. These mandates may include weekly evaluations and/or the student may be asked to take a medical leave of absence. If the student does not comply he/she may be administratively withdrawn. Please refer to the Administrative Leave Policy noted in the Student Handbook.

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3. IF IDENTIFIED BY COUNSELING SERVICES

- ❖ If a potential problem with a student's health as related to an eating disordered behavior becomes a concern to a Counseling Services' staff member, he/she is to conduct an initial psycho-social assessment.
- ❖ Obtain written releases to appropriate sources so that referral and follow-up can be accomplished. At minimum, a limited release is necessary to confirm that the referral has been completed.
- ❖ Refer the student to Health Services for a medical evaluation.
- ❖ Encourage the student to develop a team of professionals for treatment. The initial team on campus will include medical (if athlete, team physician and athletic trainers), counseling, and nutritional professionals. Additional team members may include medical specialists, psychiatrists, outside therapists, and/or inpatient hospitalization.
- ❖ Follow up will be completed by Counseling Services to ensure that the student has been seen at the referral sites.
- ❖ The referring counselor may continue counseling the student or refer the student to a private practitioner.
- ❖ If the student is unwilling or unable to cooperate with an agreed upon treatment plan as determined appropriate by the team of professionals or if the student is at medical risk, the Director of Health and Counseling Services will refer the student to the Dean of Students. The student must follow mandated actions as deemed by the Dean of Students. These mandates may include weekly evaluations and/or the student may be asked to take a medical leave of absence. If the student does not comply he/she may be administratively withdrawn. Please refer to the Administrative Leave Policy noted in the Student Handbook.

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4. IF IDENTIFIED BY THE ATHLETIC DEPARTMENT

- ❖ If a potential problem with a student's health as related to an eating disordered behavior becomes a concern, he/she is to immediately report the concern to Health Services. If the student is a varsity athlete, he/she is to immediately report the concern to the Head Athletic Trainer or Team Physician. **If the concern is of an urgent or immediate nature and the Team Physician is not on duty, contact Health Services at 740-587-6200.**
- ❖ If the Team Physician deems an assessment and/or treatment is appropriate, the varsity athlete will be referred to Health and Counseling Services. Practices and competition may be suspended until cleared by the Team Physician.
- ❖ Obtain written releases to appropriate sources so that the referral and follow-up can be accomplished. At minimum, a limited release is necessary to confirm that the referral has been completed.
- ❖ Encourage the varsity athlete to develop a team of professionals for treatment. The initial team on campus will include the team physician, athletic trainers, counseling and nutritional professionals. Additional team members may include the coach, medical specialists, psychiatrists, outside therapists and/or inpatient hospitalization.
- ❖ Notification of the above referrals will be initiated by Health Services after obtaining a release of information for members of the professional team.
- ❖ Follow up will be completed by Health Services to ensure that the varsity athlete has been seen at the referral sites.
- ❖ If the varsity athlete is unwilling or unable to cooperate with an agreed upon treatment plan as determined appropriate by the team of professionals or if the student is at medical risk, the Director of Health and Counseling Services will refer the student to the Dean of Students. The student must follow mandated actions as deemed by the Dean of Students. These mandates may include weekly evaluations and/or the student may be asked to take a medical leave of absence. If the student does not comply he/she may be administratively withdrawn. Please refer to the Administrative Leave Policy noted in the Student Handbook.

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IF IDENTIFIED BY A FACULTY MEMBER

- ❖ If a potential problem with a student's health as related to an eating disordered behavior becomes a concern, the faculty member may consult with any member of EDIT to discuss concerns about the student, the behaviors that have been observed and the feasibility of whether or not to speak with the student. **If the concern is of an urgent or immediate nature, contact Health Services at 740-587-6200.**
- ❖ If a faculty member feels comfortable speaking privately with the student, the faculty member should approach the student in a nonjudgmental manner, express concern and speak about what has been observed. More insight about the nature of eating disorders can be found at **Eating Disorders Information Network (EDIN) 404-816-3346, www.edin-ga.org, and National Eating Disorders Association (NEDA) 1-800-931-2237, www.nationaleatingdisorders.org.**
- ❖ The faculty member may also refer the student to Health and Counseling Services.
- ❖ If the faculty member continues to be concerned and has not received confirmation that the referral has been completed, he/she is to contact the Director of Health and Counseling Services.

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5. IF IDENTIFIED BY SECURITY, FACILITIES SERVICES, DINING SERVICES, AND OTHER SUPPORTIVE OPERATING STAFF OR MEMBERS OF THE DENISON COMMUNITY

- ❖ If a potential problem with a student's health as related to an eating disordered behavior becomes a concern, the community member may consult with any member of EDIT to discuss concerns about the student, the behaviors that have been observed and the feasibility of whether or not to speak with the student. **If the concern is of an urgent or immediate nature, contact Health Services at 740-587-6200.**
- ❖ If the concern occurs in a residence hall, please contact the Assistant or Associate Director for that quad.
- ❖ If the concern occurs in a dining facility, please contact an EDIT member.
- ❖ If any member of the Denison community has a concern regarding eating disordered behaviors witnessed, please contact Health Services at 587-6200.

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7. IF IDENTIFIED BY A FRIEND OR FAMILY MEMBER

- ❖ If a potential problem with a student's health as related to an eating disordered behavior becomes a concern, the friend or family member may contact Health and Counseling Services or any member of the Eating Disorder Intervention Team listed at the end of this document.
- ❖ If a friend or family member feels comfortable speaking with the student about their concerns, they should approach the student in a nonjudgmental manner, express concern, speak about what has been observed, and offer support regardless of the student's initial response. Before speaking with the student, the friend or family member should educate themselves about eating disorders and may refer to the **Eating Disorders Information Network (EDIN) 404-816-3346, www.edin-ga.org**, and **National Eating Disorders Association (NEDA) 1-800-931-2237, www.nationaleatingdisorders.org**.
- ❖ The friend or family member should refrain from getting into a power struggle, blaming the student, trying to solve the problem, focusing on weight, calories, and appearance, rejecting the student, and getting angry if the student is not ready to pursue treatment.
- ❖ The friend or family member should refer the student to speak with a professional at Health and Counseling Services at 740-587-6200.
- ❖ If the friend or family member continues to be concerned and has not received confirmation from the student that the referral has been completed, the concerned party should contact the Director of Health and Counseling Services at 740-587-6647.

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B. ONCE IDENTIFIED AND REFERRED TO CAMPUS PROFESSIONALS

- ❖ Students will be supported and receive individually specific treatment for their eating disorder concerns. Not all students who engage in eating disordered behaviors are in grave danger. Students will not be forced or threatened into treatment if it appears that they are not engaging in imminent life-threatening behaviors. If students are deemed to be in imminent danger, in-patient hospitalization will be recommended.

C. STUDENTS WITH A PRE-EXISTING EATING DISORDER CONDITION

- ❖ Students who have previously experienced eating disorder issues are strongly urged to provide that information on their Health Form with enrollment to Denison University. This allows our professionals to proactively support your student should the eating disorder condition reemerge.

D. ROLE OF THE ACADEMIC DEANS

- ❖ Students who are unwilling or unable to cooperate with recommendations and who are deemed to be at grave medical or emotional risk by Health and Counseling Services' professionals may be urged to take a temporary medical leave from school. The Dean of Students will be advised of the situation and will be the authority responsible for initiation of a medical leave-of-absence or an administrative withdrawal. The Dean of Students will approve the student's request for return to school with the input from the Director or the Medical Director of Health and Counseling Services.
- ❖ The health and safety of our students is our greatest purpose. Therefore, if a Denison student, currently seeking treatment at a remote Eating Disorder Treatment Facility, is on campus and deemed a potential "health and safety risk" by members of the Health and Counseling Services, Denison University holds the right to obtain pertinent medical and psychological information to document the status of the individual's active involvement in their treatment plan and their level of health. During the time of the individual's involvement with an off-campus provider, this information will be sought, in an ongoing manner, and will include, but is not limited to the following:
 - Current Weights
 - BMI
 - Symptoms/Appearance
 - Behaviors
 - Suicidality
 - Co-occurring disorders
 - Discharge summary (if applicable)

WHO TO CALL

Any Health and Counseling Service professional listed below may be contacted to accept a referral or answer questions. In addition, any EDIT member may be contacted with questions, concerns, or referrals.

Health and Counseling Services Professionals

Counseling Services

740-587-6647

Sonya Turner, Psy. D

Director of Health and Counseling Services

Tim Durham, LISW, CDCC

Associate Director of Counseling Services

Crystal LaPidus-Mann, LISW

Staff Counselor

Stephanie Clouse, Ph.D

Staff Counselor

Health Services

740-587-6200

Charles Marty, MD

Director of Health Services

Molly Thurlow-Collen, RN, CNP

Associate Director of Health Services

Michelle Barcelona RN, CNP

Nurse Practitioner

Eating Disorder Intervention Team Members

Kristan Hausman

hausmank@denison.edu

740-587-5709

- Residential Development, Associate Director North

Crystal LaPidus-Mann

lapidusmannc@denison.edu

740-587-6647

- Staff Counselor

Sandra Mathern-Smith

mathern@denison.edu

740-587-6713

- Associate Professor of Dance

Marci McCaulay, Ph.D

mccaulaym@denison.edu

740-587- 6696

-Interim Director, Center for Women and Gender Action

Laura D. Russell, Ph.D.

russelll@denison.edu

740-587- 8523

- Assistant Professor, Communication Department

Sally Scheiderer

scheids@denison.edu **740-587-6289**

-Academic Administrative Assistant Communication Department

Lynn Schweizer

schweizer@denison.edu

740-587-6657

- Associate Director of Athletics, Physical Education & Recreation

Molly Thurlow-Collen

collen@denison.edu

740-587-6775

-Associate Director of Health Services

RESOURCES

What Should I Say?

Tips for Talking to a Friend Who May Be Struggling with an Eating Disorder

If you are worried about your friend's eating behaviors or attitudes, it is important to express your concerns in a loving and supportive way. It is also necessary to discuss your worries early on, rather than waiting until your friend has endured many of the damaging physical and emotional effects of eating disorders. In a private and relaxed setting, talk to your friend in a calm and caring way about the specific things you have seen or felt that have caused you to worry.

What to Say—Step by Step

Set a time to talk. Set aside a time for a private, respectful meeting with your friend to discuss your concerns openly and honestly in a caring, supportive way. Make sure you will be some place away from other distractions.

Communicate your concerns. Share your memories of specific times when you felt concerned about your friend's eating or exercise behaviors. Explain that you think these things may indicate that there could be a problem that needs professional attention.

Ask your friend to explore these concerns with a counselor, doctor, nutritionist, or other health professional who is knowledgeable about eating issues. If you feel comfortable doing so, offer to help your friend make an appointment or accompany your friend on their first visit.

Avoid conflicts or a battle of the wills with your friend. If your friend refuses to acknowledge that there is a problem, or any reason for you to be concerned, restate your feelings and the reasons for them and leave yourself open and available as a supportive listener.

Avoid placing shame, blame, or guilt on your friend regarding their actions or attitudes. Do not use accusatory "you" statements like, "You just need to eat." Or, "You are acting irresponsibly." Instead, use "I" statements. For example: "I'm concerned about you because you refuse to eat breakfast or lunch." Or, "It makes me afraid to hear you vomiting."

Avoid giving simple solutions. For example, "If you'd just stop, then everything would be fine!"

Express your continued support. Remind your friend that you care and want your friend to be healthy and happy.

After talking with your friend, if you are still concerned with their health and safety, find a trusted adult or medical professional to talk to. This is probably a challenging time for both of you. It could be helpful for you, as well as your friend, to discuss your concerns and seek assistance and support from a professional.



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www.NationalEatingDisorders.org Information and Referral Helpline: 800.931.2237

GUIDELINES for FAMILY & FRIENDS

- **Learn as much about eating disorders as you can.** Include information on treatment options.
- **Learn about, and develop a support network** in which you can talk openly about your feelings and frustrations, and where you can develop a plan of action to deal with the person with the eating disorder.
- **Talk directly to the person with the eating disorder about your concerns.** Pay close attention to detail about behaviors you've noticed and are concerned about, and speak with the person about them.
- **Offer information to the person about eating disorder treatment options and programs.** Offer to go with them to talk with a professional about your concerns.
- **Be sensitive, but be firm.**
- **Do not discuss the issue with others,** unless the person with the eating disorder has given you permission. But do encourage other concerned individuals to speak with the person with the eating disorder.
- **Try to be objective, calm, and caring in discussing the individual's behaviors that concern you.** Avoid offering simple solutions to the person like "just eat and you'll feel better," or "don't throw up anymore." If it were that simple, there wouldn't be a problem.
- **Accept the person for who she/he is.** Make it clear to them that your feelings don't depend on their weight, shape, size, or eating habits.
- **If a person is in acute medical danger or when dealing with minors you must exercise responsibility and authority.** Trying to CONVINCED them they need treatment may not be an option.
- **Try to maintain as normal and healthy a lifestyle as possible.** It's important for you and the person with the eating disorder not to structure your life around the eating disorder.
- **As much as possible, try not to allow your life to be disrupted by discussions** (arguments, threats, bribes, guilt, or blame) concerning issues of weight, eating, and food.
- **Encourage the person with the eating disorder to take responsibility.** Allow them to participate in treatment decisions. Don't shield the person from the consequences of having an eating disorder.
- **Try to stay patient.** The physical, psychological, behavioral, social, and cultural rehabilitation of a person with an eating disorder takes time.
- **Remember there is no single cause for an individual's eating disorder.** Don't blame yourself. Your job is to be supportive. Looking for reasons and blaming the past is counterproductive.
- **Share your thoughts, feelings, frustrations** (without discussing the person) **with others who are involved.** Also talk directly to the person with the eating disorder without laying guilt or blame.
- **Be a good role model around food and when discussing food or weight related issues.**
- **Take care of your own social and emotional needs.** If you are exhausted (emotionally or physically), you won't be able to provide much emotional support.
- **Compassion does not mean being manipulated by the person.** Require that the person be responsible for his or her behavior and deal with the consequences of it.
- **Remember the person has an eating disorder, but don't let the person's identity to get wrapped up in that.** Refrain from speaking of "the anorexic" or "the bulimic."

What Should I Do?

Guidelines for Friends, Roommates, and Families of People with Eating Disorders

1. When we care about someone with an eating disorder, our natural tendency is to see the eating disorder as a problem and to try to help the person get rid of that problem.

But it is worth remembering that an eating disorder is not only a problem but also an *attempted solution* to a problem.

That is, the disorder serves some purpose. Like many other symptoms and apparently maladaptive behaviors, an eating disorder, for all of the problems it creates, is an effort to cope and to communicate. Starving may be in part an attempt to establish a sense of self, an effort to experience some sense of one's own power, agency, worth, and specialness. Bingeing may be in part an attempt to comfort or numb oneself. Purging may serve as a physiological and psychological release, a reliable means of achieving relief from pain, anxiety, or numbness. An eating disorder is an expression of that which the person has found no other way of expressing—typically feelings of shame, doubt, rage, grief, inadequacy; the experience of not being recognized as a separate being with a right to live her own life; the sense of being unseen, unknown, unaccepted for who she is.

There is no simple cause of eating disorders, and certainly no simple solution or cure. Many people find some combination of medical care, individual psychotherapy, group therapy, and self-help groups helpful in their process of recovery. Change is often slow, and recovery typically includes lapses and setbacks. Both the person with the eating disorder and those who care about her may feel frustrated and impatient with the pace of the process. Groups for people with eating disorders and groups and workshops for family members and friends can be sources of hope and support.

2. It is important in life not to take responsibility for things over which we have no power and to recognize those over which we do.

Ultimately, we don't have power over whether someone gets well, wants to get well, seeks help, stays with help, doesn't binge tonight, stops purging, or treats herself with care or respect. We might wish all of those things for someone. We might wish them from the bottom of our heart. We might make ourselves available to talk. We might recommend counselors and books and other resources. We might make an appointment for the person and offer to accompany her to that appointment. But ultimately, we have no power over another person's choice of how — or whether — to live.

(Note: We are referring to people who are of a certain age. Parents appropriately have more power and responsibility in the lives of children. And yet parents will recognize even in the exuberance of a toddler's emphatic "No!" the self's determination to be included and respected in the making of choices.)

What we *do* have power over — and what we *can* take responsibility for — is the choice to express our concern and our authentic response to someone. Although we cannot know whether or how another person will receive our concern, we can still take responsibility for expressing it.

3. When we express our concern, we are wise to speak of our own experience rather than assume that we know what is true or best for the other person.

That is, we are wise to use "I" statements rather than "you" statements. When we speak in "I" statements, we take responsibility for our response. When we speak in "you" statements, we tend to make judgments about the person, which leave her feeling that she has to take a defensive position. We end up locked in a battle of wills that leads nowhere.

Examples of "You" statements: "You're too thin." "You need help." "You aren't eating enough."

Examples of "You" statements disguised as "I" statements: "I think you are out of control." "I think you are just trying to get attention."

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Note: "You" statements can be appropriate and useful when they express basic rights (e.g. "You deserve better"; "You deserve to eat"; "You have a right to your own life") or specifically referenced statements of fact (e.g. "Actually, you are thinner than that woman whom you say is too thin") rather than judgments.

Examples of "I" statements:

- "I've heard you throwing up in the bathroom. I'm concerned. Let's get some help."
- "I feel afraid that you're hurting yourself. I'm concerned that your health could be in danger or that you could die. Let's get some help."
- "Look, I think we're both at risk for getting caught up in some sort of denial here. I know I've been avoiding talking to you about how concerned I am. I don't like it when we act as if nothing is wrong, because my sense is that something is very wrong. It's too much for us to handle alone. Let's get some help."
- "I look at you and I see the light going out of your eyes and I feel like I'm losing you. I miss you. I'm afraid I really will lose you. And I'm scared for you."
- "I'm afraid for our friendship because it feels like there's so much we aren't being honest about anymore."
- "I want more for you than this life of obsession and guilt and self-control and self-contempt. There's so much more to life — and to you for that matter."
- "I want to say 'Stop, don't do it!' But I know it's not that simple."
- "I'm sorry, but I'm not going to work out with you anymore because I feel like I'm helping you abuse yourself."
- "I know you say that I shouldn't be concerned and that I should mind my own business. But I *am* concerned. And that is my business. In fact, to help me deal with that concern, I've consulted with a doctor and a therapist."

Concern isn't expressed only in direct verbal statements. A hug, loving teasing, a hand on the shoulder — such spontaneous gestures are powerfully healing. Being genuinely curious to know how the person experiences things; wondering with her about the things she wonders about; letting her know that you notice what makes her upset and what makes her laugh; wanting to spend time with her; letting her know the ways in which you are tickled or touched by her spirit; asking her opinion or asking her to join you in doing something — these, too, are expressions of care and concern.

It is important to remember — and help her remember — that she is more than her eating disorder.

4. We need to remain true to ourselves, authentic.

We sometimes feel that we should not be angry with someone who is sick. But the truth is, we feel angry. In families and roommate groups and other relationships, people get very worried about what they should and shouldn't do: they get caught up in trying to anticipate other people's responses and feel responsible for those responses. They start tip-toeing around as if walking on eggshells.

The effect is deadly. If we abandon ourselves by not being authentic, we don't do anyone any good. In fact, we aggravate the situation. If we feel angry and also concerned and scared, then why not acknowledge that *that* — in all of its fullness and true-to-life complexity — is what we feel. The truth is, that *is* what we feel, whether we acknowledge it or not. If we disregard that truth, we can get caught in a web of denial. In dysfunctional relationships, everyone is at risk for denying the truth

- not trusting their perceptions;
- acting as if things are fine when in some part of themselves they know things are not at all fine;
- acting as if they do not know what in fact they know;
- pretending they do not feel what in fact they feel.

It's okay — in fact, essential — to set limits for yourself. The truth is, you *do* have limits, so what point would there be in acting as if you didn't? You don't have all the time in the world to listen; you can let someone know how much time you can offer, and when, and then really be there for that time, even if it is a very limited time. You can set limits on things like whether and to what extent you will keep the house free of food she doesn't want around. You can make it clear that you cannot accommodate all of her

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preferences and that you will not take responsibility for her eating. You can also set limits on specific behaviors that affect you. For instance, you can make it clear that if she throws up, she must clean up the bathroom afterwards. You can make it clear that stealing your food is unacceptable behavior.

5. Don't focus on eating and weight.

Friends and family members who are trying to be of help often end up focusing their concern on whether someone is eating enough, weighing enough, weighing too much, bingeing too much, purging, exercising too much, etc. These are valid concerns; eating disorders can result in serious health problems, and even death.

Anyone with an eating disorder needs to be under medical care: it's simply a matter of her safety.

But it is important to remember that the person with an eating disorder needs people in her world to respond to more about her than her weight and her eating. She may feel profoundly misunderstood and feel that her deeper pain and her fuller self are unrecognized when family and friends attend only or mainly to her eating and her weight. What is more, focusing on eating and weight can be counterproductive. When a person with anorexia nervosa hears someone say that she is too thin, she is apt to be pleased. Being too thin is precisely what she is trying to be: that defines her as special. When a person who is overweight hears someone say that she is too heavy or that she is eating too much, she can feel insulted, ashamed, and demoralized. It's not as if she doesn't already know those things. Such judgments and assessments can leave her feeling even worse about herself and result in her wanting to binge as a way of numbing herself to her feelings of self-contempt.

To say that one should not focus on eating and weight is not to say one should never speak about someone's eating or weight.

It is important to acknowledge that given her purging/diet/low weight, you are concerned for her safety.

Even if she is not concerned, you can own that you are and that you need to know that she is not in danger of serious health consequences, including cardiac arrest due to electrolyte imbalances. You can say, "I need to know that you're medically safe. Let's make an appointment for you to see a doctor or nurse practitioner."

It is also important to let the person know how you see her:

- "I know that you feel 'disgustingly fat,' as you put it, but I want you to know that I see you as painfully thin — literally as if you are in pain."
- "I know that when people tell you you look healthier, you say they really mean you look fat, but that's not at all what I mean. I mean that you look radiant — your eyes are brighter, your smile is brighter, you seem more relaxed. It's like you're more here." (See comments about "I" statements in #3 above)

6. We sometimes work with the mistaken belief that there is a right thing to do with someone who has an eating disorder and that if we did that right thing, then the person would be helped and we would not feel helpless. When we believe that, we misunderstand our helplessness as a sign that we are not doing enough. It is a fact that we are ultimately helpless over *making* another person feel some other way or be some other way.

Our helplessness is not necessarily a sign that we should be doing something else; it is a sign that there is a real limit to what we can do to make another person be or feel something else.

She may feel that she has no real effect on people, that she is known and appreciated more for her achievements and her appearance than for her self. Her eating disorder may be, in part, her attempt to communicate just how ineffectual and worthless she feels. Our feeling of inadequacy and ineffectualness is in part a result of our resonating with *hers*.

We may resonate with other feelings as well. When we feel frustrated, angry, scared, or even disgusted in response to someone with an eating disorder, we feel those things in part because we are empathizing

with — picking up on — the person's own feelings of frustration, anger, fear, and self-contempt or disgust.

Our feelings are not necessarily a sign that we are doing something wrong or not doing enough; they are information for us about what the other person's experience may be.

Although we can never be certain that we know what someone's experience is, our feelings as we listen to her are our guides in *trying* to know, or sense, her experience.

7. Human company and empathy matter.

Hurt and pain are often more bearable in the company of another human being. It is healing and comforting to share one's perspectives without being judged. To have another human being sense what one is experiencing and convey that he or she "gets it" — that is, understands and appreciates one's experience — is a precious gift.

The willingness to join someone so that we can see the world through her eyes requires that we not be invested in changing her or in getting her to change her perspective. Ultimately, we do not have the power to change another person. We therefore must learn to bear our own helplessness, that is, to accept that there is a real limit to what one human being can do to relieve another's pain. If we can bear our sense of helplessness, we won't try to make someone feel better so that we will feel better. We are then free to imagine what it is like to feel what she feels. "Imagine" not in the sense of "concoct" or "dream up" but in the sense of "get the picture" she is painting of her experience. We can then convey our image, or sense, of her experience:

- "It's as though you could never do enough"
- "It's as if you believe you are nothing more than your achievements"
- "And you're so weary of it all?"
- "If only someone could see that there's so much more to you?"
- "And sometimes you just ache for someone to hold you, to comfort you?"
- "It's as if you couldn't let yourself know the depth of that yearning?"

With such responses, we say, in essence, "I sense that this is how things feel to you — is that what it's like?" We are then open to her revisions of our understanding: "No, actually, it's more like"

To empathize, we need not necessarily agree with the person's feeling or stance.

We might think that there is a more useful perspective she could take, a wiser or healthier place she could stand. But if we try to talk her into shifting perspective, we are likely to leave her feeling unheard, misunderstood, and frustrated — and to feel unheard, misunderstood, and frustrated ourselves as a result. Before she can take another perspective, she needs to know that someone recognizes the legitimacy and importance of hers.

But we cannot take someone's perspective instrumentally so that she will take ours. That would be manipulative and disrespectful. We must join her — stand beside her at her window on the world, so to speak — simply because we are curious to know how she experiences things from where she stands. Empathy is an effort to understand someone's experience as she experiences it and to convey that understanding in a way that both lets her know that we "get it" and indicates that we are open to her revisions and refinements of our understanding.

Empathy presumes our desire to know what she yearns for, what she needs, where she hurts, and what she fears. She may not know the answers, but our asking and our listening are still important.

It may seem as if empathy is not very helpful . . . that it just leaves the person stuck in her own misery, and that what the person really needs is to be cheered up, or reassured, or distracted, or given the right advice, or put in touch with the right expert or the right book, or told in no uncertain terms that she has got to change.

But if you think about a time when you truly felt helpless or discouraged or frustrated . . . what kind of response did you want? A pep talk? A challenge to your point-of-view? Advice? Information?

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Reassurance? Jokes and distractions? Confrontation? Or acknowledgment of what you were feeling and going through? And trust from others in your own being, your own soul, your own sense of timing?

Despite the good intentions of pep talks and despite the wisdom of advice, such "helpful" responses often don't feel so helpful. The person we're trying to help often feels that we are simplifying the complexity of her experience, that we just don't understand.

There is a place for challenge, advice, information, experts, recommendations, pep talks, reassurance, distraction, jokes, and confrontation.

But that place is generally after a person first feels that her experience is understood and accepted for what it is. John Birtchnell explains how this counterintuitive effort at empathy helps:

Motorists will know the correct way to bring a skidding car under control is to turn the steering wheel in the direction in which the car is skidding. By turning into the skid, one is bringing the steering apparatus into alignment with the movement of the car. This action is counter to the natural inclination to turn the car sharply in the opposite direction. The maneuver is analogous to what is, to my mind, the correct way to respond to people who are suffering. Instead of trying to alleviate or divert attention from the pain, I believe one should focus down on it, encourage its emergence, and be accepting of it . . . [If you accept a person's pain,] you have turned into the skid and brought the sufferer into alignment with his suffering.

(From Birtchnell, J. Turning into the skid. The Samaritan. 1977 Autumn issue. Slough, England: The Samaritans.)

We often resort to advice, reassurance, and other means of trying to talk someone out of her perspective and into some other one because we cannot bear to stay with her in her struggle. It simply feels too painful. Empathy requires that we trust her being and her timing in a very fundamental sense. We must believe in her capacity to heal and to grow. Empathy helps create an environment that supports healing and growth. When we try to understand a person's experience as she experiences it — not as we would like her to experience it or think she should experience it — something powerfully healing happens.

People often say about their struggles in life, "All the help in the world won't do me any good. I need to do this on my own." That's true. It is also true that even though each of us needs to climb the mountains of life on our own, under our own steam and on our own two feet, we do not need to make the entire climb *alone*.

It helps, when climbing, to have company. As people recover, they come to know that they do not need to bear their difficulties and hurt alone or engage in compulsive behavior to escape from their pain period. They come to know that human company helps even if there are real limits to what one human being can do to relieve another's pain.

8. People who have recovered acknowledge the importance of being loved and being believed in.

When we ask people who have recovered from an eating disorder what helped them to recover or what led them to seek help, many say that they had heard from people for years that they needed to take their pain seriously, to get help, and to treat themselves with care and respect. And for years, it seemed as if none of those loving voices got through. In fact, those voices may have been met with contempt, drowned out by the harsh and judgmental inner voices with which the person spoke to herself. Many women with eating disorders feel a deep and abiding sense of guilt and shame. They feel "rotten at the core," so deeply undeserving that they do not feel they can accord themselves compassion in their pain or accept compassion from others.

But then one day one of those loving voices takes hold somewhere inside the person. And even one benevolent voice inside makes a big difference. People who have recovered say that it was important that friends and family members kept trying to get through to them and kept delivering the same messages over and over, because one day they could hear and act on what they could not hear or act on before. They needed to keep hearing voices of love and respect, even when those voices seemed to have no effect. Hearing such voices repeatedly was part of the process by which they came to internalize a more compassionate and generous self-regard.

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People who have recovered also say that it was important that someone believed in them, continued to see and respond to the health and potential in them, and remembered that there was more to them than the eating disorder. They talk about how someone's trusting in their being, or soul, and in their timing helped them trust in themselves.

9. People with eating disorders often experience great shame about their eating behavior and great shame about their imperfections as human beings. They fear that if anyone really knew them, really saw them for who they were, that people would reject them.

They yearn to know that someone could both know the worst about them and love them and care about them anyway. If we think about this, it means that if we say to someone, "No, I'm not angry. I know you can't help it, and I love you," we are saying that we cannot both be angry with her and love her anyway. How much more honest — and ultimately healing — it is to say, "Yes, I am angry. Yes, I am frustrated. I'm angry because I love you, and I see you treating yourself with such contempt. You deserve better, and I wish you believed that."

10. Get support for yourself.

It can be frustrating and confusing to care about someone with an eating disorder. You may feel helpless, enraged, and hopeless. You may also feel vulnerable to becoming preoccupied with your own eating and weight. Don't try to do it alone. Find a friend, counselor or support group, some place where you can talk openly and receive support from others.

You may find the frustration and helplessness somewhat easier to bear if you have information about eating disorders, in particular about why people develop them and about the psychological purposes the disorder serves in their lives. Readings are one source of information; this handout includes a brief list of books. You could also speak with a doctor or therapist about your questions and concerns. Consider letting the person with the eating disorder know that you are seeking the information to help you understand her experience. But don't let your information search diminish your curiosity about her particular experience of things (see observations on empathy in #7 above).

It can be especially frustrating when someone who is hurting refuses to seek or engage in any sort of help. Many women with eating disorders regard their needs and desires with disdain and contempt. They feel ashamed not only of their disordered eating but even having needs and desires — much less attempting to respond to them. This shame makes it hard for someone to seek help or to engage in any help she does manage to seek. Consider letting her know that you are so concerned that you are seeking professional consultation. Letting her know that you take her pain seriously may, in time, help her to take her pain seriously, too.

RESOURCES

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