

## **Some Basic Principles for Understanding and Referring Eating Disorders**

Adapted from the writings of Michael Levine, Ph.D.

### **General perspectives**

1. Anorexia nervosa and bulimia nervosa are not completely distinct disorders and in this regard are both very serious.
2. Eating disorders command our attention because they are prevalent and serious, not because they constitute a dramatic, fascinating “epidemic of our time.” Regardless of their good intentions, poorly prepared and titillating education/prevention programs carry the distinct possibility of teaching dangerous weight management practices.
3. People with eating disorders are struggling with fantasies, motives, anxieties, and coping mechanisms that are established and vigorously reinforced by our culture.
4. People interested in eliminating eating disorders and in reducing the misery and ineffectiveness attendant to weight preoccupation, unhealthy weight management, and binge-eating must begin with an examination of their own attitudes, behaviors, and lifestyles.
5. It is useful to conceive eating disorders as part of a spectrum of problems created by the intersection of:
  - Our cultural obsession with slenderness as a physical, psychological, and moral issue.
  - The distorted meaning of both femininity and masculinity in today’s society.
  - The developmental psychology of adolescence and early adulthood.

### **Identification and the offering of help**

6. Know the warning signs of anorexia nervosa and/or bulimia nervosa, including those of an emergency. People with eating disorders require immediate attention and quite possibly including hospitalization, if they are:
  - Unable to function effectively because they are too weak, too sick, or too caught up in binge-eating and purging.
  - Suicidal
  - Acting out in a bizarre or disorganized fashion via tantrums, promiscuity, substance abuse, self-mutilation, etc.
  - Unable to keep any food “down”.
  - Consistently behaving in ways that leave family and friends “at wits end” – frightened, angry, exhausted, and over-involved.
7. Although people with eating disorders are typically frightened by their own behavior, they enjoy some aspects of it (e.g., losing weight) and they are convinced that stopping will bring the terror of “becoming fat”. Ambivalence + secretiveness + cleverness + the overlap between the symptoms and culturally sanctioned practices = problems in detection. Even if you know a lot about eating disorders, and even if you know the person well, do not be too hard on yourself or others if you fail to detect the non-emergent signs in a timely fashion or at all.
8. Be aware that there are high-risk groups, but do not be misled by stereotypes. In general, risk is increased significantly by an emphasis on the following combinations: slender appearance + competition + perfectionist goals for achievement.

9. Know how the psychological effects of an eating disorder, including the effects of starvation (e.g., emotional instability, self-absorption), may reduce a person's ability to benefit from the concern and efforts of family, friends, and mental health professionals.
10. Remember the purpose of detention and referral is not accurate labeling or other demonstrations of expertise about "eating disorders". It is:
  - Identification of a problem
  - Communication of care and concern
  - Effective referrals
11. Collaborate with concerned friends so as to:
  - Affirm their concerns
  - Identify emergencies
  - Increase their awareness of resources
  - Support mature decision-making
  - Protect their rights
  - Remain open to further consultation

### **Referral and treatment**

12. Most people (e.g., parents, deans, teachers, coaches, RAs) are not trained therapists. Thus, they should never become, either intentionally or inadvertently, the sole and private salvation of eating disordered individuals who need someone to talk to.
13. Not all people who emit warning signs of anorexia nervosa and/or bulimia nervosa actually have a serious eating disorder. It is good to remember that eating disorders are complex and potentially chronic problems. Consequently, they require professional evaluation and multidimensional treatment.
14. Family and friends neither cause nor cure eating disorders but they contribute significantly to prevention and recovery.
15. Staff should be trained and otherwise encouraged to collaborate with professional "counselors" in making effective referrals and receiving feedback about the process.

### **Prevention**

16. Eating disorders are not simply a "women's issue". Certain subgroups of males (e.g., wrestlers, athletes, gay men) are at risk for eating disorders. There is no doubt that male-female interaction and relationships can influence how women think about and treat (or mistreat) their bodies. Consequently, prevention programs should target various groups of males, including athletes, fathers, fraternities, etc.
17. Prevention education should be carefully planned to avoid the transmission of distorted attitudes, weight management practices and misinformation.
18. Currently we do not have an integrative theory about the emergence of eating disorders and related conditions during the adolescent or adult years, so at this time no one knows how to prevent them. Nevertheless, action is necessary. It seems likely that adults and adolescents – as models, teachers, advisors, and agents of social influence – can play a role in prevention by helping people and social "systems" (e.g., schools, teams) to:
  - Evaluate thoroughly and where necessary. Change customs and subcultures that encourage objectification of the body, glorification of slenderness, prejudice against body fat and the overweight, and discrimination against women.

- Embrace diversity, including body weight and shape. This will require education about the genetic and other biological processes underlying body weight and body shape.
- Understand the negative effects of “dieting.”
- Develop a flexible acceptance of body shape and self.
- Learn healthy ways to cope with anxiety, frustration, loneliness, and other forms of psychological (interpersonal) distress.