

UP TO THE PLATE

A F.E.A.S.T.
FAMILY GUIDE TO
THE IMPORTANCE OF
NUTRITION
FOR UNDERSTANDING
AND TREATING
**EATING
DISORDERS**

“Food is medicine for eating disorders, however there is no special kind of diet that will cure these complex illnesses.

Recovery from an eating disorder begins with weight restoration and normalization of eating behavior. This means being able to eat enough to meet nutritional needs and energy requirements, and being comfortable eating a variety of different foods.”

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UP TO THE PLATE:

THE IMPORTANCE OF NUTRITION

FOR UNDERSTANDING AND TREATING EATING DISORDERS

IF EATING DISORDERS ARE MENTAL ILLNESSES, WHAT DOES FOOD HAVE TO DO WITH IT?

Eating disorders (EDs) are mental illnesses in which the central anxiety has to do with food and eating. And, unlike a fear of flying or snakes, for example, eating is part of everyday life and not something that can be avoided without grave medical and psychological consequences. The four main ED diagnoses include: anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorders (BED), and avoidant/restrictive food intake disorder (ARFID).

Malnutrition, which is found in all EDs, is a serious medical condition, and nutritional rehabilitation is a fundamental component of treatment. For patients with restrictive eating behaviors and weight loss, weight restoration and nutritional rehabilitation are essential goals of treatment. For patients with binge and/or purge behaviors, weight stabilization and normalization of eating behaviors are critical.

While the physical symptoms of starvation are fairly obvious, many people do not realize that when the brain becomes malnourished, it negatively affects mood, behavior, appetite regulation, relationships, and can even distort a patient's perception about their own body weight and shape.

The concept that malnutrition negatively affects the brain is not new, but advances in science have revealed that the process is much more complex than previously understood. For example, researchers have discovered that genetics can influence how a person responds to malnutrition, and we now believe that this plays a fundamental role in triggering and maintaining EDs in susceptible individuals.

Over the years, research has led to promising new developments in understanding how to restore weight and health in patients with AN, stop binge behaviors in BED and binge-purge behaviors in BN, and halt ED thoughts that are common to all of these disorders.

Our multidisciplinary team of health professionals has put together this guide to help families understand the relationship between EDs and the importance of nutrition. Outlined below are our answers to frequently asked questions on this topic.

MY DAUGHTER WANTED TO “BE HEALTHY”, SO SHE DECIDED TO GO ON A DIET. IS THAT WHAT CAUSED THE EATING DISORDER?

Research has shown that EDs are associated with many different factors such as: genetics, culture, social expectations, behavior, psychology and biology. In fact, there does not seem to be one single cause to explain why people develop EDs.

We do know that dieting, either as an attempt to lose weight or to “eat healthy,” increases the risk of developing an ED. In fact, young people who diet moderately are six times more likely to develop an ED. Many societies place a high value on developing a thin or muscular body and this may lead to attempts at dieting and/or over-exercise, which can trigger an ED in those who are most vulnerable. Dieting can also lead to other unhealthy or disordered eating behaviors such as bingeing and purging.

While not all people who go on a diet will end up with an ED, we know that starting a diet is definitely a risk factor for developing an ED in adolescents. For example, we know that some individuals have certain personality traits that make them more prone to develop obsessive dieting or exercise patterns. Most people cannot maintain dieting behaviors for too long because it is stressful, and the body will respond to the need to eat normally. However, new research in neurobiology has found that for individuals who develop EDs, behaviors such as restrictive eating, bingeing, and/or purging may actually affect the brain in ways that relieve anxiety, which then serves to support the unhealthy eating behaviors.

MY SON WAS DIAGNOSED WITH ANOREXIA NERVOSA. WHY CAN'T HE JUST EAT LIKE OTHER BOYS HIS AGE?

To be afraid of food, and to be scared that just about any food item, no matter how small or low in calories, will bring about rapid weight gain, cause harm or discomfort, and even lead to obesity, is a hallmark of AN.

This reaction to food is very hard for families to understand, but comes from the manner in which AN disrupts the brain's normal appetite functions. Whereas a healthy teen will look at a candy bar, or an apple, or a plate of pasta, and say “wow, that looks good, I'm hungry, I'd like to eat that”, your son looks at that same food and derives no pleasure from it. Instead, he becomes very anxious about what that food item will “do to” him.

These fears can be very individual. Whereas one patient may fear that “this apple will make me fat, and I don't want to be even fatter than I already am,” another patient may fear that eating specific foods will make them ill, or sabotage their athletic performance, or make them appear weak-willed or unworthy to others. It is important to understand that these thought patterns are irrational and disordered and are symptoms of the illness. Consequently, your son simply can't eat or relate to food in the same way he used to before he became ill.

WHAT IS THE DANGER OF EATING TOO LITTLE?

Eating too little can lead to serious and potentially life-threatening health problems. Complications can include:

- low blood pressure, heart rate, and breathing rate
- poor growth in height and weight
- interruption of sexual development
- heart problems that can lead to abnormal heart rhythms
- brittle bones and risk of bone fractures
- abnormal electrolytes (minerals in the blood or other body fluids)
- dehydration
- slow emptying of the stomach
- constipation
- loss of, or irregular menstrual periods
- dry skin, hair loss and lanugo hair (fine hair that can grow all over the skin)
- inability to concentrate.

IS THERE A SPECIAL DIET THAT WILL CURE AN EATING DISORDER?

Food is medicine for EDs, however there is no special kind of diet that will cure these complex illnesses.

Recovery from an ED begins with weight restoration and normalization of eating behavior. This means being able to eat enough to meet nutritional needs and energy requirements, and being comfortable eating a variety of different foods.

There are six nutrients that our body needs: protein, carbohydrate, fat, water, vitamins, and minerals. Each nutrient has its own unique function and all are needed to maintain good health. It is important that the patient eats a wide variety of food to ensure the body gets all the nutrients it needs.

Many individuals with EDs severely restrict the foods they will allow themselves to eat. Some patients become overwhelmed by the fear that specific foods, or entire food groups, will cause them to gain weight or will harm their health. The extreme anxiety associated with eating these “fear” foods can be very hard to overcome; but, gradually increasing the variety and quantity of food served will help to challenge these fears and will ensure your child is getting all the recommended nutrients.

MY SON IS IN TREATMENT FOR ANOREXIA. WHY DOES HE HAVE TO EAT SO MUCH MORE THAN HIS PEERS AS PART OF HIS RECOVERY PLAN?

Basal metabolic rate (BMR) is the amount of energy that the body consumes at rest and supports functions like digestion, breathing, and maintaining body temperature. When your son was at very low weight as a result of having AN, his BMR slowed down to conserve as much energy as possible. This is a

protective response, controlled by the brain, and is sometimes referred to as a “starvation state.”

With nutritional rehabilitation, the brain responds to correct for this period of starvation, causing your son’s BMR to increase and thus his energy intake (calories consumed) needs to increase dramatically. In addition to the food needed to regain lost weight, your son needs more food to fuel his physical development, and even more energy for catching up on delayed growth.

Therefore, your son invariably requires more food than his peers, so that ongoing weight gain is achieved in a timely manner. The amount of additional calories required varies for each individual patient, and the best indicator that the body is receiving enough energy is adequate and sustained weight gain.

OUR DAUGHTER NEEDS TO REGAIN LOST WEIGHT. HOW DO WE KNOW THE MOST APPROPRIATE TARGET WEIGHT FOR HER TO BE AT?

The appropriate weight for your daughter cannot simply be read off reference charts and it may differ from the healthy weight for someone else, even of the same age and height. It will also depend on her current stage of pubertal development and whether or not she has further growth potential. Puberty is the time when young people have changes in their body (height, weight, and development of sexual characteristics) as they move from being a child to an adult. During puberty, your daughter’s body will grow faster than at any other time in her life, except for when she was a baby.

Food restriction (as seen in AN) can delay puberty, while disordered eating behaviors (as seen in BN and other EDs) can compromise both short- and long-term health. Food is medicine for EDs, and restoring full nutrition (quality and quantity) is critical for healthy adolescent growth and should be a priority in any ED treatment plan.

The appropriate target weight for your daughter will be the weight at which her body *functions* normally. It is the weight at which she has regular menstrual periods, thinks less about food and weight, is able to eat a variety of foods, and also gets back the personality she once had before she became ill. The weight at which this is likely to happen will depend on her growth patterns before she developed the ED, and the length of time she spends without restricting her caloric intake after weight restoration.

Continued dietary restriction, even after achieving a healthy weight, can lead to continued absence of menstrual periods. For women with AN, on average it takes about 9 months to resume menstrual periods. If your daughter is still growing, her progress will need to be assessed every 3-6 months, and her weight target may need to be changed as she continues to grow and develop.

Healthy weight cannot be determined by appearance, BMI, or the patient’s wishes. Ongoing professional consultation and monitoring with an ED specialist team is critical. Even among experts, there are different methods and protocols.

OUR DAUGHTER IS A TEENAGER. WHY ARE WE TREATING HER LIKE A CHILD WHEN IT COMES TO NUTRITION?

If your daughter is suffering from an ED she is probably malnourished. As such, her brain is simply not functioning well and cannot make good decisions. A starved brain prevents your daughter from appreciating how unwell she is and derails her ability to eat intuitively. In this state, she has no way of understanding what kinds and quantities of food she needs to eat, and may not even be able to recognize when her body is hungry.

It is really difficult for parents to appreciate the extent to which an ED overtakes the way the teen thinks and feels about all things food related. It can be very confusing for parents to be guided to take over (albeit for the short term) all decisions related to your daughter's eating and weight when she behaves like a normal teenager in most other domains. Even more confusing is that your smart and apparently rational teen will demonstrate a wealth of knowledge about nutrition; in fact, she may even prepare wonderful nutritious meals for the whole family, that she cannot bring herself to eat.

Because it is normal for your daughter to resist eating what is prescribed for her, you will have to emphasize the necessity of full and complete nutrition as her body heals and her brain recovers. Because she may not be able to understand it at this time, it is important that you, as her caregiver, make sure that the amount and type of food given to her is what *she* needs to recover, regardless of what the rest of the family is eating.

This means that at the end of the day, the job of refeeding belongs to you at home, or the ED team in an inpatient setting. If your child is medically stable, then it's far better for your team to support you to do this job at home, until your daughter is ready and capable to eat like a healthy teen once more. The latter will only occur with full nutritional rehabilitation and lots of support for re-learning how to eat again.

IS LONG-TERM RECOVERY FROM AN ED POSSIBLE?

The short answer is 'yes', there is always hope for a successful recovery from an ED. Long-term outcome studies now confirm that a good 50-60% of patients will have a full recovery. Nevertheless, the process is obviously quite a bit more complex, and results will vary widely from patient to patient.

For adolescent patients, we now know that if the ED is recognized early, say within a few months or even a year from the time it started, that they stand a better chance at full recovery compared to those with a longer duration illness (e.g., more than 3-4 years). That means that adolescents who receive proper care can go on to recover completely from their ED and lead healthy and fulfilling lives as adults.

While it is clear that *early recognition* increases success rates, *early and aggressive intervention*, is critical to recovery from an ED for all patient

populations. Such interventions should include: weight and/or nutritional restoration, stopping dangerous or disordered behaviors, and psychological support to the patient and his/her caregivers.

DO PEOPLE WITH BULIMIA NERVOSA NEED THE SAME FOOD AS THOSE WITH ANOREXIA NERVOSA?

Nutritional rehabilitation is the first step in recovery from both AN and BN. This can be achieved by eating a wide range of foods that contain a variety of fats, carbohydrate, and protein. In terms of the nutritional quality of the food, there is very little known about what specific nutrients in what amounts are ideal for re-feeding.

During the first stages of treatment, the calorie requirements are different for people with AN compared to those with BN. People with AN need to regain weight as part of their recovery and larger quantities of food are required until a healthy weight is restored, and usually longer. This is because AN disrupts the body's normal metabolic rate for a long period of time – longer than the time it takes to regain lost weight. Although calcium, vitamin D, and protein are necessary for regaining bone and muscle mass in people with AN, ***overall caloric intake appears to be most important factor for successful re-feeding.***

People with BN, however, may not need to increase their calories if they have not lost weight. Instead, the focus of the nutrition therapy is on spreading the calories into a normal pattern of meals and snacks to avoid periods of fasting that may trigger bingeing and purging. Stopping these disordered behaviors is critical to recovery from bulimia, and people with BN may need to temporarily avoid foods that “trigger” their binges and purges. For example, if someone always binges on sweets, then it might be wise to avoid such foods until they are farther along in their recovery.

WHAT IS THE DANGER OF BINGEING?

Binge eating or bingeing is when a person eats an unusually large amount of food at once, in a short period of time. This usually takes place in private. The individual who binges often feels that they have no control over their eating during the episode. They often experience feelings of guilt or shame after bingeing. Some individuals may follow a binge with purging (see below).

Binge eating is dangerous and can cause the development of serious physical and mental health problems. One serious side effect of bingeing is gastric dilatation. This is when the stomach becomes bloated after ingesting a large amount of food. The pressure in the stomach builds up and may cause difficulty breathing or abnormal heart rhythms. In addition, the enlarged stomach can cut off the blood supply and cause the stomach tissue to become necrotic (dies) or even rupture (break open). Inflammation of the pancreas (an organ that produces special proteins that help with digestion, and hormones that control the way your body uses sugar), known as pancreatitis, can also develop as a result of

binge eating. In addition, individuals who binge are at risk for mental health problems such as depression, anxiety, and substance abuse.

A person who binges may be a normal weight or overweight and may have significant weight changes from day to day. Those who are obese are at risk for a number of serious and long-term health problems such as high blood pressure, high cholesterol, type-2 diabetes and heart disease.

WHAT IS THE DANGER OF PURGING?

Purging describes any behaviors used by individuals in order to prevent weight gain. Purging behaviors may follow a binge or may occur after a small snack or a normal-sized meal. Purging behaviours can include:

- self-induced vomiting (some people use their fingers to induce vomiting and this can result in the formation of a callus on the back of the hand known as Russell's sign.)
- fasting or strict dieting,
- excessive exercise
- the misuse of laxatives and diuretics (drugs that promote the production and excretion of urine),
- the misuse of diet pills or ipecac (a medicine that causes one to vomit), and
- the misuse of enemas or alternative medications.

Purging is dangerous and can cause medical complications that affect every organ system in the body. Self-induced vomiting, the most common form of purging, can cause:

- tooth decay (exposure to stomach acids or from bingeing on foods high in sugar) and other dental problems,
- swollen salivary glands,
- esophageal inflammation and bleeding,
- stomach ulcers and bleeding,
- electrolyte abnormalities, such as low potassium or sodium,
- abnormal heart rhythms, and in some cases, death.

The use of laxatives, diuretics, or enemas can cause:

- fluid and electrolyte abnormalities,
- edema (swelling caused the body holding onto fluid),
- dehydration,
- increased risk of kidney damage and
- irritation to the bowel.

Purging behaviors, including excessive exercise, can contribute to the loss of, or irregular menstrual periods in young women.

WE KNOW THAT OUR DAUGHTER NEEDS TO EAT MORE, BUT WHEN WE TRY TO INCREASE HER MEAL SIZE SHE REFUSES TO EAT. WHAT SHOULD WE DO?

Food refusal is a hallmark of AN. As mentioned earlier, patients with AN are often fearful of food, eating, and gaining weight. In addition, they are likely to feel uncomfortable, overly full and bloated when they begin eating larger amounts as part of their recovery. For these reasons, it can be helpful to serve energy dense foods that provide a high number of calories in a relatively small volume.

The following methods for increasing energy can be used with many foods or recipes:

- **Increase the Fat:** add cream and shredded cheese to meals.
- **Eat energy dense foods first:** save fresh fruits, vegetables and fluids until the end of the meal.
- **Consider energy dense liquids:** liquids are digested faster and more easily than solids and therefore smoothies, shakes and formulas are good options for people who are feeling too full to eat.
- **Eliminate low calorie drinks:** serve whole milk or juice instead of water or diet drinks.

Although these strategies are helpful for some patients and families, they are not sufficient to overcome all of the challenges you may run into when trying to feed your daughter. Remember, food is medicine for EDs; therefore, any nutritional therapy must be accompanied by medical monitoring and psychological interventions, such as family-based treatment (FBT), which supports both the patient and the family with tools for achieving successful meal compliance.

MY SON FEELS EXTREMELY FULL AFTER EATING. HE COMPLAINS OF NAUSEA AND BLOATING. SHOULD I GIVE HIM LESS TO EAT?

It is normal for your son to feel “full” during the initial stages of the refeeding process. These feelings of fullness, nausea, and bloating should get better during the first couple of months with improved nutrition. When very little is being eaten, the stomach, which is a muscle, becomes smaller. In addition, during starvation, all body processes slow down to save energy - this includes the stomach and intestines. As such, food does not move as quickly through the digestive tract, causing feelings of fullness, bloating, nausea, and even constipation. With better nutrition and more food, the stomach will return to a normal size and digestion will speed up and eventually normalize.

No parent wants to see their child suffer, and it is natural to want to compromise on food quantities under these conditions. However, giving your son less to eat will only prolong the amount of time until he is eating enough to reach a healthy weight and a healthy mental state.

DOES MY SON NEED TO TAKE AN ORAL LIQUID NUTRITIONAL SUPPLEMENT?

Energy in the form of solid food is generally recommended for people with EDs because it allows for the normalization of diet and eating behaviors, and the return of normal gastro-intestinal function. Oral supplements are high-energy drinks that provide calories and micronutrients and may be helpful when used in specific circumstances such as:

1. When a young person requires extremely high amounts of energy to achieve weight gain or weight maintenance, such that they may not be able to meet their energy requirements from food alone.
2. When a patient with an ED has a limited range of foods that they will eat, meaning that some important nutrients (e.g., calcium, iron, zinc,) are not consumed in the right quantity for the body to function well.

In these cases, a supplement oral drink can help to boost calorie consumption and replace, or top up, essential nutrients. Patients on liquid supplements should be monitored regularly, as it is likely that their dietary intake will vary throughout treatment. Finally, liquid supplements should be considered a short-term source of nutrition, as full recovery cannot occur until the patient can eat real food in regular amounts to meet their energy and nutritional needs.

MY SON TOLD ME THAT HE “FEELS FAT” AT HIS TARGET WEIGHT. HOW DO I RESPOND TO THIS?

One of the hallmark symptoms of an ED is when a person sees themselves as too fat, even when their weight is dangerously low. These feelings often intensify while their weight is being restored to a healthier range. This is because restoring healthy brain processes that control metabolism, appetite, and perceptions of our weight and appearance usually takes longer than simply restoring lost weight.

These challenging thoughts and feelings are very real to the patient and should be discussed in a therapeutic setting so that caregivers can learn how best to respond (or not respond) to them. For instance, it is not uncommon for individuals with EDs to make negative comments about how they feel about their bodies. In this state of mind, even supportive comments such as “you look so healthy” may be misinterpreted as “you look so fat.”

It is difficult for families and friends to know how to help when patients are struggling with misperceptions about their body weight, shape and size. One effective strategy is for parents to avoid engaging in these types of conversations by learning to “separate” their child from the ED in their own minds.

Once a parent realizes that discussions about body size and shape will only be received as criticism by the ED, it becomes easier to focus on other kinds of engagement such as commending their child for non-eating related accomplishments. Positive messages such as “you seem so happy,” or “that picture you sketched is beautiful,” or simply, “I love you” are the things your

child needs to hear when they are ill and struggling with negative thoughts and feelings in their own heads.

SHOULD MY DAUGHTER TAKE VITAMIN D, CALCIUM OR A MULTIVITAMIN?

Calcium is necessary for strong bones and normal muscle function. Most dietary calcium comes from dairy products, but other dietary sources include green leafy vegetables, nuts and calcium-fortified breakfast cereals. If your daughter can meet her calcium requirements through her dietary intake, she will not require a supplement. However, many young people with EDs are not able to do so and should take a supplement containing 1,000-1,200 mg calcium/day.

Vitamin D is required for calcium absorption and without vitamin D the calcium cannot do its job. Vitamin D is made in the skin when exposed to sunlight, but deficiency is common in those living in northern climates, and in those who spend most of their time indoors. You can also get Vitamin D from foods such as fortified milk and cereal, fish, egg yolks, and liver. Vitamin D is a fat-soluble vitamin, which is stored in the fat tissues of the body and liver. Vitamin D waits around in the body fat until the body needs it. Young people who have depleted fat stores and who restrict their fat intake may become vitamin D deficient. For young people with EDs, most providers recommend a daily multivitamin containing 400-600 IU vitamin D/day.

OUR SON GAINS WEIGHT ONE WEEK AND LOSES WEIGHT THE NEXT; YET, HE IS EATING THE SAME FOOD EVERY WEEK. WHAT'S GOING ON?

During the initial week of refeeding, it is not uncommon for weight to fluctuate, as there may have been excessive fluid intake prior to treatment. In addition, caloric needs can increase dramatically during the first month of treatment, as the body's metabolism increases. Because of this, caregivers will usually need to increase food portions over time in order to see continued weight gain. If your son has been suffering from constipation, this may also cause changes in weight from week to week, depending on whether he has had a recent bowel movement.

Caregivers also need to be aware that EDs can cause individuals to "alter" their weights to disguise the effects of their ED. Weight checks can produce severe anxiety in ED patients for a variety of reasons. For some, the number itself is frightening and for others, the fear of disappointing their loved-ones can lead them to try to "trick the scales." There may also be fear of hospitalization if the acceptable weight is not met at the office visit.

Some young people have been known to hide coins, rocks, or weights under their clothes to appear heavier at weight checks. Another method used to mimic weight gains is "water loading" (drinking large amounts of water before getting weighed). Water loading is very dangerous and can lead to electrolyte abnormalities, abnormal heart rhythms, seizures, and even death.

Other ED behaviors that may interfere with proper weight gain include bingeing, purging, and over-exercising. Young people commonly hide these behaviors from their families. Thus, while it might seem that your son is taking in the appropriate amount of food, it is important to monitor him carefully for the emergence of these other behaviors.

MY CHILD WATCHES ME WHEN I COOK HER MEALS AND TRIES TO TELL ME HOW TO PREPARE IT. WHAT SHOULD I DO?

A person with an ED spends a lot of time thinking about food. They may worry about what they should or should not eat, the ingredients that go into their meals, and portion sizes. Many patients develop a set of “food rules” that seem irrational to caregivers, but which become very important to the sufferer as a way of relieving their fear and anxiety over eating. Being involved in meal preparation and serving their own food is often used as a way for the patient to control what they eat, and reinforces their disordered thinking about food. Remember, EDs are brain disorders, and a malnourished brain has a hard time making appropriate decisions regarding nutrition.

Needless to say, many patients have difficulty feeding themselves the quantity and variety that are prescribed to them for health, especially if they have been following a highly restrictive or structured set of “food rules” for a long period of time. These patients will require a lot of support and guidance from their caregivers in order to break out of the cycle of poor nutrition that has become their normal routine.

Some tips for supporting patients through meals and snacks include:

- planning meals and snacks ahead of time and keep changes to a minimum,
- offer your child limited, or no menu choices so as to reduce the anxiety related to choosing between foods which may all seem unacceptable to her,
- do not negotiate at meal time once food has been served,
- if necessary, remove your child from the kitchen while the meal is being prepared.

While a non-negotiable stance regarding meal planning may seem severe, it is a temporary, but often necessary practice until your child is further along in their recovery and able to participate in planning and eating meals in a more natural, relaxed way.

I HAVE BEEN READING CONTRADICTIONARY INFORMATION ABOUT EATING DISORDERS FROM BOOKS AND ON THE INTERNET. HOW DO I KNOW WHO OR WHAT TO TRUST?

There is an increasing body of research in the ED field that informs how clinicians practice and what patients and families should expect from treatment. Generally, information that comes from regulated professional bodies, such as the medical, psychology or dietetic professions, will be more reliable than information from blogs and web pages based on personal experiences of sufferers or therapist's case studies. Ask yourself when looking at books and information: "Is this a reliable source?" Look for signs that what you are reading is supported by scientific evidence and that the authors reference the scientific literature.

You will still come across conflicting advice however, because we simply do not know all the answers. If you are in doubt or you have questions about whether what you have read applies to your situation, you should discuss them with a qualified health care provider.

RESOURCES TO START WITH:

The Academy for Eating Disorders (AED), a global organization for EDs professionals committed to the integration of research and practice, is a good source of information that is applicable across all health care settings. Their website can be found at www.aedweb.org. In general, books recommended on the AED website have undergone scientific review by authorities in the field.

The AED has also published a booklet designed for health professionals titled: *"Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders."* This booklet is available in several languages as a PDF download from the AED's website.

In addition, some ED advocacy groups, such as **F.E.A.S.T. (Families Empowered and Supporting treatment of Eating Disorders)**, work with the scientific community to make sure that the information they give patients and families is based on the best available evidence. F.E.A.S.T. also offers support services for caregivers. For more information, please visit F.E.A.S.T. at www.feast-ed.org. To date, F.E.A.S.T. has published three other Family Guide Booklets, all of which are available to read and download in PDF format from the F.E.A.S.T. website.



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