CHAPTER 5

Get Into Your Child's Head

The Distorted Thinking Behind Your Teenager's Behavior

If your daughter or son has an eating disorder or seems to be developing one, you've probably already been told many times, "You don't understand me" or, in fact, "Nobody understands me." This feeling is very real for someone who is struggling with an eating disorder, and it's possible that you've become very frustrated trying to understand your daughter or son. Trying to communicate your position to your troubled child can be even more problematic.

The fact is that you may *not* understand what your child is experiencing. Children and adolescents with eating disorders see their behavior—especially behavior related to food, eating, weight, exercise, and health—quite differently from the way it looks from the outside. Eating disorders alter logical ways of thinking about food and body image (except for avoidant/restrictive food intake disorder [ARFID]). They distort what your son or daughter sees in the mirror or how they feel about food and eating. They implant in your child's mind irrational expectations about the consequences of eating and not eating, exercising and not exercising.

Unless you begin to understand how your teenager's thinking has been affected by the eating disorder, your efforts to be supportive

of your child's struggle against the illness will be handicapped. You may be reading your child's behavior as nonsensical or defiant, when she sees perfect sense in it and is not trying to make you feel bad but hoping to make herself feel good. It may seem irrefutably clear to you that your child is emaciated and dangerously ill, but how can you hope to get her to change her behavior if you don't realize that she still sees a fat person in the mirror and feels proud of herself for sticking to her "diet"?

Your child sees herself and all things food-related through a lens imposed by the eating disorder. We call the thoughts that emerge through this lens *cognitive distortions*. In this chapter we explore the cognitive distortions that are driving your child's behavior so you can see things the way she does and thus know better how to respond constructively.

A SHIFT IN ATTITUDE, A NEW APPROACH

Before delving into specific cognitive distortions that you may be trying to deal with every day, think for a minute about the strategy you've been using in trying to resolve your teenager's disordered eating. Have you been trying to "talk some sense" into your daughter? Or are you assuming that your adolescent thinks the same way you and everyone else does when informed by common sense and reason? Now is the time to recognize that helping a child recover from an eating disorder requires, first and foremost, a new set of assumptions and a new strategy.

Understanding exactly how your child with an eating disorder is thinking is a challenge. In fact, it is often quite tricky for doctors to fully understand just how the mind of a person with anorexia nervosa, bulimia nervosa, binge-eating disorder, or ARFID works with regard to the issues of eating, weight, and dieting. Yes, you should try to develop an understanding of the ways of thinking that guide your child's behavior. But you won't always be able to fathom what makes her do what she does or feel how she feels. So the safest strategy for you as the parents to adopt is to *assume,* as hard as this may be for you, that your child's thinking with respect to weight and shape

concerns and/or eating and food is probably almost always distorted. This may be especially true with anorexia nervosa.

It will also be helpful in coping with your child's illness not to underestimate just how firmly lodged these mental distortions, anxieties, and fears are. It's easy to underestimate the intransigence of these distortions, and you will often be tempted to talk some sense into your child. After all, it all seems so clear to you. Watching your child struggle to eat what appears to be a perfectly reasonable portion of food, for example, could certainly lead you to think or say, "Why not just eat it? It's so easy." Likewise, parents with a teen suffering from anorexia nervosa find themselves exhausted after lengthy and fruitless arguments, having tried to convince their child that a salad with dressing won't be harmful. The parents of someone with bulimia nervosa may discover that their child has made herself sick in the bathroom and might very well be tempted to advise her to "just stop doing it," adding, "It'll be easy; just get some self-control." For someone with a child with ARFID it is tempting to say, "Stop being so difficult and eat what's on your plate!" It is, of course, not easy at all—not for you or for your child. Eating disorders exert such a firm grip on your child's thinking that most of your pleading or arguing will be in vain.

We like to refer to such discussions as a fruitless debate with the eating disorder—parents trying, in a very rational way, to convince the child that eating is good for her or that she needs the salad or that the meal the parent so painstakingly prepared won't be harmful. Most of the time, parents lose these debates. The thinking of someone with an eating disorder is so firmly lodged in cognitive distortions and fears, there is no way you are going to argue your child out of her eating disorder. Someone with anorexia nervosa won't understand your perfectly logical argument about why this or that food item should be eaten. The beans, rice, or chicken you know will be nutritious for your child simply fills her with horror, because the food is "bad," "fattening," "unnecessary," "not the right food group," "scary," or deemed unacceptable in some other way.

When you find yourself tempted to try to reason with your child in these debates, it may help to keep one fact firmly in mind: *These cognitive distortions are at least sometimes the side effects of starvation,*

and dislodging such beliefs through rational debate is all but fruitless with someone who has a malnourished brain. No doubt you were shocked by the long list of medical consequences of starvation that you read in Chapter 4. Cognitive distortions are another serious consequence, possibly the most ominous of all, because this is the one that keeps the eating disorder going. Restoring weight and normalizing eating patterns and nutrition will certainly help with this matter, but we'll get to how that happens later on.

Teenagers with bulimia nervosa have many of the same concerns about what food may "do to them" as those with anorexia nervosa. Some subtle differences may center on "forbidden foods." This is not to say that someone with anorexia nervosa would not have a long list of "forbidden foods"—quite the opposite—it's just that for those with bulimia nervosa, there are very definite foods they believe are "forbidden" because they know eating these in particular will set off a binge episode that will be followed by purging. The same is the case with binge-eating disorder, except the episode is not followed by purging, but shame and guilt nonetheless. Because this chain of events is all too familiar to your child with bulimia nervosa or binge-eating disorder, these particular foods are avoided at all costs!

COGNITIVE DISTORTIONS: HOW THINGS LOOK TO YOUR CHILD AS COMPARED WITH HOW THEY LOOK TO YOU

Accepting the fact that the eating disorder itself is making it impossible for your child to grasp reality and embrace logic in food-related matters confers a couple of important benefits:

1. It helps you separate the illness from your child and thereby remain as compassionate and empathetic as possible as you guide your child toward recovery. Interpreting refusal to eat, or denial of what the mirror declares, as defiance or some other willful negative behavior is counterproductive, only reinforcing the adversarial relationship on which the eating disorder thrives. We discuss this topic further a little later in this chapter and in Chapter 7 as well.

2. It allows you to shift your attention to exploring the specific ways in which your child thinks differently from you, which in turn will give you ideas for fighting the eating disorder in everyday situations. The rest of this chapter is devoted to the common cognitive distortions that come with eating disorders, with general suggestions for how to respond constructively. Part III of this book goes into more detail on applying this knowledge to individual situations.

It's killing her, but your daughter feels good about refusing to eat, because it's something she does well.

Youth who have eating disorders, especially those with anorexia nervosa, are usually quite driven in nature. You can't just get "a little" anorexia nervosa; you have to be "perfect" at having anorexia nervosa. In fact, you have to be better at having anorexia nervosa than anyone else with this illness. We often see girls with anorexia nervosa who, when told they need inpatient care, burst into tears in our office, saying, "But I will be the 'fattest' anorexic on the ward!" or "I can't go there—I won't be as 'good' as the others."

Youth with anorexia nervosa have usually been praised for being "determined," "focused," and "energetic," not for their anorexia nervosa, of course, but for their performance at math, cross-country, or just about anything they put their minds to. Many parents describe their teen with anorexia nervosa this way: "Once he's decided to do anything, there's no way you're going to deter him," or "When he goes for something, he gives it all he has." This quality usually leads to numerous healthy achievements in school, sports, and other extracurricular activities. The difficulty arises when everyone other than your child—you, his teachers, and his peers—recognizes these achievements, but he does not. For someone with anorexia nervosa, achievements are soon forgotten, but failures (real or perceived—getting an A– as opposed to an A+) are mulled over and quickly blot out any prior accomplishments.

This all-or-nothing thinking can be devastating. For example, Freda works very hard at being the perfect student, does her work meticulously every day, has no time to go out in the evenings or even on weekends, and has an "unblemished" report card that is a strong

reminder to her that she is a "good" person and that others will like her. Without that, she'll be "nothing," "worthless," and an "utter failure." So when she was given a B in calculus, her first B ever, she was devastated. She came home sobbing, telling her parents that "things will never be the same again," "no one will ever speak to me again," and she was a "miserable failure," "dumb, stupid," and "useless!"

Often a young person with anorexia nervosa really thinks she is in fact a "loser," "good at nothing," "unattractive," and so on, when she doesn't achieve just as much as she has set out to achieve. The bar is always set high and is constantly being raised, all in an effort to convince herself that she is indeed worthy. Hilde Bruch, a famous psychoanalyst who wrote extensively about issues such as self-esteem in persons with anorexia (see Chapter 3), talked about this focus on one's failures as an "overwhelming sense of ineffectiveness."

As a result, and for reasons we don't fully understand, dieting may seem an attractive alternative solution to your child—something she thinks will "really help me feel better about myself." This may especially be the route she is attracted to when she thinks she's good at nothing else and thinks she's overweight, or someone at school or on social media made a derogatory comment about her weight, or so many other people are on diets and it seems like an admirable thing to do. Because your child has this ability to do whatever she does well, or to go all out, if she sets her mind on dieting or exercising, she will likely do these well too. Unfortunately, when she starts succeeding at dieting and/or exercise and begins losing weight, she may be encouraged by the way she looks, by the positive reinforcement she may be getting from peers or from her family, by her improved performance at cross-country running, and so on. It seems easy then for this achievement to supplant most other achievements, and it soon becomes the only thing your child thinks she does well.

In fact, anorexia nervosa is often associated with an immense sense of pride: "I can say 'no' to food when everyone else does not have such willpower" or "I can lose weight successfully when all of you are struggling just to shed a pound" or "I can run this extra mile even though I have not eaten much all day—none of you would be able to do that." This sense of "better than you" might be subtle, but if it's the only thing your teen thinks she's good at, she will do

everything to defend it. Thus, soon this ability to go without food is seen as her only sense of accomplishment, and anyone who attempts to persuade her to gain weight is seen as ignorant at best, but most likely as cruel and insensitive. It therefore feels incongruous when others criticize the teenager for being such a successful dieter (something many peers and parents have failed at) or try to "derail" his twice-daily routine of 200 crunches, 200 push-ups, 200 sit-ups, and so on. Your child feels that others are simply envious.

Again, the struggle for most parents is tackling this relentlessness that is so characteristic of eating disorders, without feeling as if they are taking something perceived to be so precious away from their child. Indeed, most youth with anorexia nervosa will make parents feel as if they're being most unkind in getting them to gain weight, while the parents will have to find a way to persevere in their efforts to help their child redirect her ability to be a "good anorexic" into another, much more fruitful and healthier endeavor.

Your child's behavior demonstrates that she's out of control, but she sees it as a way to stay in charge and express her independence.

In the usual pursuit of autonomy, there are many ways in which adolescents seek control of their own lives: choosing their own friends, driving themselves where they need to go, setting their own standards of performance, and so on. However, when adolescents' choices indicate they are not in control—binge drinking, serious risk-taking behavior, *and* anorexia and bulimia nervosa, to name just a few examples—the issue for parents is clearly how to set appropriate limits on independence and control. When dieting leads to anorexia nervosa, the adolescent needs help to reestablish normal adolescent autonomy processes and experimentation, and the options available do not include food restriction or overexercise. The same is true when food restriction leads to bouts of binge eating, whether followed by purging or not. Parents often have to assist youth in normalizing eating (for example, three healthy meals per day and several snacks) so that other aspects of adolescent experimentation do not also suffer as a consequence of the lack of healthy eating patterns.

The challenge for most parents, though, is that although the child's behavior demonstrates that she is out of control, she will more than likely see the eating disorder as the only way to stay in charge and express some independence. She will vigorously fend off any attempts you might make to help. There will be little you can do that won't be perceived as "you're always telling me what to do" or "you always want to control my every move."

Anorexia nervosa may look somewhat different from bulimia nervosa or binge-eating disorder in some respects. Youth with anorexia nervosa will probably come across as quite "together" or "in control" of their lives. In fact, the illness is often associated with a great sense of order, neatness, and discipline. Grades in school continue to be high. All this serves to confuse most parents as they contemplate the fact that their child is perhaps not in charge of things. We've often heard parents say, "Yes, she's 17 and weighs 82 pounds, but her grades are excellent, she's really working hard, and she's doing so well." The dilemma is made even more difficult by the fact that your daughter with anorexia nervosa will assert, repeatedly, that she is fine, that she is in control, and that she can make her own decisions in a rational way. Your daughter will be so persuasive in her arguments that you will find it hard not to believe her. The irony is that the illness also has the ability to convince her that she is indeed in charge of her eating and weight management, and that she can stop dieting and losing weight anytime she wants—"just not now!"

"I can take care of this myself" is also very persuasive to most parents, frightened about what they think might happen to their child but desperate in their willingness to believe that she can get better by herself, as she's repeatedly assured them she can. However, the way the physiology and psychology of starvation work is that at a certain point, usually once weight loss has clearly begun, the child loses control over this process and cannot stop dieting, or get herself to eat a decent amount of food, even if she *wants* to. The anorexia nervosa has firmly established its own control over the thinking and behavior of your adolescent.

This is a critical point to remember at all times: *Once your child has reached the point of significant preoccupation with and actual weight loss, she often cannot get better by herself, even if she proclaims that she can.*

As a parent, you need to realize that this doesn't necessarily mean she does not want to get better. It's just that the anorexia nervosa is more powerful as an illness than your child's solo efforts at defeating the illness. Remember your new set of assumptions when you're tempted to fall back into the attitude that your child is just being obstinate and all it will take for her to start eating normally again is for you to talk some sense into her.

Again, the only way to get your child out of this dilemma is for you and her treatment team to help her restore her weight. *It is only with normalization of eating behaviors and weight restoration when needed that she will be able to think in healthy and rational ways, and it is only with these improvements that she will have a chance to get back on track with a normal developmental trajectory and achieve healthy and appropriate control over her individuation and budding independence.*

Bulimia nervosa and binge-eating disorder are not altogether different, but with these illnesses it may be easier for you to notice that your adolescent is indeed out of control. You can probably think of many times that you've missed a box of cookies from the pantry: You knew it was there just this morning, and now it's gone. You remember putting last night's leftover chicken in the fridge, and now it's missing. You've noticed the candy wrappers in the trash in Maggie's room every day! And in the case of bulimia nervosa, you've also spotted the remnants of her purging in the bathroom, week after week now.

Many young people with bulimia nervosa or binge-eating disorder may feel ambivalent about anyone interfering with their attempts to control their weight, their eating, and even their purging, but are in fact often quite relieved when a parent helps them succeed in breaking the shameful pattern of binge eating and/or purging. Another difference in bulimia nervosa and binge-eating disorder, as compared with anorexia nervosa, is a youth with bulimia nervosa will not so stridently insist that she is in control of her eating. In fact, every time she has a binge-eating or purging episode, your daughter feels more and more out of control: "I feel disgusted with myself every time I do this, but I just don't know how to stop." In the case of bulimia nervosa, this is followed by thoughts such as "I am so afraid that I will gain weight if I don't make myself sick, and that's why I just

can't stop doing this." However, some youth may deny feeling out of control, especially as they'll probably make every effort to reestablish control over eating *after* a binge/purge episode. Unlike with anorexia nervosa, this sense of control seldom lasts for more than a couple of days, only to be followed by binge eating and, in the case of bulimia nervosa, purging again. Nevertheless, your daughter with bulimia nervosa or binge-eating disorder is probably more likely to assert that she is, in fact, in control of her behavior and that it isn't up to you to tell her what to do about her difficulties. This is particularly confusing to you as a parent, as you've seen your child acting quite independently in so many other areas of her adolescence. Helping her with her bulimia nervosa or binge-eating disorder may now seem almost counterintuitive!

Whether your child has anorexia nervosa, bulimia nervosa, or binge-eating disorder, it is highly likely that he won't think he is out of control and will probably resent you for trying to help. The challenge for you is how you will delicately balance your understanding of your child's developmental need for independence with your understanding of his dilemma and find a way to help him assert healthy control over his life at a time when he might resent you for your "interference." What is clear, though, is that you don't really have a choice. You have to help your child as the eating disorder continues to cloud his judgment.

To you, this is a deadly disease; to your child with anorexia, it's "just a perfectly healthy diet."

You now realize just how devastating an eating disorder is, but to see your child being flippant about her low heart rate, anemia, blood in her vomit, and swollen parotid glands is to come face-to-face with one of the most alarming aspects of anorexia and bulimia—the inability of the person with the eating disorder to appreciate just how deadly these illnesses can be. This denial of the seriousness of the severe malnutrition associated with anorexia nervosa is a core symptom of the illness. Teens with bulimia nervosa or binge-eating disorder will not necessarily understand the seriousness of their symptoms either, especially the long-term serious health consequences. Someone with

anorexia does not appreciate how lethal severe emaciation can be, and similarly, someone with bulimia does not understand that low potassium, due to frequent vomiting, for instance, can cause death. For those with binge-eating disorder, the risk of obesity, diabetes, and hypertension may seem remote. Still, it's fair to say that this denial is more pronounced in anorexia.

In Chapter 4 we explained that anorexia is an ego-syntonic illness. What this means is that, unlike those with many other mental disorders, the patient with anorexia "likes" or "cherishes" the illness or "takes comfort" in it. Someone with anorexia doesn't appreciate its dangers and will do almost anything to protect it, that is, prevent you from "taking it away." Although parents and doctors alike find this aspect of anorexia very difficult to understand, it helps to think of anorexia in comparison with other mental disorders: The patient who is depressed wants to feel better, the person who is anxious wants to relax, but the person with anorexia still wants to be thinner. This denial is actually reinforced through constant dieting and further weight loss, as well as focusing on these issues (dieting and weight) all the time to the exclusion of other, healthier perspectives. Thus, her diet is still normal to your daughter, even though everyone else sees it for what it is. Therefore, it's not uncommon for someone with anorexia to take pride in brushes with death: "Wow, I got my potassium down to 1.8, and I made it." (Showing up in the emergency room with a potassium level that low is considered most critical, and few people can be revived.)

What makes this illness so incredibly dangerous is that no matter how much you argue this very point with your teenager with anorexia—"You could have died. . . . We are so lucky they managed to revive you at the hospital. . . . We were so, so scared. . . . Do you understand how serious this is?"—these facts usually will have little impact on your son. Quietly, your teen will perceive this "crisis" as another achievement in his quest for that ideal weight.

By comparison, bulimia and binge-eating disorder are more ego-dystonic. What this means is that although an adolescent with bulimia or binge-eating disorder exhibits many of the aspects of denial of her illness that are common in anorexia, there is less pride involved in her symptoms. Rather, great discomfort and shame are

associated with binge eating and purging. Nevertheless, this doesn't mean that your son or daughter will be forthcoming and ask for help as an adolescent who is depressed or anxious might. Quite the opposite is true. Because thinness is highly valued and the seriousness of the illness is not appreciated, *and* because of the guilt and shame associated with binge eating, most adolescents will do their best to binge eat without your knowledge. For those with bulimia, the anxiety that the food they ate will make them gain 5 pounds overnight is so overwhelming that they absolutely "have to" get rid of it and will make every effort to make sure there's a way to purge after the binge-eating episodes. It certainly is not uncommon for a teenager with bulimia to evaluate an invitation for a movie and a meal with her friends based not on what movie they'll see or what kind of food (Asian, Italian, Mexican) they'll eat, but rather on the answers to questions such as "Will I be able to purge at that restaurant?" or "Can I slip away at that movie theater to use the bathroom to throw up?"

Thinking, Fears, and Disgust in ARFID

Youth with ARFID have concerns and worries that differ from those that characterize anorexia nervosa, bulimia nervosa, and binge-eating disorder. These concerns are not focused on weight and shape, but instead are serious cognitive and emotional reactions to food and eating that lead to social, nutritional, and developmental impairments. The child who is "too busy" to eat, is never hungry, and whines at every meal when encouraged to eat enough to grow and have metabolic health is not willfully disobedient, though it may seem that way to parents who are worried about him. Instead, he feels "forced" to eat when he feels no hunger, making him frustrated by being told what to do and failing to recognize his need for nutrition. Similarly, the child who is afraid that if she eats she will choke, not be able to breathe, and maybe die is not being melodramatic. Her fear is genuine and disorganizing her emotional life and relationships with others, especially her parents, who are frightened for her health. Fear—whether in anorexia nervosa or in the context of ARFID—is a very powerful emotion, so much so that in response a

person will do almost anything to avoid experiencing it. Avoiding fear leads to avoiding eating, and avoiding eating leads to malnutrition. You child does not choose to be afraid—they are trying not to be afraid—but they are afraid of being afraid.

For those who have ARFID as a result of extreme picky eating, it is not fear so much as anticipation of feeling disgusted that motivates their limited food choices. Disgust is a powerful response that has both emotional and cognitive dimensions. Disgust is likely a biologically based response that helps protect us from poisonous or harmful foods. Similarly, sensitivity to tastes and textures vary significantly from person and person—one person may like hot sauce and another cannot bear it—and these sensitivities have both biological and social origins. So, when your child has an extremely limited range of foods in his diet, it is important to remember that disgust and food taste and texture sensitivities are not really your child's choice but rather his response to foods he finds disgusting (or appear likely to be so). Trying to argue with your child about these responses to eating leads to frustration on all sides.

As has probably become clear by now, gaining a better understanding of how the eating disorder leads your child to think and behave in very fixed ways concerning weight, shape, and eating issues will be helpful to you in finding the right way to help your adolescent overcome this struggle. That doesn't mean this understanding will automatically suggest an instantly effective strategy; it's just that without this understanding you're unlikely even to know why your efforts fail. Chapters 7 and 8 offer various ideas for helping your child, based on your understanding of these cognitive distortions.

You're the enemy, even though you're trying to save your son's life, because you're "forcing" him to do the one thing he is trying to avoid: eat.

The cognitive distortions and emotional reaction borne of eating disorders, by their very nature, create an adversarial relationship between you and your child. You want your child to eat appropriately to regain his health; he is firmly committed to continuing to lose weight or to hiding the truth that he is binge eating and purging

or continuing to eat the same four things that he feels comfortable consuming. The fact that you can't "talk some sense into him" means that any attempt you make to confront your child's false beliefs and consequent denial only makes you seem like a greater enemy.

The rift between you may seem to widen from your own perspective too when you try to confront your child about irrational beliefs surrounding food and weight. You may very well have come to count on the rational discussion and sharing of decision making that are among the beneficial developments of life with an adolescent. In fact, you may feel today that you have a perfectly rational person around the house most of the time—"We can talk about homework, our vacation plans, or the music she likes to listen to"—but when it comes to food, eating, and weight issues, "it's as if a switch was turned off; she makes no sense, and the worst is, she doesn't see the difference." The fact that your child is no longer meeting your expectations for rationality may make you feel as if it's the child who is creating the adversarial situation. With this kind of standoff, who wins?

The eating disorder wins.

That's because the real—and only—enemy is the anorexia nervosa, bulimia nervosa, binge-eating disorder, or ARFID. Recognizing this is the key to responding constructively to these powerful emotional responses and cognitive distortions.

The concerns associated with eating disorders can be so severe that rational discussion and decision sharing about your child's health are no longer possible. Parents have to be prepared to accept the idea that in the areas of food, eating, and weight, they are no longer dealing with a child who is rational. It is the *illness* they are dealing with.

We've seen many parents in distress when their usually kind child lashes out when the parents make any attempt to intervene in the illness: "I don't want to eat that! You're killing me. Can't you see how unhappy you make me?" or "I hate you, I want nothing to do with you, don't even talk to me!" or "Leave me alone! You are making me *so* miserable." Desperate utterances from your child sounding anything like these are obviously distressing to any parent. What the young person with an eating disorder wants is for you to back off in

your efforts to help. As tempting as this might be for many parents, acquiescing only means allowing the illness to triumph.

What can you do? Negotiating with your child under these circumstances is a great challenge and one that you are most likely to lose. In defense of his illness, your son will try to make sure that your efforts fail, whether you are trying to get him to eat more or to keep him from purging the food that he has consumed. Knowing that there is little you can do to rationally argue, discuss, or convince your son about the perils of his illness and that the behaviors he is manifesting are illness related as opposed to those of "your child" (separating the illness from your adolescent) will help you when you're trying to help him. Knowing that getting involved in "eating disorder debates" will be fruitless and that you will probably lose the argument and end up being convinced, against your own better judgment, that an apple is better than a pasta dish with a cream sauce for a starving teenager, it's best not to argue. Instead, you will want to find a way to let your child know that you understand his dilemma, that the illness doesn't allow him to be rational about food and weight right now, that you understand that for the time being he sees you as the enemy, but that none of this can deter you from doing what you know will save his life—to get him to eat what he should eat to be healthy and/or to keep him from binge eating and purging.

Earlier we mentioned the concept of separating the illness from your adolescent. This is an important principle in dealing with a teenager with an eating disorder, just as it is in helping someone of any age with any psychiatric disorder. Understanding how the illness is "separate" from your child will be crucial in helping you understand your child's troubled behaviors and deal with the illness effectively. We discuss this principle in more detail in Chapter 7.

"Not eating" is not just the most important thing in the life of your daughter with anorexia nervosa: It's "the only thing."

For parents, it is often very difficult to understand just how important eating or not eating, weight loss, or feeling the "right" size is to their child. In fact, for someone with anorexia nervosa, nothing

can be more important than focusing on that next pound to lose or making sure not to eat at all until 5:00 P.M. every day of the next week. For someone with bulimia nervosa, nothing can be more important than how she can get rid of the food she has just eaten, believing it's going to make her fat. Indeed, managing to adhere to all these "rules" and "regulations" around eating or not eating eventually eclipses the importance of school, family, and friends, or at least it appears to do so, especially if the eating disorder behaviors are allowed to continue unchecked. It is especially hard for parents to witness their kind child appear completely oblivious to other crises in the family—it's not uncommon for a person with anorexia nervosa to show little concern for a parent who was just diagnosed with a severe illness, because she is so preoccupied with the quest for thinness. This young person is, of course, not heartless; it's just that eating disorders have a way of overtaking the sufferer, leaving little room for anything else.

Paradoxically, when someone with anorexia nervosa continues to starve himself, it actually becomes easier and easier not to eat. At the onset of the illness the young person has to work very hard to keep his appetite "in check," making sure he doesn't "give in" to these "horrible urges" to eat, always feeling that he cannot let his guard down for a moment. With increasing weight loss, though, it becomes easier to feel a sense of mastery over these urges, and with time the young person no longer feels any hunger. However, with increased starvation, he also becomes more preoccupied with thoughts about food and weight. In fact, some young people find themselves in the unenviable position where they can think of virtually nothing else but "What is that half bagel from this morning going to do to my weight?" or "What can I do to avoid having lunch with my friends?" or "How can I make sure that I have no more than a salad without dressing for dinner?" and so on. It's hard to imagine just how much of their time, on a daily basis, will be taken up by such thoughts. Some teens with anorexia will say, "I can think of nothing else but my weight—literally nothing else!"

Much of what happens with the dieting adolescent, especially when starvation has set in, also happens to people who lose extreme amounts of weight because of a variety of medical illnesses. In fact,

much of what we know about the effects of starvation on the human mind and on human behavior is derived from what we have learned from individuals without an eating disorder. Ancel Keys and his colleagues, in a landmark study in Minnesota in the early 1950s, published their results of a semi-starvation study of World War II conscientious objectors. The physical and psychological changes in these healthy men who were starved for several months were the same as those we typically observe in our patients with an eating disorder—the men became increasingly preoccupied with their weight and with food once they had lost a substantial amount of weight. It's almost as if the part of the brain that controls hunger and satiety will not let you forget about the one thing you need most when you're starved—food! The good news is that once these starved study participants were allowed to eat normally again, their weights were restored and the symptoms of starvation also disappeared. These observations reveal exactly what we also witness in many patients with anorexia when they return to a healthy weight.

Your daughter with anorexia nervosa has consumed mere crumbs of food, but she thinks she's telling the truth when she says she's eaten a huge amount of food today.

When your child has consumed only a few bites of her sandwich and proclaims to have eaten "tons" or "too much" or a "huge amount," there are at least two ways in which her account is accurate from her perspective. First, she sees eating anything at all as a failure and a sign of weakness. So, psychologically, even a small amount is the same as a large amount to her. The anxiety and guilt she experiences after eating half a bagel are the same as if she had eaten a whole sandwich. Second, and in reality, the stomach of someone with anorexia nervosa usually decreases in capacity, and as a consequence, the rate at which the stomach empties has been slowed. It's therefore quite likely that your child will feel full and stay feeling that way longer after eating even a relatively small amount of food. Moreover, prolonged starvation has allowed your child's hunger cues to be stilled, making eating even more difficult when she states that she's not hungry. So, when she does eat, even what are in

fact mere crumbs, your daughter will feel that she has overeaten on both accounts. "I will get fat if I eat that bagel (half an apple/three carrots/and so on)," she will say, or "I just can't eat that much, I've already had enough," in reference to the small bowl of salad without dressing that sits half eaten. These incidents are, in fact, experienced by your child as really having eaten too much or really finding it hard to eat the "whole" salad.

The situation is further complicated when parents want to believe their child's account of what was eaten when they (the parents) weren't around to supervise a meal. And parents can become increasingly despondent when their child doesn't gain weight despite "all the food" she claims to be eating on a regular basis. It is very important for you to remember that eating even half an apple at school lunch, when your child has promised himself (though really promised his anorexia nervosa) not to eat at all, is seen by him as a calamitous transgression of crucial food rules and that the half apple was a huge amount of food—"huge" because it "should not have been eaten." Likewise, asking your child to tell you what she ate for lunch at school might get you a response along these lines: "A yogurt and an apple and a milkshake." That may sound like enough, but if you inquire carefully, it may in fact mean that in reality she ate a scoop of yogurt, ate a bite of an apple, and had a sip of a milkshake. As has become clear to you by now, even when your child protests about "too much food" or says, "I can't possibly have more to eat," recovery from anorexia can really come about only when sufficiently healthy amounts of food are consumed to return your child's thinking about these issues to normal and, of course, to restore gut functioning to normal.

The same scenario may be true for an adolescent with bulimia nervosa or binge-eating disorder, but it will take a slightly different form. Whereas your child who binge eats will also try to restrict her food intake and may also consider mere crumbs of food "a lot," many young people who binge eat are very scared that if they eat "one more crumb" than their self-imposed food rules allow, they will "just go ahead and eat the whole cake." Sadly, that is what happens for young people who binge eat, and that's why your child will so rigidly try to hang on to these beliefs.

No matter how emaciated she becomes, what your daughter with anorexia nervosa sees in the mirror is a fat person.

This is called *body image distortion,* which is a result of an overfocus on weight and shape that eventually leads to misapprehension of realities. Many young people with anorexia nervosa overestimate their own body size, and quite paradoxically, the thinner they become, the more they may see themselves as fat. Body image distortion is much less common among those with bulimia nervosa, binge-eating disorder, or ARFID. In the case of bulimia nervosa and binge-eating disorder, instead of body image distortion per se, there is an overvaluation of appearance, especially related to weight. Some youth with eating disorders may go so far as to cover all mirrors in their homes so that they can never catch a glimpse of themselves.

Unfortunately, the only "solution" the young person can think of to escape this agonizing dilemma is to lose yet another pound, thereby establishing a cycle of further weight loss and further distortion of reality. One insightful young person with anorexia nervosa described her experience like this: "I thought I was fat when I wore these pants. Now that I have gained weight I can't see any difference (I still look as fat), but the pants are the same. I guess I can't see things the way they really are. My fear of being fat makes me look fat no matter what." Many young people, though, know they are thin and don't actually see themselves as fat, yet they still cannot escape "feeling fat." Someone might say, "I know I'm not fat, but every morning I wake up feeling fat, and I know there's only one way to tackle my problem and that's to lose more weight. Perhaps then I won't feel fat." What may be happening here for some young people who are predisposed to developing an eating disorder is that it's "easier" to wake up in the morning and focus on their weight than to think about "that issue at school" or "the breakup with my boyfriend." Many teenagers with eating disorders may not know how to tackle or resolve the issues that cause them to feel depressed or anxious, but it's a little "easier" to go on a diet and lose weight. So, instead of waking up saying "I am depressed" or "I am anxious" and then having to figure

out how to deal with that feeling, it seems somewhat more manageable to "replace" the depression or anxiety with "I feel fat," because at least "I have a plan to cut back on my food intake some more and lose another pound. Maybe then I'll feel okay."

Obviously, losing that extra pound does not help with the feeling of fatness. But even with that evidence before her—that losing an extra pound doesn't eliminate her feeling of being fat—you will find it very difficult, if not impossible, to convince your child that she isn't fat. As long as that "feeling" persists, the young person will stay on the cycle of trying to lose weight, and not eating will continue to cause the body image distortion that tells her loud and clear that she is fat. Body image distortion usually, but not always, improves or even normalizes after weight has been restored for a period of a few months in an outpatient setting.

Your son with bulimia nervosa continues to vomit even though his weight is clearly increasing.

One of the ironies of bulimia nervosa is that the weight-control strategy of purging is quite ineffective. It is impossible to vomit up the full amount one has eaten during an hour-long binge-eating episode—too much food has already entered the intestinal tract. Thus, a hefty percentage of these high-calorie foods remains in the system and adds weight. Over time, then, instead of losing weight, patients with bulimia nervosa tend to gain weight. However, this only adds to the urgency of their efforts to control their weight, which leads to increasing self-starvation, binge eating, and then purging. Still, they keep on doing it. Why?

The answer is, in part, that over time binge eating and purging are experienced as a coping strategy for life's other problems. Over time, young people report feeling tremendous relief after purging. This reinforces the purging behaviors whether or not they lead to weight loss. Many people who have been ill for a while readily admit that they know the purging does little to help them with weight control: "It's just that I have to do it. I feel much better afterward, even if that feeling doesn't last very long." So, when your son feels he didn't

perform well at a wrestling meet, he may binge eat and purge. The same is true when your daughter breaks up with her boyfriend or is having academic trouble. In other words, binge eating and purging are no longer efforts at weight control alone; they are also used more generally in an effort to cope with other problems. When a behavior like binge eating and purging is being used to manage life's other problems, it's harder to let go of, and the "logic" that it doesn't control weight doesn't pertain.

Your daughter seems prideful about her self-starvation but miserable at the same time.

One of the hardest things to appreciate about severe dieting is that although your child appears to be reveling in the accomplishment of lower and lower weights, she is also quite miserable. Anorexia nervosa is a very tough taskmaster. Whenever your child eats even a small amount, she experiences severe harassing and critical thoughts about failure and worthlessness. These thoughts are unrelenting and merciless. In addition, the preoccupation with eating, obsessive and repetitive thinking about how much was eaten and how many calories were consumed, weight gain, and so forth disrupt usual thinking, making it sometimes difficult to focus in school or during social gatherings. The point is, however determined and steadfast your child appears, she is really suffering, physically and psychologically, as a result of the punitive thinking experienced.

Young people with bulimia nervosa are usually filled with shame and feelings of failure because they "give in" to eating and "purge" even though it's disgusting. These adolescents experience a combination of guilt, shame, recrimination, and anxiety about gaining weight. It helps to have a sympathetic view of this experience, because as a parent, when your child is suffering, you want to relieve that suffering, even if the illness behaviors are themselves frustrating and provoke anger in you.

Children with ARFID often feel they are a disappointment to their parents—they feel that if they eat when they are afraid, disgusted, or not hungry they will be miserable, but if they do as their

parents ask, they will feel uncomfortable, feel overwhelmed, or have extremely unpleasant eating experiences. They are stuck between a rock and a hard place. Consequently, they are sometimes oppositional, angry, tearful, and defiant in the face of parental requests to eat more and/or differently. Parents who understand these feelings and react to them with compassion, while also not allowing their child to continue undereating or eating a completely unhealthy diet, will be more successful in the long run at helping their child manage and recover from ARFID.

Your son weighs himself 10 times a day and is constantly pinching himself to see if he has any fat despite his obvious severe weight loss.

Body checking and repeated weighing appear irrational to us because we know that weight does not vary much during a single day and that pinching or repeatedly checking our appearance in the mirror will not provide new information. However, the anxiety about weight gain and a concomitant hyperfocus on body fat are pervasive in young people with anorexia nervosa, bulimia nervosa, and binge-eating disorder. To combat perceived weight gain or actual but needed weight gain, those with these eating disorders look for reassurance in these constant "checking" activities, whether it's pinching the stomach or thighs a hundred times a day or standing in front of the mirror for what seems like hours at a time, checking and rechecking to see whether any weight was put on. Unfortunately, the reassurance is only momentary (if at all), and they quickly need to check again. If you remember that these behaviors also reinforce the hyperfocus on shape and weight concerns, you will see why it's often necessary to find ways to help your child reduce his dependence on such strategies so as to reduce his anxiety about weight and shape. For instance, you might make this struggle a great deal easier for your child if you remove your bathroom scale. You can reassure your child that he will be weighed at regular intervals at the doctor's office, and it is at the doctor's office that these concerns can be addressed.

Your daughter promises to stop binge eating, but every day you find missing food cartons and potato chip bags under her bed.

Your daughter's intentions to stop binge eating are sincere and genuine. She wishes she could follow through on them. It is not a loss of willpower or a character problem or just wanting to be spiteful. Rather, it is that she has learned to use food to manage her emotions, conflicts, and self-esteem. Food is very reinforcing for most of us (though not—as we have noted—for some children with ARFID) because it is immediately rewarding on a physical and neurochemical level. Food has also been used to soothe, comfort, and reward in socially condoned ways throughout history and currently. Your daughter may not care about the long-term effects of binge eating on her weight or health, but the short-term rewards are hard to ignore, especially when she is feeling overwhelmed and doesn't have an alternative strategy to help her cope.

WHAT'S A PARENT SUPPOSED TO DO?

When you understand your child's thinking with regard to the emotional and cognitive problems we've discussed, you've laid the foundation for whatever practical interventions you will implement to help fight your child's eating disorder. By separating the illness from your child (also called *externalizing the illness*), you support your child as a developing young person while insisting that she fight the eating disorder nonetheless.

As we've shown, eating disorders are clearly very complicated illnesses, both in terms of the effects of starvation and maladaptive eating and eating patterns on the mind and the body, and in terms of how coexisting psychiatric illnesses further complicate the picture. In addition, as we've seen in this chapter, how your child experiences the effects makes her thinking and behaviors appear irrational and confusing, though there is a kind of logic when you understand them better.

Treatment for eating disorders must respond to these complicated thoughts, behaviors, and, at times, medical problems. What this usually means is that good treatment pays attention to all aspects of these illnesses—psychological, psychiatric, medical, and nutritional. Good treatment also means that you, the parent, play an active role in helping your child receive care and that you actively participate in this care. Your involvement in treatment is particularly helpful here, as these emotional and cognitive distortions are so persistent and so powerful that someone has to be on hand to help counteract them, and, obviously, the parents (and the rest of the family) are usually the only ones routinely in the position to do this.

In the following chapter, we outline what research to date has been able to tell us about the effectiveness of the best-studied treatments for eating disorders. If you choose to have family therapy along the lines of FBT (see Chapter 7), it will help you use everything you now know about how your child thinks to enhance your success in taking charge of the problematic eating behavior. If you choose among other types of treatment, you can still use what you know about emotional and cognitive distortions to support the treatment team's efforts, as described in Chapter 8.

FOR MORE INFORMATION

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