



Frequently asked questions



What is an eating disorder?

Eating disorders are serious, but treatable, illnesses with medical and psychiatric aspects. The eating disorders most commonly known to the public are anorexia and bulimia. There are also other eating disorders, such as binge-eating disorder. Some eating disorders combine elements of several diagnostic classifications and are known as “eating disorder not otherwise specified.” These disorders often coexist with a mental illness such as depression, anxiety, or obsessive-compulsive disorder. People with an eating disorder typically become obsessed with food, body image, and weight. The disorders can become very serious, chronic, and sometimes even life-threatening if not recognized and treated appropriately. Treatment requires a multidisciplinary approach with an experienced care team. Please see the other documents in the toolset for more information about diagnosis, treatment, and common misconceptions.

Who gets eating disorders?

Males and females from ages as young as 7 or 8 years old get eating disorders. While it's true that eating disorders are more commonly diagnosed in females than males and more often during adolescence and early adulthood than older ages, many cases are also being recognized in males and in women in their 30s and 40s. Eating disorders affect people in all socioeconomic classes, although it was once believed that they disproportionately affected upper socioeconomic groups. Anorexia nervosa ranks as the 3rd most common chronic illness among adolescent U.S. females. Recent studies suggest that up to 7% of U.S. females have had bulimia at some time in their life. At any given time an estimated 5% of the U.S. population has undiagnosed bulimia. Current findings suggest that binge-eating disorder affects 0.7% to 4% of the general population.

Can eating disorders be cured?

Many people with eating disorders who are treated early and appropriately can achieve a full and long-term recovery. Some call it a “cure” and others call it “full remission” or “long-term remission.” Among patients whose symptoms improve—even if the symptoms are not totally gone—(called a partial remission), the burden of the illness can diminish a lot. This can open the way for healthier relationships with food to be implemented, quality of life to improve, and patients feeling happier and more productive. Treatment must be tailored to the individual patient, and most treatment plans involve a combination of psychotherapy, nutritional support, and possibly even medication. The biggest step towards recovery is getting the person with the eating disorder to admit it and accept help.

Controversy exists about the term “cure,” which implies that a patient does not have to be concerned with relapse of the disorder. Many clinical experts prefer the term “remission” and look at eating disorders as a chronic condition that can be very effectively managed to achieve complete remission from signs and symptoms. Patients may, however, be at risk of a relapse at some future point in life. Many patients in recovery agree that remission more accurately describes their recovery, because they continue to need to manage their relationship with food, concepts about body image, and any coexisting mental condition, such as depression.

If someone I know intentionally vomits after meals, but only before big events—not all the time—should I be concerned?

Yes. Anyone who feels the need to either starve or purge food consumed to feel better has unhealthy attitudes about one or more issues: physical appearance and body image, food, and underlying psychological issues. This doesn't necessarily mean the person has a diagnosable eating disorder, but expressing concern to a friend about the behavior is warranted. If they deny the problem or get defensive, it might be helpful to have information for them about what eating disorders actually are. See the fact sheet on anorexia nervosa and bulimia nervosa.

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I know someone who exercises every day p to 3 or 4 hours a day. Is this considered to be a sign of an eating disorder?

Perhaps. If the person is not training for a rigorous athletic event (like the Olympics) and if the compulsion is driven by a desire to lose weight, despite being within a normal weight range, or if the compulsion is driven by guilt due to bingeing, then, yes, the compulsion to exercise is a dimension of an eating disorder. If you know the person well, talk to him/her about the reasons he or she exercises this much. If you are concerned about weight or the rationale behind the excessive exercise regime, seek to put the person in touch with information and resources that could help.





I'm noticing some changes in weight, eating habits, exercise, etc., with a student, but I'm not sure if it's an eating disorder. How can I tell?

Unless you are a physician, you can't make a diagnosis, but you can refer the student to appropriate resources that might help. Keep in mind, however, that denial is typically a big part of eating disorder behavior and a student may be unreceptive to the suggestion that anything is wrong.

What if I say the wrong thing and make it worse?

Family, friends, and school staff often express concern about saying the *wrong* thing and making the eating disorder worse. The causal and maintaining factors of eating disorders are complicated. Just as it is unlikely that a person can say something to make the eating disorder significantly better, it is also unlikely that someone can say something to make the disorder worse. Refer to the **Dos and don'ts to be supportive** in the parent toolkit for guidance on how to support someone with an eating disorder.

A group of students is dieting together. What should we (parents/teachers/student friends) do?

Seeing a friend, family member, or fellow student develop an eating issue or disorder can sometimes lead other students to feel confused, afraid, or full of self-doubt. Other students may begin to question their own values about thinness, healthy eating, weight loss, dieting, and body image. At times students may imitate the behavior of their friends. Imitating the behavior may be one way of dealing with fear, trying to relate to the friend with the eating disorder, or trying to understand the illness. In other cases, a group of students dieting together can create competition around weight loss and unhealthy habits. If dieting is part of the accepted norm of the peer group, it can be difficult for any young person seeking peer acceptance to resist joining the behavior. Approaching a student who is imitating the behavior of a friend with an eating disorder should be similar to approaching a student with a suspected eating problem.

What should be done when rumors are circulating about a student with an eating disorder?

If a student has an eating disorder and other students are talking about it to the point where the student with the eating disorder is very uncomfortable coming to school, a strategy to deal with the gossip is in order. What a student is suspected of having or is diagnosed with, is an eating disorder, fellow students may have different reactions. Rumors often develop that further isolate the student experiencing the eating disorder. Rumors can also be a form of bullying. Here are some suggested strategies:

- Assess the role of the rumors. Sometimes rumors indicate students' feelings of discomfort or fear.
- Demystify the illness. Eating disorders can sometimes become glamorized or mysterious. Provide actual, age appropriate information that focuses on several aspects of the illness such as the causes as well as the social and psychological consequences (not only the extreme physical consequences).
- Work privately with students who are instigating and/or perpetuating rumors:
 - Talk about confidentiality and its value. For example, promoting the idea that medical information is private and therefore no-one's business
 - Without identifying the students as instigators of the rumors, encourage them to come up with ways of dealing with the rumors by establishing a sense of shared concern and responsibility. For example, "*Can you help me work out a way of stopping rumors about (student's name), as he/she is finding them very upsetting?*"



Are the issues different with males with an eating disorder? What do I say?

Some aspects may be different in males. Important issues to consider when talking to or supporting a male who may have an eating disorder include the following: **Stigma.** Eating disorders are promoted predominantly as a female concern. Males may feel a greater sense of shame or embarrassment. It may be even more important not to mention the term “eating disorder” in the discussion, but rather focus on the specific behaviors you have noticed that are concerning. Keep the conversation brief and tell him what you’ve observed directly and why it worries you. For more guidance, refer to the document in this toolkit: “Ways to start a discussion with someone who might have an eating disorder.”

Eating disorder behavior presents differently in males. Although the emotional and physical consequences of eating disorders are similar for both sexes, males are more likely to focus on muscle gain, while females are more likely to focus on weight loss.

What’s the difference between overeating and binge eating? Is attendance at a program like Weight Watchers sufficient to treat binge eating?

Most people overeat now and then, but binge eating is distinguished by eating an amount of food within a specified time that is larger than the amount that most people would consume during a similar time and circumstance, and feeling out of control over eating during the binge. Because programs like Weight Watchers often include a self monitoring component, such as detailing daily eating patterns, they can be helpful in decreasing food consumption. However, they may be insufficient in addressing the underlying emotional or psychological components of an eating disorder and consequences of binges.

Can’t people who have anorexia see that they are too thin?

Most cannot. Body image disturbance can take the form of viewing the body as unrealistically large (body image distortion) or of evaluating one’s physical appearance negatively (body image dissatisfaction). People with anorexia often focus on body areas where being slim is more difficult (e.g., waist, hips, thighs). They compare their other body parts then, and believe they have “proof” of their perceived need to strive for further weight loss. Body image dissatisfaction is often related to an underlying faulty assumption that weight, shape, and thinness are the primary sources of self-worth and value. Adolescents with negative body image concerns are more likely than others to be depressed, anxious, and suicidal.

I know someone who won’t eat meals with family or with friends at or outside school. How can he/she not be hungry? Does he/she just not like food?

Most likely, the person is overwhelmingly preoccupied with food. A person with an eating disorder does not like to eat with others, does not like anyone questioning his/her food choices, and is totally consumed with refraining from eating. Is the person hungry? Yes! But the eating disorder controls the person.

KEY SOURCES:

American Psychiatric Association <http://www.healthyminds.org/factsheets/LTF-EatingDisorders.pdf>

Victorian Centre of Excellence in Eating Disorders, The Royal Melbourne Hospital, Australia <http://www.rch.org.au/ceed/>

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