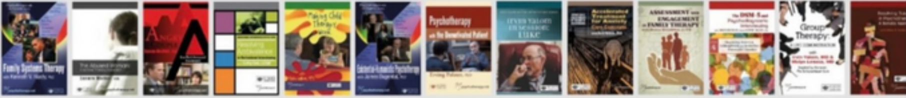
PsyflixTR



SERTİFİKALI PSİKOTERAPİ KURSLARI

BİREYSEL VE KURUMSAL ÜYELİK İÇİN
kimpsikoloji.com

Irvin Yalom önderliğinde organize edilen ve dünyaca ünlü terapistlerin ve terapi kuramı kurucularının, ekollerin en önemli temsilcilerinin psikoterapi seanslarını video olarak izlemek ve seans hakkındaki yorumlarını dinlemek ve bu kursları (American Psychological Association (APA) başta olmak üzere Social Workers (ASWB) New York State Social Workers (NYSED BSW) New York State Mental Health Practitioners (NYSED MHP) Certified Counselors (NBCC) Addiction Counselors (NAADAC) MFTs and LCSW (CA BBS) California Nurses (BRN) Canadian Counsellors kurumlarından CE (Continuing Education-Sürekli Eğitim) akreditasyonlu sertifikayla belgelendirmek isteseniz veritabanımıza bireysel veya kurumsal olarak erişmek için bizimle iletişime geçebilirsiniz.

@PsikoTerapiVideolari
psyflix.com.tr

kimpsikoloji.com
/kimpsikoloji

Akademi.KimPsikoloji.com

YAYINDA

SERTİFİKALI

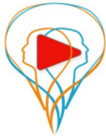
PSİKOTERAPİ KURSLARI

BİREYSEL VE
KURUMSAL ÜYELİK İÇİN
kimpsikoloji.com

BİREYSEL VE
KURUMSAL ÜYELİK İÇİN
kimpsikoloji.com

Irvin Yalom önderliğinde organize edilen ve dünyaca ünlü terapistlerin ve terapi kuramı kurucularının, ekollerin en önemli temsilcilerinin psikoterapi seanslarını video olarak izlemek ve seans hakkındaki yorumlarını dinlemek ve bu kursları (American Psychological Association (APA) başta olmak üzere Social Workers (ASWB) New York State Social Workers (NYSED BSW) New York State Mental Health Practitioners (NYSED MHP) Certified Counselors (NBCC) Addiction Counselors (NAADAC) MFTs and LCSW (CA BBS) California Nurses (BRN) Canadian Counsellors kurumlarından CE (Continuing Education-Sürekli Eğitim) akreditasyonlu sertifikayla belgelendirmek isteseniz veritabanımıza bireysel veya kurumsal olarak erişmek için bizimle iletişime geçebilirsiniz.

@PsikoTerapiVideolari
akademi.kimpsikoloji.com



kimpsikoloji.com
/kimpsikoloji

Instructor's Manual

for

ANOREXIA: WHAT THERAPISTS AND PARENTS NEED TO KNOW

PsyflixTR

RSD SERTİFİKALI RSD

PSİKOTERAPİ KURSLARI

BİREYSEL VE KURUMSAL ÜYELİK İÇİN

kimpsikoloji.com

Irvin Yalom önderliğinde organize edilen ve dünyaca ünlü terapistlerin ve terapi kuramı kurucularının, ekollerin en önemli temsilcilerinin psikoterapi seanslarını video olarak izlemek ve seans hakkındaki yorumlarını dinlemek ve bu kursları (American Psychological Association (APA) başta olmak üzere Social Workers (ASWB) New York State Social Workers (NYSED BSW) New York State Mental Health Practitioners (NYSED MHP) Certified Counselors (NBCC) Addiction Counselors (NAADAC) MFTs and LCSWs (CAMFT) California Nurses (BRN) Canadian Counsellors kurumlarından CE (Continuing Education-Sürekli Eğitim) akreditasyonlu sertifikayla belgelendirmek isteseniz veritabanımıza bireysel veya kurumsal olarak erişmek için bizimle iletişime geçebilirsiniz.

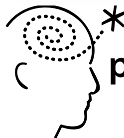
@PsikoTerapiVideolari

psyflix.com.tr

kimpsikoloji.com

Manual by

Shirin Shoai, MA



psychotherapy.net

The *Instructor's Manual* accompanies the video *Anorexia: What Therapists and Parents Need to Know* (Institutional/Instructor's Version). Video available at www.psychotherapy.net.

Copyright © 2015, Parents to Parents

Published by Psychotherapy.net
150 Shoreline Highway, Building A, Suite 1
Mill Valley, CA 94941
Email: contact@psychotherapy.net
Phone: (800) 577-4762 (US & Canada)/(415) 332-3232

Teaching and Training: Instructors, training directors and facilitators using the *Instructor's Manual* for the video *Anorexia: What Therapists and Parents Need to Know* may reproduce parts of this manual for teaching and training purposes only. Otherwise, the text of this publication (including the digital version available to streaming customers) may not be reproduced or shared without the prior written permission of the publisher, Psychotherapy.net. The video *Anorexia: What Therapists and Parents Need to Know* (Institutional/Instructor's Version) is licensed for group training and teaching purposes. Broadcasting or transmission of this video via Internet, video conferencing, streaming, distance learning courses or other means is prohibited without the prior written permission of the publisher.

Shirin Shoai, MA

Anorexia: What Therapists and Parents Need to

Know Cover design by Shelley Hagan.

Order Information and Continuing Education Credits:

For information on ordering and obtaining continuing education credits for this and other psychotherapy training videos, please visit us at www.psychotherapy.net or call 800-577-4762.

Instructor’s Manual for

ANOREXIA: WHAT THERAPISTS AND PARENTS NEED TO KNOW

Table of Contents

Tips for Making the Best Use of the Video 4

Family-Based Therapy (FBT) for Anorexia in 5

Adolescents Discussion Questions 1

Role-Play 1

Reaction Paper for Classes and Training 1

Related Websites, Videos and Further Reading 3

Complete Transcript 1

Video Credits 5

About the Contributors 1

More Psychotherapy.net Videos 6

1

8

3

2

3

3

3

4

Tips for Making the Best Use of the Video

1. USE THE TRANSCRIPTS

Make notes in the video **Transcript** for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video. **Streaming customers can make use of the "clips" function to cho excerpts for teaching purposes.**

2. FACILITATE DISCUSSION

Pause the video at different points to elicit viewers' observations and reaction to the concepts presented. The **Discussion Questions** section provides idea about key points that can stimulate rich discussions and learning.

3. ENCOURAGE SHARING OF OPINIONS

Encourage viewers to voice their opinions. What are viewers' impressions of what is presented in the interview?

4. CONDUCT A ROLE-PLAY

The **Role-Play** section guides you through exercises you can assign to your students in the classroom or training session.

5. SUGGEST READINGS TO ENRICH VIDEO MATERIAL

Assign readings from **Related Websites, Videos and Further Reading** prior to or after viewing.

6. ASSIGN A REACTION PAPER

See suggestions in the **Reaction Paper** section.

Family-Based Therapy (FBT) for Anorexia in Adolescents

Anorexia Nervosa (AN) is a potentially life-threatening eating disorder characterized by self-starvation, excessive weight loss and negative body image. Anorexia can affect individuals of all genders, races and ethnicities. While it is most common among females, about 10-15% of all individuals with anorexia are males. People of all ages develop anorexia, but it is most comm for onset to occur during adolescence. It is the third most common chronic illness among adolescents in the United States.

Diagnostic criteria for Anorexia Nervosa from the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5)

1. Restriction of energy intake relative to requirement, leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health.

2. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Eating disorders are serious illnesses, not lifestyle choices. In fact, anorexia has the highest mortality rate of any mental illness. And yet, the scope and severity of eating disorders are often misunderstood, even by those in contact with affected individuals. For instance, it can be very easy to confuse behaviors in the early stages of anorexia with a simple desire to "eat healthy," "get in shape" or "just lose a few pounds." Unfortunately, for those genetically at risk for an eating disorder, these seemingly harmless goals can quickly escalate into rapid weight loss and a full-blown eating disorder. This is one reason why it is important for parents, educators, physicians and coaches to be fully aware of the red flags.

Not everyone with anorexia experiences all of the same symptoms and behaviors. Common food-related behaviors include:

• Excessive weighing of oneself; setting progressively lower and lower goal weights

- Other body-checking behaviors such as looking in mirrors, measuring or assessing body parts or frequently asking others for reassurance with questions like, “Do I look fat?”
- Changes in weight, even slight fluctuations up or down, have a significant impact on mood and self-evaluation
- Frequent comments about feeling “fat” or overweight despite weight loss
- Excessive exercise; adhering to a rigid exercise regimen despite foul weather, fatigue, illness or injury
- Denial of hunger
- Rigid counting/calculating of calories and/or fat grams
- Refusal to eat certain foods, progressing to restrictions on entire categories of food (e.g. no carbohydrates, no meat, no processed foods)
- Development of food rituals (e.g. eating foods in a certain order, excessive chewing, rearranging food on a plate)
- Possible use of laxatives, diet aids or herbal weight loss products
- Consistent excuses to avoid mealtimes or situations involving food

Changes in Personality and Social Behavior

Individuals at risk for anorexia are often high-achieving individuals with a tendency toward perfectionism. These personality characteristics can become heightened during the disorder. Other behavior changes and warning signs include:

- Increasing isolation; withdrawal from friends and activities that were once enjoyed
- Symptoms of depression and anxiety (this can be a sign of an underlying co-occurring disorder or a biological response to extreme low body weight)
- Irritability, moodiness
- Interpersonal conflicts
- Defensive stance when confronted about weight or eating behaviors
- Low energy and fatigue
- Use of “pro-Ana” websites (internet groups that promote/support anorexia)

• Posting of “thinspiration” on social networking sites (images of emaciated models used as inspiration to pursue anorexic behaviors)

• Wearing layers or baggy clothes to hide weight loss (and to keep warm as body temperature drops)

Health Consequences and Medical Complications

In addition to the signs and symptoms of anorexia listed above, anorexia can lead to significant changes in health and physical functioning. In anorexia nervosa’s cycle of self-starvation, the body is denied the essential nutrients it needs to function normally. The body is forced to slow down all of its processes to conserve energy, resulting in serious acute and long-term medical consequences such as:

• Abnormally slow heart rate and low blood pressure

• Damage to the structure and function of the heart; increased risk of heart failure and death

• Reduction of bone density (osteopenia and osteoporosis), which results in dry, brittle bones

• Muscle loss and weakness

• Severe dehydration, which can result in kidney failure

• Edema (swelling)

• Fainting, fatigue, lethargy and overall weakness

• Dry skin and hair, brittle hair and nails, hair loss

• Anemia (can lead to fatigue, shortness of breath, increased infections, and heart palpitations)

• Severe constipation

• Prepubescent patients may have arrested sexual maturity and growth failure

• Drop in internal body temperature, with subsequent growth of a downy layer of hair called “lanugo,” which is the body’s effort to keep itself warm

• Amenorrhea (loss of menstrual cycle)

• Infertility, increased rates of miscarriage and other fetal complications

• Increased risk for suicide

Approximately 50-60% of individuals with anorexia recover over time, with better recovery rates observed in younger patients and those with a

shorter duration of illness when diagnosed. For adolescents with AN, a form of family-based treatment has been shown to be successful in improving recovery from the illness. This video focuses on that modality, Family-Based Therapy (FBT).

Family-Based Therapy: An Overview

Also known as the Maudsley Approach, FBT is an evidence-based model of outpatient therapy for families of children and adolescents with anorexia or bulimia. FBT was developed by Drs. Christopher Dare, Ivan Eisler, Gerald Russell, and George Szmukler in the late 1970s and early ‘80s at the Institute of Psychiatry at the Maudsley Hospital in London, England. In 1994, Dr. Daniel Le Grange introduced the approach to his colleagues at Stanford University in the United States. In FBT, parents play a very active role in helping their child restore a normal weight and regain stability in eating. When appropriate, FBT is recommended as a first line of treatment for children/adolescents who are safe to be treated outside of a hospital setting and can comply with the treatment protocol. FBT therapists are specially trained to guide families in this three-phase, intensive therapeutic model.

FBT can mostly be construed as an intensive outpatient treatment where parents play an active and positive role in order to help restore their child’s weight to normal levels expected given their adolescent’s age and height; hand the control over eating back to the adolescent; and encourage normal adolescent development through an in-depth discussion of these crucial developmental issues as they pertain to their child.

Under a systems approach, families of individuals with AN learn to make changes in the way they communicate, manage conflict, and tolerate negative emotions, which all can aid in their loved one’s recovery. Specifically for children and adolescents, family therapy emphasizes a strong parental alliance, resolution of family difficulties and support for the adolescent’s developing independence. Family therapy also helps people understand the role the eating disorder has played within their family, what factors may be maintaining the disorder, and how to differentiate between their family member and their family member’s illness.

More “traditional” treatment of anorexia suggests that the clinician’s efforts should be individually based. Strict adherents to the perspective of individual treatment argue that the participation of parents, whatever the format, is at best unnecessary, and at worst interferes in the recovery process. Many proponents of this approach would consider “family problems” as part of the etiology of AN. However, this view may contribute to parents feeling themselves to blame for their child’s illness.

The Maudsley Approach, in contrast, opposes the notion that families are pathological or should be blamed for the development of AN, and considers the parents as a resource and essential in successful treatment for AN.

Phase I: Weight Restoration

FBT proceeds through three clearly defined phases, and is usually conducted within 15-20 treatment sessions over a period of about 12 months. In Phase I, also referred to as the weight restoration phase, the therapist focuses on the dangers of severe malnutrition associated with AN, such as hypothermia, growth hormone changes, cardiac dysfunction, and cognitive and emotional changes, assessing the family's typical interaction pattern and eating habits, and assisting parents in "refeeding" their daughter or son. The therapist makes every effort to help the parents in their joint attempt to restore their adolescent's weight. At the same time, the therapist endeavors to align the patient with her/his siblings. A family meal is typically conducted during this phase, which serves at least two functions: it allows the therapist to observe the family's typical interaction patterns around eating, and it provides the therapist with an opportunity to support parents in their endeavor to encourage their adolescent to eat a little more than she was prepared to.

The way in which the parents go about this difficult but delicate task does not differ much in terms of the key principles and steps that a competent inpatient nursing team would follow. That is, an expression of sympathy and understanding by the parents with their adolescent's predicament of being ambivalent about this debilitating eating disorder, while at the same time being verbally persistent in their expectation that starvation is not an option. Most of this first phase of treatment involves coaching the parents toward success, expressing support and empathy toward the adolescent, and realigning her with her siblings and peers. Realignment with one's siblings or peers means helping the adolescent to form stronger and more age-appropriate relationships as opposed to being overly engaged in a parental relationship.

Throughout this phase, the role of the therapist is to model to the parents an uncritical stance toward the adolescent; the Maudsley Approach adheres to the tenet that the adolescent is not to blame for the challenging eating disorder behaviors, but rather that these symptoms are mostly outside of the adolescent's control (externalizing the illness).

Phase II: Returning Control Over Eating to the Adolescent

The patient's acceptance of parental demand for increased food intake, steady weight gain, as well as a change in the mood of the family (i.e., relief a

having taken charge of the eating disorder), all signal the start of Phase II of treatment.

This phase focuses on encouraging the parents to help their child to take mor control over eating once again. The therapist advises the parents to accept that the main task here is the return of their child to physical health, and that this now happens mostly in a way that is in keeping with their child's age and their parenting style. Although symptoms remain central in the discussions between the therapist and the family, weight gain with minimum tension is encouraged. In addition, all other general family relationship issues or difficulties in terms of day-to-day adolescent or parenting concerns that the family has had to postpone can now be brought forward for review. This, however, occurs only in relationship to the effect these issues have on the parents in their task of assuring steady weight gain. For example, the patient may want to go out with her friends to have dinner and see a movie, but if the parents are unsure that their child will eat dinner on her own, she might be required to have dinner with her parents and then join friends for a movie.

Phase III: Establishing Healthy Adolescent Identity

Phase III is initiated when the adolescent is able to maintain weight above 95% of ideal weight on her/his own and self-starvation has abated.

Here, treatment focus starts to shift to the impact anorexia has had on the individual in establishing a healthy adolescent identity. This entails a review of central issues of adolescence and includes supporting increased personal autonomy for the adolescent, the development of appropriate parental boundaries, as well as the need for the parents to reorganize their life togethe after their children's prospective departure.

This video features interviews, discussion and footage of the key challenges families participating in FBT may encounter with their adolescent children during treatment. As you watch, take note of the ideas presented, the ways in which parents regard their therapeutic tasks, the skills and interventions used to support the child, and the family's response to the aspects of therapy shown. Use any questions or comments you have to start a discussion about treating adolescent anorexia with FBT.

Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

1. Anorexia nervosa: Have you worked with clients with anorexia in your practice? With other eating disorders? If so, what approaches and interventions have you found effective? How does work with this condition differ from other presenting issues you've encountered? What are your initial thoughts about individual vs. family-based therapy for this disorder?

2. Adolescents and families: Have you worked with adolescent clients before? How about families? If so, what approach(es) do you tend to use with them? How does adolescent therapy compare and contrast with adult therapy? In your experience (or opinion), what are the more challenging aspects of this population for you? The easier aspects?

3. A "brain disorder": How familiar are you with the neurology of anorexia? Does the characterization of anorexia as a brain disorder surprise you? What are your thoughts on the personal and/or cultural implications of classifying anorexia (and other mental illnesses) in this way, as opposed to a lifestyle choice or matter of willpower? How might you support a family (or client) who is resistant to this interpretation?

4. Self-talk: How do you tend to approach negative self-talk in clients? In your opinion, what function, if any, might self-criticism appear to serve from a client's point of view? Do you agree? Why or why not? In your experience, what are some potential pitfalls of attempting to help a client change their internal dialogue? How have you worked with this?

5. Perfectionism: Does it surprise you that anorexic clients often exhibit tendencies toward perfectionism? Why or why not? Do you lean toward perfectionism in your own life? How might you tell when a client's perfectionistic tendencies veer into unhealthy territory?

6. Refeeding: What are your emotional reactions to the illustration of refeeding from the video? Does its description as "counterintuitive" make sense to you? How might you support a parent who felt hesitant or negative toward this intervention? How would you support an adolescent?

7. Mindfulness: Do you use mindfulness-based interventions in your clinical work? How about personally? If so, what benefits have you observed in your clients (or yourself) as a result? If not, what other approaches do you take to help clients manage emotionally reactivity? What thoughts, feelings, or sensations arise in you as you consider offering mindfulness skills to clients?

8. Engaging the rational brain: In your opinion, what purpose(s) does engaging the rational brain serve for anorexic clients? In your own work, how can you tell when a client needs to shift states? How do you handle it? What additional activities can you think of to help families engage the rational part of their child's brain during meals?

9. Relapse: Does your clinical work include addressing relapse? If so, how do you tend to address it with clients? What approach do you take with clients who relapse? What do you think are some factors that contribute to a client relapsing?

10. The model: What are your overall thoughts about FBT? Does FBT align with the way you view effective therapy? Why or why not? What aspects of FBT can you see yourself incorporating into your work? Which aspects of FBT would seem most challenging to master?

11. Key moments: What are some key moments from the video? What stands out about them for you? Describe FBT's role in those moments, and the client's (and/or their family's) shifting states during them.

12. Personal reaction: How would you feel about having FBT treatment? Would your family be open to it? Would it be effective with you? Why or why not? Did any of the challenges from the video resonate with your personal experience? If so, what would you need from a therapist to feel supported? Does this fit with the FBT model?

Role-Play

AAfter watching the video and reviewing “FBT for Anorexia in Adolescents” in this manual, break participants into groups of two and have them choose one of two 25-minute role-play scenarios:

1. A therapy session with an anorexic adolescent client; or
2. A therapy session with the parent of an anorexic adolescent.

Therapy session with an anorexic adolescent client

One person will start out as the therapist and the other will be the client, and then invite participants to switch roles. Clients may play themselves, role-play the client from the video or a client they know, or they can completely make it up. The therapist will facilitate the session, using general therapeutic skills such as empathic reflection, validation, etc., and will also incorporate knowledge gleaned from the video—i.e., psychoeducation about neurobiology, an overview of FBT, mindfulness tools, activities during meals, or relapse information. After 25 minutes have passed, participants may take 5 minutes to debrief together, then switch roles. The primary emphasis here is on giving the therapist an opportunity to practice using FBT skills and interventions, and on giving the client an opportunity to see what it feels like to participate in this type of therapy.

Therapy session with the parent of an anorexic adolescent

One person will start out as the therapist and the other will be the client, and then invite participants to switch roles. Clients may play themselves, role-play the client from the video or a client they know, or they can completely make it up. The therapist will facilitate the session, using general therapeutic skills such as empathic reflection, validation, etc., and will also incorporate knowledge gleaned from the video—i.e., psychoeducation about neurobiology, an overview of FBT, mindfulness tools, activities during meals, or relapse information. After 25 minutes have passed, participants may take 5 minutes to debrief together, then switch roles. The primary emphasis here is on giving the therapist an opportunity to practice using FBT skills and interventions, and on giving the client an opportunity to see what it feels like to participate in this type of therapy.

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about using FBT? Invite the clients to talk about what it was like to role-play an anorexic adolescent or a parent, and how they felt about the approach. How did they feel in relation to the therapist? Did they understand the essence of the approach? What worked

and didn’t work for them during the session? Did they feel the therapist’s support and encouragement to stay with the process? How confident are they that they can benefit from this type of therapy? Then, invite the therapists to talk about their experiences: How did it feel to facilitate the session? Did they feel they sufficiently handled the presenting challenges? Did they have difficulty introducing the approach, applying techniques, or managing uncomfortable emotions? What would they do differently if they did it again? Finally, open up a general discussion of what participants learned about conducting sessions using FBT.

An alternative is to do this role-play as a 30-minute exercise in front of the whole group, with one therapist and two clients: a parent and an anorexic adolescent. The rest of the group can observe, acting as the advising team to the therapist. The clients may choose either to start an initial inquiry with the therapist about FBT, or they may already be in treatment and are coming to session with questions or issues maintaining treatment. At any point during the session the therapist can time out to get feedback from the observation team, and bring it back into the session with the clients. Perhaps a team member can jump in with an appropriate intervention. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using FBT with anorexic adolescents and their families.

Reaction Paper for Classes and Training

• **Assignment:**Complete this reaction paper and return it by the date noted by the facilitator.

• **Suggestions for viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.

• **Length and style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

What to write: Respond to the following questions in your reaction paper:

1. Key points: What important points did you learn about anorexia in families? What stands out to you about how FBT works? Did you get a solid sense of the ideas offered here, and of the flow of the model over all? Why or why not?

2. What I found most helpful: As a mental health practitioner, what was most beneficial to you about the ideas or techniques presented? What tips or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. What does not make sense: What ideas or interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4. How I would do it differently: What might you do differently from the FBT approach when working with clients? Be specific about what different approaches, interventions, or techniques you would apply.

5. Other questions/reactions: What questions or reactions did you have as you viewed the video? Other comments, thoughts or feelings?

Related Websites, Videos and Further Reading

WEB RESOURCES

Academy for Eating Disorders (AED) **www.aedweb.org**

International Association of Eating Disorder Professionals (IAEDP) **www.iaedp.com**

Training Institute For Child And Adolescent Eating Disorders **www.train2treat4ed.com**

Maudsley Parents (Parents' site for eating disorders and FBT) **www.maudsleyparents.org**

National Eating Disorders Association (NEDA) **www.nationaleatingdisorders.org**

RELATED VIDEOS AVAILABLE AT WWW.PSYCHOTHERAPY.NET

Evidence-Based Treatment Planning for Eating Disorders and Obesity with Timothy Bruce and Arthur Jongsma, Jr.

Motivational Interviewing Step by Step: 4-Video Series with Cathy Cole

Tools and Techniques for Family Therapy with John Edwards

Family Therapy with the Experts: 10-Video Series

RECOMMENDED READINGS

Treasure, J., Smith, G. & Crane, A. (2016). *Skills-based Caring for a Loved On with an Eating Disorder: The New Maudsley Method (2nd Ed.)*. New York, NY: Routledge.

Lock, J. & Le Grange, J. (2015). *Help Your Teenager Beat an Eating Disorder (2nd Ed.)*. New York, NY: Guilford.

Lock, J. & Le Grange, J. (2015). *Treatment Manual for Anorexia Nervosa: A Family-Based Approach (2nd Ed.)*. New York, NY: Guilford.

Collins, L. (2014). *Eating With Your Anorexic: A Mother's Memoir*. New York, NY: Biscotti Press.

Musby, E. (2014). *Anorexia and Other Eating Disorders: How to Help Your Child Eat Well and Be Well*. New York: Aprica.

Brown, H. (2011). *Brave Girl Eating: A Family's Struggle with Anorexia*. New York, NY: William Morrow Paperbacks.

Costin, C. & Grabb, G. S. (2011). *8 Keys to Recovery from an Eating Disorder Effective Strategies from Therapeutic Practice and Personal Experience*. New York, NY: W. W. Norton & Company.

Herrin, M. & Larkin, M. (2012). *Nutrition Counseling in the Treatment of Eating Disorders (2nd Ed.)*. New York, NY: Routledge.

Siegel, M., Brisman, J, & Weinshel, M. (2009). *Surviving an Eating Disorder: Strategies for Family and Friends (3rd Ed.)*. New York, NY: Harper Perennial.

Complete Transcript

KAREN MERRILL: Our daughter is now 33. And when she was a teenager-- a young teenager-- she suffered anorexia and bulimia.

CAROL MADSEN: I began to notice a problem right around 13 1/2 years old-- when she was about 13 1/2 years old.

MARK SABEY: When our daughter was 12, she just stopped eating. She just ate less, and less, and we're going, something's going on here.

ROBERT BLAIR: She began to restrict fats. And then she would restrict other things. We knew that there was something going on. We weren't sure what it was. But we felt that something was taking over our daughter.

MARGARET YOUNG: For me, with my daughter, I knew something was wrong. I didn't know what was wrong. I went to the high school counselor, and we talked about her disappearing from classes. And the counselor asked me a few questions. And I just finally turned and said, I know something's wrong. I don't know what it is.

DANIEL MADSEN: I remember that our daughter would-- in the beginning-- tend to approach me about exercise decisions or whatever. Because that was something I felt was healthy. And maybe I didn't understand the depth of what the anorexia was playing in her mind.

MERRILL: My friends came up to me afterwards and said, you know your daughter is anorexic, right? And I was like, she's really skinny. I know. But anorexic? Really? And somebody else had to point it out to me, which horrified me.

LISA SABEY: All the while, we were trying to connect with her, doing whatever we could to have her feel a part of the family, a part of us. And she just felt like it was become-- she was becoming more and more distant. And we were just becoming more and more frantic.

BLAIR: This was a daughter who had been ideal. But there were times she would scream at me at the top of her lungs and say, you're Satan. You're Satan. And it was frustrating. I didn't know what to do.

M. SABEY: One of the things that hurt the worst was we had good relationships with her before this. And it's like, where did she go? Who is this person that is inhabiting her body? It was like she was just so different and so closed. And when did we become the enemy?

BLAIR: And at this time, I remember I would wake up in the middle of the

night wondering, will she be alive?

MERRILL: It can be very life threatening, and that was really scary to us when she was so thin and unhealthy.

L. SABEY: It was a hard six years. It was hard for Mark. It was hard for me. It was hard for her brothers. And it was especially hard for her. It's a viciously dark, dark disorder.

M. SABEY: Yeah.

NARRATOR: We want you to understand, first and foremost, that anorexia is a brain disorder. The chemistry, function and structure of the brain is affected and altered. The brain is not functioning correctly. The food restriction, and if present, the compulsive exercise, exacerbates and reinforces the brain malfunctioning.

DR. OVIDIO BERMUDEZ: There is a body of science building that says that the brain changes. And importantly, I think the brain changes in the way that it functions. I think we need to view malnutrition as really a medical emergency, right?

Does that mean that every child, 2, 3, 4 months into anorexia nervosa is going to be deathly ill? No. That's not my point. But I think the medical emergency part comes from the fact that every organ system is really suffering-- is having to adapt in some way-- including their brain.

NARRATOR: The more anorexics restrict, the more they want to restrict. The more they exercise, the more they want to exercise. This is a classic vicious circle. Both are damaging. Binging and throwing up may also be present, which can make the whole disorder that much more difficult to deal with.

Increasing the complexity of anorexia is that there is often one or more other mental illnesses interacting with it. This could include things like depression, anxiety disorder, bipolar disorder, and obsessive compulsive disorder. Some seem to come with the anorexia, and others precede the anorexia. This is a complex and dangerous disorder.

Anorexia has the highest mortality rate among young women of any mental illness. Anorexia also seems to put rigidity into your child's life, which makes relationships difficult.

BLAIR: Ed attacked your child's sense of identity. It seemed to us that the longer Ed was there, the more we had lost our daughter. This model child that we'd had that we were thinking, wow. What a wonderful child. She seems to do everything right-- now was the opposite. She was fighting us on all of these-- anything to do with exercising, anything to do with eating. We felt

very lost and at conflict on whether to be more loving or to be more strict.

C. MADSEN: Restricting, dieting, and obvious loss of weight, as well as being very rule-based, even with dutiful things that we would think are good-- but extended and not-- didn't seem to see much emotion-- here it was just really task-based, rule-based.

BERMUDEZ: Excessive exercise really brings to the table a significant added danger, right? As the number of calories are decreasing, if the activity is increasing, then it widens the gap on the deficiency that that body has to contend with. As a matter of fact, it's really important, because relatively speaking, some of these individuals that really get engaged in compulsive exercise can relatively be eating, right?

Boy, doctor, but I watch her eat. Or I watch him eat. And the reality is is as long as that a gap exists, the person will end up in the same spot as if they were not exercising but not eating at all, right? It's really about the gap. So it's important to recognize that.

BLAIR: Anorexia is an abusive dictator residing in your child's mind. For us, it seemed like the longer anorexia was there, the more it seemed to take over our child's life. She even started to lie.

RON MERRILL: You find out quickly that unless they're telling you that they are doing the things that they shouldn't be doing, they are lying.

M. SABEY: Although anorexia takes over the child's mind, your child is not the eating disorder. Your child is still in there somewhere. For me, separating in my mind my child from the eating disorder was really helpful. I personified her anorexia and called it Ed.

BERMUDEZ: This is really hard on families, right? We worry. We lose sleep. We sometimes blame ourselves. We quite often don't just know what to do. But as difficult as this may be for you as parents, this is much harder for the individual who's living it. This is much harder for your son or daughter.

M. SABEY: The author of 7 Habits of Highly Effective People, Stephen Covey, teaches us first to understand the person we're trying to connect with. I wish I had understood my daughters' thoughts. It was only after she had recovered that we found out that her internal dialogue-- and the way she talked to herself was so much darker than we had realized.

PAUL HARPER: Usually it seems to me at the core of any disorder is a lost sense of self and self hate.

L. SABEY: Understanding what your child is thinking and the internal world

she's living in, I think is so important. I really believe if I had understood, I mean truly understood, my compassion and my patience would have skyrocketed. And it would have been so much easier to deal with her.

NARRATOR: This is a composite of typical thoughts from several people, reported while they were anorexic.

VOICEOVER: You are a worthless piece of shit. Everyone hates you. You only cause trouble. There's nothing you can do right. You are not worthy of love--ever! You are demanding, selfish, greedy, and mean!

D. MADSEN: I remember being very frustrated-- at first, not really understanding the depth of the problem, not really understanding what my child felt and why.

L. SABEY: One of the things that was so frustrating for me was that my daughter wouldn't tell me what was going on. And I would say, please, please just help me know what's going on. What are you feeling? And she would just say, I don't even know, mom. I don't even know.

After several years of her anorexia, I found a poem she had written. And I realized how incredibly confusing this whole disorder was to her. It wasn't that she was trying not to communicate to me. It honestly was she didn't even understand herself.

VOICEOVER: I wipe away all signs of pain and hide it inside to stay. They don't know. I can't show. It's too far tucked away.

I feel it in my heart. It aches. It breaks. The burden crushes into a million pieces that don't fit-- no guidance, no future, no way out-- only pain and hiding, keeping them out. They can't see past my steel walls. And most of the time, neither can I.

NARRATOR: There are some aspects of anorexia that seem to be self-reinforcing. For someone who has high anxiety or other strong emotions, anorexia may simplify his or her life by focusing solely on weight. This exclusive focus does not help resolve life's challenges, complexities, pains, or mistakes. Instead, it creates a stiff, protective armor that also functions as an emotional straight jacket, becoming tighter and tighter.

LAURA COLLINS: What many families find when they discover that their loved one has anorexia nervosa, is that they were anxious and concerned before they became ill. They were perfectionistic, good students.

HARPER: Highly accomplished-- grades, AP classes, all of those kinds of things. And they push themselves. They're pushing and pushing themselves.

COLLINS: Not eating enough or exercising more than they were compensating for by eating, feels calming. It quells the anxiety.

BERMUDEZ: So if you're already anxious, and you're already obsessive, and you're already fearful, you may get so anxious and so fearful as the brain starves, that rather than be more likely that you get out there and find food, and do the right thing, it may actually paralyze you.

And that's often what we tend to see, at least one aspect of what we tend to see, is gee. My daughter or my son is changing, right? They used to be more capable. They used to be more-- they could get out there and solve problems for themselves.

And they're narrowing their world as they become more anxious, more obsessive, sometimes more depressed, and have difficulty self-managing or managing their context, like they were very capable of doing just a little while ago. That's really hard for parents.

YOUNG: Well, there was one time where she had been determined that she was going to be in all the AP classes and get straight A's in all of them. She was going to get the biggest awards at graduation ceremony.

And there was a day where I went-- I tried to find her in school. And she wasn't there. And I actually called the police, because I didn't know what had happened to her. I had no record of where she had gone except that she wasn't at school.

So the police finally found her. And she had gone to the gym. She had stood outside of that AP English class, terrified that she would not be able to do it, and finally went to the gym.

NARRATOR: There is one emotion that does not seem to be restricted in anorexia, and that's guilt. Ed, the dictator, imposes extreme guilt when an anorexic eats. Eating is an incredibly stressful thing for the person suffering. Here is a sample of what may be going on inside your child's mind while eating.

VOICEOVER: It was like I blinked and was suddenly caught in this bizarre emotional riptide. There are all these emotions swimming around inside my head that didn't make sense together. First, I felt super guilty when I ate. Each bite intensified my fear of losing the power I had over my body-- the power that made me strong and worthy.

I kept telling myself that I didn't deserve to eat, especially anything that tasted good. I had conflicting emotions. Food tasted so good when I was malnourished, but that just increased the power I felt when I could deny

myself. And at the same time, the feeling of defeat when I had to eat unsafe foods was overwhelming. Every second I was eating, I was hyper-aware of what everyone else was eating and how much they ate.

I also had bizarre physical feelings like I was stuck in my skin. If I felt empty and hungry, I felt in control and less anxious. After a meal, I would self-harm. It was a release of pressure, like justice had been paid for the mistake that I made.

If I ever heard or read that a food was bad for me, it stuck in my mind and was added to my very long list of bad foods. When I was eating anything outside of my extremely small comfort zone, I felt ashamed and angry at myself and at whoever was making me eat. Calculating and thinking about what I was eating became an obsession for me. It was all I could think about-- calories, numbers, portions, good foods, bad foods.

When I had to eat to the point of fullness, it was the worst feeling of all. I could handle eating a little as long as I was still hungry after eating. But when I had to eat to the point of being full, I hated myself. I felt such anger and defeat. I felt like I was nothing.

NARRATOR: You've probably heard of the fight, flight, or freeze response. When anyone is stressed, a hormone called cortisol is released. Cortisol actually shuts down the rational part of the brain, making a person more emotional and reactive.

When an anorexic is eating, he or she is prone to experience extreme emotions. This explains why a child can explode over little things like being asked to finish a glass of milk or the last spoonful of a casserole. You are dealing with the brain that has been hijacked. It is reactive and overly emotional. You are not dealing with your child's rational brain.

Historically, therapists thought that giving the anorexic more control would be helpful. This is no longer accepted. It may be natural to assume that your child is being difficult and making completely voluntary choices to not eat. Realize the dark clouds of anorexia are converging in on your child's brain, combined with medical factors caused by starvation, that become a mental tsunami that the child cannot adequately escape from on his or her own.

The sooner one deals directly with it, the better. But dealing with it does not mean taking blame for it. Although it's very easy for parents to question themselves when a child develops anorexia and to wonder what they did wrong, realize that you did not cause the eating disorder. This is a brain disorder.

BERMUDEZ: Families don't cause eating disorders. In my opinion, don't put a lot of energy into feeling guilty and trying to figure out-- what did we do wrong? I think you're better served by putting the energy into how do we best understand this, right? And how do we best move forward to help our daughter?

NARRATOR: The old school of thought that parents and family dynamics caused anorexia has been reversed to understanding that you, the parents, are usually your child's best resource in combating anorexia. In fact, the most successful therapy is based on parents helping their child. It's called Family Based Treatment, or FBT, for short.

A joint study from the University of Chicago in Stanford, in 2010, concluded that FBT is more than twice as effective in producing recovery from anorexia as individual therapy, with a 1/4 of the incidents of relapse. Daniel Le Grange, from the University of Chicago, explained,

"What this study unequivocally demonstrates is if you have an adolescent with anorexia nervosa who is medically stable, Family Based Treatment should be the first line of treatment."

In FBT, hospitalization is utilized only until medical danger is past.

BERMUDEZ: When we are facing the situation as a family or as a professional, of a child that has anorexia nervosa, I think we need to first and foremost think about Family Based Treatment. And it's a treatment model that has developed and is now available just about worldwide, in three phases.

The family works with the child and assumes responsibility for the refeeding process. Then in the second phase, there is a transition to the child taking more responsibility for their refeeding process and the maintenance of appropriate nutrition. And in the third phase, the child, with the support of the family, moves on to really take on more appropriate developmental progress-- the emphasis and the importance that getting the brain back on track nutritionally takes precedence, right? But once we get through that phase, the rest really becomes about empowerment and collaboration.

NARRATOR: Let's define some of FBT's terms. Refeeding means increasing daily caloric intake so that the child returns to a healthy weight. Caloric intake and weight goals should be discussed with a professional.

Normally, calories are increased every other day to a point where there will be a consistent weight gain. If weight plateaus, calories are increased. Refeeding usually requires you, the parent, to decide what your child will eat and to support him or her to eat it.

The parent puts the food on the plate. This is called plating-- places the food in front of the child and sits by him or supportively, while the child eats everything on the plate.

Often, Phase 1 also includes denying or strictly limiting your child's exercise.

M. SABEY: We had to tell her, you cannot dance. We took it away for six months and said, you cannot dance until you reach your goal weight.

L. SABEY: When she exercised, she felt better. And she was happier. So you feel like you really are taking the one part of her life that is happy and makes her feel better. And it's like, how can I possibly take this away from her? Yet, in hindsight, she and every other recovering anorexic I've talked with all have said that exercise was absolutely part of their eating disorder. Until they gave that up, they couldn't get over their eating disorder.

Refeeding is like having to live a life you have been taught against, and having

to force a child to do what is incredibly hard, and take away from the child what the child loves. So you're constantly just feeling like you're the bad guy. But you realize-- this is what my child needs.

NARRATOR: Many parents wonder, why refeed instead of just insist that

their child eat enough food on their own? The answer is threefold. First, refeeding is compassionate. Second, refeeding is usually necessary. And third, refeeding is efficient.

BLAIR: I realize how much stress it was choosing what to eat for my daughter.

I was coming home from Europe. We were on a plane, and she had only eaten one salad. And we had a stopover in Chicago. And I told her she had to eat something when we got to Chicago.

When we got there, we were looking for a Subway. She wanted whole wheat.

We couldn't find a Subway. We went through maybe 30 different restaurants trying to find one that had the acceptable bread for her. We couldn't find one. She refused to eat anything that didn't fit her specific requirements. I was frustrated.

She hadn't eaten. I was scared. I was angry. And I demanded that she eat something before we get on the plane. She looked at me and she said, I hate you. I will never forgive you for forcing me to do that.

But I held firm. I said, you are going to eat something before we get on that plane. She couldn't do it. Finally, she turned to me and she said, dad, you pick something. And I will eat it.

Every aspect of eating, including what to eat, is intensely stressful for an anorexic. Having parents choose and plate food, independent of their

anorexic child input, can actually take away the stress from the child.

Some compare anorexia to cancer and refeeding to chemotherapy. If your child had cancer and needed chemotherapy, yet feared the pain, and suffering, and consequences of chemo, you would nonetheless compassionately support him or her through the process. Think of eating as your child's chemotherapy, or medicine, for anorexia.

YOUNG: With our daughter, we gave goals for calorie intake. And she would fight them. We plated the food. We set it in front of her. She would fight us. But we would say, this is your medicine. And you need to take it. She would continue to fight, but we remained with her and calmly supported her in what needed to happen. And at a certain point, she seemed relieved that we were there to give her the support and also the instruction.

NARRATOR: Your child's brain and every body organ is being affected by malnutrition. Your child is very unlikely to be able to refeed without your help. Sufficient calorie intake and weight is necessary for a healthy body and brain.

M. SABEY: Right now, your child's brain patterns are destructive. They've gone down the same restrictive neural pathways so many times that restriction has become the default, something like, when stressed, restrict what I eat. Eating is stressful. Restrict even more.

NARRATOR: Your refeeding helps your child override the destructive anorexic neural pathways that have been built up over time.

BERMUDEZ: It's the idea that you want to pull that brain out of the wrong marinade to bring it back on track into a more normal developmental circumstance.

NARRATOR: Because of his or her restriction, your child's metabolism has slowed down. It's gone into survival mode, somewhat like a bear in hibernation. As a bear comes out of hibernation, it needs a lot of food to move its body from a slowed metabolism to a normal one. Similarly, your child will eventually need more calories than what most people his her age and size need-- sometimes nearly double what a peer may eat.

Because of its dictatorial power over your child, your choosing foods and calorie intake will help your child recover much more efficiently and quickly. Although most parents choose to plate their children, parents working with professionals may individually tailor refeeding to their child's needs and family circumstances.

Refeeding and not allowing your child to exercise can seem brutal. It may

seem to all of you that you are taking over your child's life. Remember, your child is ill, and the illness has made it that he or she cannot choose wisely about what to eat and how much to exercise.

YOUNG: It may seem strange that a child will explode over a mouthful of food that she has to finish. You have to be the referee. When the referee at a game sees all of the fans exploding, and yelling, and doing whatever they want to do that can be very disruptive, that referee knows the rules and has to maintain his calm-- has to make sure that the game continues according to the rules. That's who you are.

NARRATOR: Anorexia and chaos reinforce each other. Ed creates chaos and thrives in overreactions and heightened emotions. Ed threatens and blames, isolates and induces fear. Ed has the advantage in emotionally chaotic situations, because parents become emotionally charged themselves-- naturally-- limiting their ability to focus, plan, strategize, think logically, and stick to the rules.

When you start refeeding, realize that Ed will fight you tooth and nail. Stay calm. Stick to the rules.

There are three powerful techniques to help you avoid an emotional hijack.

They are, first, label your own emotions as they arise. The simple act of labeling your emotion helps you remain more rational. When your emotions start to escalate, consciously breathe deeply and focus on your breath. Deep, focused breathing diffuses cortisol. Third, think of your child as separate from their anorexia.

L. SABEY: This is not easy. I blew up several times.

M. SABEY: When we could tell that our daughter was becoming rigid and refusing to eat, freezing up, we would try to state objectively what we were seeing.

L. SABEY: I see you playing with your food, cutting it up into tiny pieces. And I see your head is down.

M. SABEY: Then we would explain what we guessed was going on.

L. SABEY: I guess that anxiety is really high right now. Can you tell me if I'm close?

M. SABEY: We would then ask how she would describe her feelings.

L. SABEY: Can you give me a name for what you're feeling right now?

TEENAGER: I'm so mad at you. I hate this food, and I hate you. You're treating me like a baby.

M. SABEY: Finally, we would acknowledge her feelings, acknowledge that it's hard, and gently remind her that she has to finish the food on her plate.

L. SABEY: I know this is hard, but we have to stick to the rules.

NARRATOR: This is where parental persistence becomes so important. Stay calm. Don't give in. Most children will eventually finish the food on their plate.

You can attempt to even the playing field between Ed and your child by engaging the rational part of your child's brain before, during, and after meal times.

M. SABEY: My daughter reported that playing spelling, word games, or math games at the dinner table really helped her to be less anxious about eating. You can play calming music, plan a family vacation, write thank you notes, share good things that happened that day, do deep breathing as a family, watch funny YouTube videos, tell jokes, memorize quotes or poems.

NARRATOR: Now let's move on to Phase 2 of FBT, which is the transition between intensive parental oversight in regards to eating and exercising, to eventual independence in Phase 3. During this transition time, your child is given more and more freedom to dish up his or her own plate and just start to moderately exercise. As he or she demonstrates the ability to remain healthy, you're able to back off the monitoring more and more. Although you do remain vigilant and supportive, you can relax a little more and back off.

Phase 3 does not begin until your child has reached at least 95% of his or her target weight and has demonstrated the ability to wisely self regulate food intake and exercise. There is no definite boundary between phases. Relapse is
common, and going back and forth between phases is typical.

You return responsibility for eating and exercising to your child. Weight continues to be monitored. It is at this stage that traditional therapy can be utilized to address other mental illnesses, because the brain has recovered sufficiently to learn and apply therapeutic skills.

FBT will not work for every child. There are other options. If FBT does not work for your family, for whatever reason, don't give up. Regardless of what therapy you use, nutritional rehabilitation should be a vital beginning.

MERRILL: I got on the phone and tried to find somebody that could help her and guide her into therapy, and unfortunately got her into the worst therapist we could possibly have gotten her into.

BLAIR: Finding the right therapist who understands FBT is important. Children who feel closest to their family members report greater success in

overcoming anorexia than those that feel more distant.

M. SABEY: A book that really helped us was Harriet Brown's book, Brave Girl Eating. And it was just nice to read about a mother in a family that had gone through the same things that we were going to through.

L. SABEY: We'd read it, and we would say, yes! That is exactly our experience too.

M. SABEY: One quote here that was also what we experienced-- it says,

"Most teens with anorexia turn away from their families-- a process that's encouraged by most therapists and treatment providers."

BLAIR: Part of recovery for many children is learning to communicate more openly with their family, especially with their parents, about what's going on within them emotionally. Contrary to what many therapists believe-- that the importance of confidentiality and talking individually with the child-- FBT views the family as an important resource, and working with the family, and helping the family communicate more openly about the stresses, the anxiety the child is going through. It seems to be much more helpful than having the child individually work with a counselor and not share that with the family.

M. SABEY: At the beginning of our daughter's anorexia, we did not have an

FBT counselor. And we accepted her psychologist's claim that confidentiality was essential. Confidentiality was the only option he gave us. But we feel like that confidentiality backfired and tended to separate us from our daughter.

My daughter came to believe that she needed to keep stressful feelings and

daily challenges inside her until she went to see her counselor every week. This not only distanced her from everybody in the family, but unintentionally taught her that her family was not her best resource for help. Continuing such isolating therapy was one of the worst mistakes that we made. And we believe it detracted from recovery and prolonged our daughter's fight with anorexia.

BERMUDEZ: Parents have a right to be well-informed about the treatment of

their children.

L. SABEY: Our daughter embraced the identity of anorexic. And when a

therapist would tell her things about being anorexic, she held onto those as if those were what she was supposed to do.

M. SABEY: If a therapist just listens to an anorexic child's dark story, the listening empathetically, in some ways, reinforces it. And what needs to happen is that story needs to be challenged. And they need to be taught how to talk back to that negative view, that negative thinking, the incorrect perspective.

L. SABEY: I really wish I'd understood what skills could be taught and would have worked with the therapist to teach skills to my daughter, like how to deal with anxiety, or how to communicate through feelings. All of those skill-based treatments, I would have been thrilled about.

C. MADSEN: The most helpful thing from the professionals, I think, was teaching my daughter emotional coping mechanisms, mostly, yoga-based, meditation-based, recognizing the negative impact of anorexia, and recognizing triggers, and anxiety, and being able to, in that moment, have coping ways-- whether counting or different finger movements. I think that was helpful-- a calming the mind.

L. SABEY: Really, as parents, you have to be informed. And search for a therapist that understands FBT and will work with you through FBT. And utilize your strength as a person who loves your child more than anybody else in this world. No therapist will love your child like you do. No therapist will give her your heart, your soul like you will. And that is powerful. And FBT embraces that love, and embraces the connection that will not die.

NARRATOR: By focusing on hope for recovery, we do not imply that will be an easy ride. Anorexia takes a toll on the whole family. In her book, Brave Girl Eating, Harriet Brown explained it like this.

"When anorexia chose my child, it chose our family. It called into question--

YOUNG: --many of our deeply held beliefs and traditions. It challenged our assumptions, our way of being with one another. When it built walls between us, we put in doorways. When it let grief into our house, we opened every window and shooed it out. When it called us names-- jailer, torturer, liar-- we answered-- mother, father, sister. Our child was the one diagnosed with anorexia, but it happened to all of us."

NARRATOR: Be as gentle to yourself and other family members as you possibly can. This is hard for everyone. We love this essay by a young girl who has completely recovered from anorexia.

VOICEOVER: "I nearly died my freshman year. And parts of me did-- brutally murdered by that she-monster some label anorexia. I call her despair. I vividly remember the lifeless feeling.

I remember the question, what do you want to do with your life? And having no idea how to answer. Want, desire, hope, were foreign to me. Life was simply the misery I was forced to survive. It was a geometric line without depth, or width, or time.

I had lost sight and hope of happiness in one blow. It took months, years of

excruciating healing. But I eventually became capable of hope again. And so I began to see if I could trust myself enough to be myself.

Trusting requires faith. Faith requires hope. And hope is a hypothesis. My hypothesis was that maybe someday I could be happy again.

But to determine the truth of that statement, I had to experiment. I had to leave the comfort of nothingness or being nobody. I had to run away from the monster that had taken my life away, the monster that had become me. I had to destroy a part of myself. And so I ventured to regain my happiness.

The experiment succeeded. And at long last, I was filled. I found myself. I was emancipated.

I discovered a love for learning behind my desire for good grades. I discovered I yearned for friends and not just people to sit next to. I learned that happiness is not so easy as smiling, and listening not so easy as talking.

But above all, overcoming anorexia taught me that I never want to do her battle again. I fear despair. And I'd do everything in my power to continue hoping and hypothesizing. I hope to laugh along the way of the rest of my life, because life is so good."

D. MADSEN: Our experience is-- at least in my mind-- it's fading somewhat-- three or four years after.

C. MADSEN: My daughter has done great. It was a really hard struggle for what seemed like a really long time. It was very dark. But she, I feel, has fully recovered.

MERRILL: It is a hard journey. I'm not going to lie. But there's a lot of good things that came out of it. For one thing, our daughter had four extremely healthy children and four healthy pregnancies. And we're so grateful for that. And she's a highly functioning member of society who wants to give back.

D. MADSEN: I began to notice more of the change in her thoughts and really, her desire to change, and displace the eating disorder from its place in her life.

C. MADSEN: Her health is restored, and her personality has returned. And she is back to her happy and healthy self.

L. SABEY: Right now, as she's recovered, it's so fun to talk with her. We keep saying, this is our daughter. She's back! It really was. We lost her for six years. And now, slowly, she's coming back to who she is.

YOUNG: Life is good. Having a child with an eating disorder can be overwhelming to anyone. It certainly was overwhelming for us. As you continue to be engaged in their recovery, you can understand that recovery really is possible. Continue to make the effort.

Video Credits

Special thanks to the families and clinicians shown for sharing their experience and expertise.

Graphic Design: Shelley Hagan

Copyright © 2015, Parents to Parents

About the Contributors

Manual Author

Shirin Shoai, MFT, is a writer for Psychotherapy.net and a licensed psychotherapist in Oakland, CA. She holds a master's degree in integral counseling psychology from the California Institute of Integral Studies (CIIS) and has more than a decade of editorial experience at CBS Interactive, Apple, and various nonprofit organizations.

More Psychotherapy.net Videos

We have videos covering a wide range of experts, approaches, therapeutic issues and populations.

We continually add new titles to our catalogue. Visit us at www.psychotherapy.net or call (800) 577-4762 for more information.

Approaches

ACT
Adlerian Therapy
Art Therapy
Body-Oriented Therapy
Brief Therapy
Career Counseling
Child Therapy
Cognitive Behavioral Therapy
Consultation/ Supervision
Couples Therapy
Dialectical Behavior Therapy
Emotion Focused Therapy
Evidence-Based Therapies
Existential-Humanistic Therapy
Family Therapy/ Family Systems
Gestalt Therapy
Group Therapy
Integrative Therapy
Interpersonal Psychotherapy
Jungian Therapy
Mindfulness
Motivational Interviewing
Multicultural Therapy
Narrative Therapy
Object Relations Therapy
Person-Centered Therapy
Positive Psychology
Psychodrama
Psychodynamic Therapy
Reality Therapy
REBT
School Counseling
Social Work
Solutions-Focused Therapy

Experts

Devin Ashwood
Aaron Beck
Judith Beck
Rollo May
Monica McGoldrick
Donald Meichenbaum

Insoo Kim Berg
James Bugental
Cathy Cole
Albert Ellis
Art Freeman
Carol Gilligan
Kenneth Hardy
Steven Hayes
James Hillman
Kay Jamison
Sue Johnson
Jon Kabat-Zinn
Otto Kernberg
Arnold Lazarus
Peter Levine
Hanna Levenson
Marsha Linehan
...and more

Salvador Minuchin
William Miller
Jacob & Zerka
Moreno John
Norcross
Violet Oaklander
Erving Polster
Carl Rogers
Virginia Satir
Martin Seligman
Ronald Siegel
John Sommers-Flanagan Rita Sommers-Flanagan
Carl Whitaker
Reid Wilson
Derald Wing Sue
Irvin Yalom
Phillip Zimbardo

Therapeutic Issues

ADD/ADHD
Addiction
Anger Management
Alcoholism
Anxiety
Beginning Therapists
Bipolar Disorder
Child Abuse
Culture & Diversity

Healthcare/Medical
Infertility
Intellectualizing
Law & Ethics
Obsessive-Compulsive
Parenting
Personality Disorders
Postpartum Depression
Practice Management

Therapeutic Issues

Death & Dying
Dementia/Alzheimer’s
Depression
Dissociation
Divorce
Domestic Violence
Eating Disorders
Grief/Loss
PTSD
Relationships
Sexuality
Suicidality
Trauma
Weight
Management
...and more

Population

Adolescents
African-American
Asian American
Athletes
Children
Couples
Families
LGBT
Inpatient/Residential Treatment
Latino/Hispanic
Men
Military/Veterans
Older Adults
Parents
Prisoners
Step Families
Therapeutic
Communities Women