CHAPTER
3

Beginning the Dialogue with Your Child

We never know whether the words we use and others hear, convey the same meaning . . . how much more so when it is your son.

Elie Wiesel[1]

There is no single, definitive protocol or "correct" course of action for you and your child to follow that will guarantee a solution to her eating problems. This chapter will help you to initiate a many-faceted recovery process as you first confront your child.

THE PARENTAL ROLE

Your attitudes and beliefs about children and teenagers and the role of parents affect the way you respond to your child. It is important to identify your attitudes and the many misconceptions about the parental role when it comes to eating disorders.

Common Myths About Eating Disordered Children and Their Parents—And What the Facts Are

Myth 1. *Parents are the cause of their child's eating disorder.* As discussed in Chapter One, parents cannot cause their child's eating disorder.

Myth 2. *Parents should always become involved in monitoring what their child eats.* It is sometimes, although not always, appropriate for parents to become involved in the refeeding process in eating disorder recovery,

depending upon circumstances and the child's needs. It is always appropriate for parents to prepare meals, have a house that is well stocked with nutritious foods, and to expect their child to eat.

Myth 3. *Parents should never become involved in monitoring what their child eats.* As mentioned in the discussion of myth 2, this depends on what the individual child requires at any given time. (Chapter Seven offers some information about practical food monitoring.)

Myth 4. *All kids are rude and obnoxious to their parents during adolescence; it's a natural part of the separation process.* Anger is acceptable. Rudeness and inconsiderateness should not be. They are one sign of a self-centered child with poor self-esteem who is incapable of properly expressing what she feels. Your child's attitudes toward you tell you a great deal about the quality of your parenting and what she sees as acceptable behavior in your home.

Myth 5. *By the time a child reaches her teenage years, it is too late for parents to have any influence on her.* It is never too late for people to have positive influences on each other. Parents err in thinking their adolescents have grown up beyond their reach. The opposite is true.

Myth 6. *It is normal for siblings to fight a lot and be mean to each other.* Frequent fighting is not normal, and like rudeness and inconsiderateness (see the discussion of myth 4), this behavior signals a child who is facing problems. Hitting is communication through violence, not words.

Myth 7. *The best way to guarantee a child's healthy separation from the family is to give her as much freedom as possible as early as possible.* The capacity of a child to separate healthfully from parents correlates directly to how healthfully *bonded* she is with them first. Children learn how to be successfully separate *only* after they have enjoyed a healthy and meaningful connection. Sending children away to overnight camp at age six, seven, or eight is no guarantee that they will separate healthfully later.

Myth 8. *It is inappropriate for parents to purchase a health club membership for their recovering child.* It is very appropriate to exercise. The goal for the eating disordered child is to participate in life in a moderated and balanced fashion; extremes such as total abstinence should simply not be options. A health club membership could provide a helpful practice ground for setting self-limits, as long as the privilege is not abused.

Making Contact

Communication between parent and child is a dynamic that is complex at best, and it becomes even more so when communication takes the form of discussion about an eating disorder. Consider the following case study.

> Alice, a bulimic adolescent, sat together with her family in my office. Her mother, Joan, asked her to explain something about her eating disorder. Alice's internist had sent a note home asking mother to stop bringing *trigger foods* into the house. Having no idea what a trigger food was, Joan turned to Alice for an explanation.
>
> " I don't feel comfortable talking to you," was Alice's response. "This has nothing to do with you. It's not your problem. The subject is closed."
>
> Alice's defensive response prompted Joan's tearful description of how helpless she felt. "Here I am, expected to help you recover from something I do not understand, and no one will even explain it to me!"
>
> "If Alice would discuss her disorder with you, what would you like to know?" I asked Joan. There was no hesitation in her response. "I would want to know about what the eating disorder is and how it got started, what drives it, and how she can address it. I would want to know why she is required to go to the internist's office every week, what triggers her problematic eating habits, and if what we are doing at home is making things better or worse. But most of all, I would want to know why she won't speak to any of us about her problem!" Turning to Alice, Joan said, "I've always known what to do in the past, but suddenly I feel lost. . . . It's as if I don't know who you are anymore, or who I'm supposed to be."
>
> Alice had nothing to say on the subject—nor could she explain why. "Do you feel your mother is being intrusive by asking such questions or that she could simply be trying to express her concern and desire to be more helpful?" I asked. Alice said she *felt* her mother was intrusive although she *understood* that her mother was only trying to help. She did not *know* the answers to her mother's questions or how to begin accepting help from anyone. Under the influence of her eating disorder, Alice had become more remote from her parents than ever. Because she could not recognize and respond to her own feelings, she was helpless to attend to her own needs, let alone the needs of her parents.

Though parents must retain clear and appropriate privacy boundaries with their adolescent children and respect the child's remoteness under the influence of an eating disorder, this does not exempt parents from being parental and from learning what is essential for them to know. It is precisely when parents are feeling most helpless and lost that they will be called upon to be most forthcoming and persistent.

From the very moment of their children's birth, parents strive to prepare them to leave home as emotionally healthy and highly functioning adults. Parents are teachers. Lessons taught about life will influence their child's eating. Lessons taught about eating, food, and nutrition likewise teach children about life and how to live it. An eating disorder suggests that an adolescent's developmental tasks have veered off course. It is for the parent to get them back on track.

Understanding Obstacles to Parental Advocacy

As the healthy child matures and internalizes family and cultural values and controls, her need for external controls diminishes. When emotional development is interrupted and veers off course, however, the individual lacking fully developed internal resources turns to external resources, such as eating disorders to fill the void. When a child is incapable of exerting self-control, it is the parents' responsibility to pick up the slack and to provide the emotional structure that is lacking, at least until the child is capable of exercising her own initiative and has no further need to rely on disease.

Too many parents withdraw their influence from their children's lives prematurely, precisely when their children are least able to make responsible judgments on their own and when they need parental guidance the most.

EXERCISE A Avoiding Parent Traps Here are some parental behaviors and attitudes that act as obstacles, preventing parents from helping their children. To help yourself recognize such traps, read each statement. Does it resonate with your own thoughts and actions? Circle Y for yes, N for no.

1. Y/N I fear that becoming involved with my child's eating disorder will jeopardize my relationship with my child.
2. Y/N I feel that the best way to be supportive to my child is with hugs and acquiescence, eliminating emotional conflicts even when that means not being true to myself.
3. Y/N Because I feel guilt for causing, or at least not preventing, the onset of disease, I feel inadequate when approaching my child.
4. Y/N I sometimes interrupt my child before really hearing what she has to say, offering advice before I know what she needs and wants.
5. Y/N I remember my own behaviors as a teenager and wonder, "Who am I to offer advice when I was worse than she at that age?"

6. Y/N Knowing that I have no power over my child's actions when I'm apart from her, I assume I have no influence at any time.
7. Y/N Assuming that involvement connotes intrusiveness, I worry that my child will be angered and alienated by my interest in her.
8. Y/N Because I believe that my eating disordered child is emotionally fragile, I hesitate to say anything that might offend her.
9. Y/N Sometimes I forget that no response is a poignant response; it implies just about any meaning my child chooses to assign to it.
10. Y/N I believe that substance use (alcohol, cigarettes, drugs) and fad dieting are a natural part of growing up. I don't mind if she engages in these activities at home.

These notions are all nonproductive and can hinder your efforts to partake effectively in your child's recovery.

EXERCISE B Walking on Eggshells: The Delicate Dance of Fear Do you find that you are afraid to ask your child questions because her answers may uncover unpleasantness, arouse your anger or hers, disclose a secret, or reveal a problem? Read each of the following questions. If you could ask your child the question, circle Y for yes. If you would be afraid to ask, circle N for no.

1. Y/N Are you eating the lunches I make for you every day?
2. Y/N Why do you feel it is so critical for you to lose five pounds? What will it be like for you if it doesn't happen? If it does?
3. Y/N Which are the articles that interest you the most in the magazines you are reading?
4. Y/N What kinds of issues are of greatest concern to you and your friends?
5. Y/N Do you understand what an eating disorder is? How would you explain it to someone else?
6. Y/N Do you know how people behave when they have an eating disorder?
7. Y/N If you had an eating disorder, what would be your greatest concern?
8. Y/N You've been in the bathroom a long time; are you okay?
9. Y/N I found all of these candy wrappers in the garbage. Do you know where they came from? (If the answer is no: Would you feel free to discuss this with me if they were yours?)

10. Y/N You seem agitated and upset. Are you aware of what might be bothering you?

If your answers indicate that you're reluctant to discuss such things with your child, think about what's holding you back. Could there be unspoken issues between you and your child that demand protection? Could your hesitancy or ambivalence about asking what you need to know be giving your child a sense of being too powerful? Ironically, the more parents walk on eggshells in an effort not to miff their child, the more overpowerful she feels, and the greater her need to rely on the eating disorder.

Here are eight additional common obstacles for parents to overcome as they approach their eating disordered children. You may be experiencing several of these obstacles at once.

The Adolescent Mood Obstacle Adolescence is marked by the onset of puberty with its chaotic onslaught of hormones and role confusion. As one college freshman reported, "I know I'm not ready to be an adult, but I'm certainly not a kid any more, either." Because this life stage can be characterized by moodiness, impulsivity, rebelliousness, and wholesale alienation from adults, adults typically *expect* teens to ignore parents, to be rude, noncommunicative, and hostile. But when you see such extreme behaviors as normative, you often miss what your child is *really* trying to say through these attitudes. The distancing teen, faced with a laissez-faire parent, easily slips out of the family's reach—a prophecy self-fulfilled.

The Professional Advice Obstacle Health professionals typically advise parents to back off in the interest of supporting their child's fledgling independence. There are certainly circumstances where this advice is appropriate, but each case is unique, and each circumstance must be analyzed apart from such sweeping generalizations.

The Overweight Fear Obstacle In trying to prevent children from becoming overweight, parents typically *create* fears and misconceptions in them. There are more than twenty million (roughly 25 percent) overweight young children in the United States today.[2] Our children are being raised among the temptations of abundant and affordable food, fast foods, absent parents, and sedentary and con-

venience-oriented lifestyles. Car-pooled everywhere, our children have decreasing opportunities to use their bodies actively. What are parents to do if not to become vigilant about their child's fat intake, purchasing *lite,* low-fat, and no-fat foods in an effort to teach healthy eating? It is easy to misinterpret what healthy eating is and to confuse our children with these misinterpretations. *Healthy eating is the capacity to eat anything and everything, any time, as long as it is in moderation.* Unhealthy eating is restrictive, unbalanced eating of any kind.

The Support Obstacle Being supportive is a learned skill. With eating disorders, your child may have an adverse reaction to your *knowing* about her problem, let alone to accepting your help. Supporting her in eating disorder recovery requires responsiveness tailored to her changing needs. Her behaviors, and it is to be hoped her words, will keep you abreast of these changes, alerting you to the times when you ought to back off (but never to the point of losing emotional contact) and when you must sally forth. It is for you, the parent, to straddle the thin line between interceding and interfering with precision and flexibility throughout your child's recovery—and indeed throughout her life.

The Friend Versus Parent Obstacle One of the toughest obstacles of all is the temptation to behave like your child's friend, especially at those times when her goals for herself parallel your goals for her, when she is feeling strong and capable, or when she is feeling particularly weak and needy. Yet it is up to you to remain consistent and focused, never losing sight of the big picture. As a friend, you run the risk of losing your objectivity; in the role of parent, you do not. Don't let empathy with your child lead to your inadvertent support of her disease.

The Burden of Proof Obstacle So many parents feel they have no right to *accuse* their child of what might or might not be a disease. One parent admitted that she'd known about her daughter's bulimia for two years but felt her "hands were tied" because she could never "prove it beyond a reasonable doubt." Her fears about destroying their relationship, compounding her daughter's pain, and becoming inappropriately involved in a "place" where she did not belong caused her such consternation that she did not sleep a wink the night before she finally confronted her daughter.

The Miscommunicating Family Obstacle When considering the functional health of your family, that is, how members of your family relate to one another, remember that communication is as much about what *is not* said as it is about what *is* said. What is not said is *interpreted* and *felt.* Children simply fill in the blanks with their misconceptions. A father criticizes a television celebrity for being fat, and his child translates that as, "Dad doesn't love fat people. I'd better not ever get fat." A mother exercises religiously every day, spending much of her time in a leotard. Her nonverbal messages are not lost on her young daughters.

The "I Can't Tolerate Controls Myself" Obstacle Parents of today's eating disordered children tend to be baby boomers, members of the generation that grew up during the sixties and made freedom from constraints their goal in life. Perhaps responding to their own feelings that they were parented oppressively, these individuals tend to be loath to provide discipline for their children. However, when offered freedom and power without rules, children will fabricate devices (like eating disorders) to make up for the missing structure.

Activity Understanding Your Parenting Style Discuss your parenting style with your partner. Does he or she perceive your style as you do? How do you perceive your partner's style? Does he or she agree? How do your styles complement each other? How do your differences compound your child's difficulties? How do you assess which styles work best in specific situations? Have you ever asked your child for her perspective on your parenting styles? When it comes to helping a child with an eating disorder, parents must agree on their values and philosophies and act consistently.

What Is Good for the Goose Is Not Necessarily Good for the Gander

Yet another obstacle for parents attempting to assist their children is the fact that behaviors and lifestyles that serve a parent well may cause problems for a child. One mother confided in her bulimic daughter that she was about to "commit a sinful act" by eating a fatty dessert but that she had promised herself she'd "exercise like crazy tomorrow." She could not understand how her "healthy" exercise regime and fat intake vigilance could adversely affect her bulimic daughter, but it did.

Another mother encouraged her bulimic daughter to keep a tally of daily calories side by side with the mother's own tabulations. This woman never allowed herself more than 1,200 calories per day, approximately half the amount her daughter needed to maintain a healthy metabolism and eating lifestyle. For the mother, weight restriction offered a degree of self-control within the context of her shaky marriage; for the daughter, weight restriction became an out-of-control aspect of her eating disorder.

These parents managed to maintain a functional balance in their lives, but their disordered children did not. The parents' primary or secondary means for reducing anxiety and coping with problems fell short of making them clinically eating disordered. Biochemically they were probably not as vulnerable to disease as their children. In a similar vein, by offering a glass of wine to a nonalcoholic, one is providing a delicious, relaxing, and even medicinal enhancement to an evening meal; the same well-intentioned offer made to a recovering alcoholic may be construed as a less than benign invitation to fall off the wagon.

Well-intentioned parental communications can become confused and misinterpreted messages when offered to children outside of a context of values and greater meaning. Even when parents are supporting what they feel is best for their child, like the mother who never allows her children to have dessert, they can be creating obstacles to helping that child. It is important to know when short-term gains are best forfeited in favor of longer-term ones.

Whereas some parents impose too many controls, and others impose too few, both leave their children incapable of self-regulation. Establishing proper controls and withdrawing them when appropriate is key to developing your child's capacity for internal self-regulation and self-esteem. Moreover, when parents show no flexibility, the child has no room to learn self-expression and problem solving based on the requirements of the moment.

Remember that words and actions carry messages of tremendous power, especially in light of the particular sensitivities of eating disordered individuals. One purpose of this book is to empower you to harness the enormous power of words to accomplish *good.*

EXERCISE C Recognizing Your Own Obstacles Before approaching your child about what may be an eating disorder, you may find it helpful to anticipate the trouble spots, in a effort to prepare yourself to face these obstacles. You may also

want to discuss them with your partner or a therapist before you talk to your child. To identify potential obstacles, read each of the following descriptions of what you will do to talk productively with your child and write down the difficulties you think you might have in carrying out these actions.

1. I can approach my child with empathy. I can help my child feel understood and accepted so she will partner with me as her ally.

   Obstacles:

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   _____

   _____

2. I can concern myself with the *process* of problem solving rather than with finding specific solutions to specific problems. I can think things through aloud with my child ("I'm wondering if this *other* option might be a preferable alternative." "Can you talk to me about *how* you are thinking about this?" "Have you considered thinking this other way, or asking so-and-so for an opinion?").

   Obstacles:

   _____

   _____

   _____

3. I can keep conversations goal directed. My goals are to hear my child, to let her hear herself, to share my values with her, and to encourage her to accept assistance. It can't hurt to explain to her what I hope to accomplish by engaging in a specific interaction with her ("Here is why I am asking this." "This is what I have in mind.").

   Obstacles:

   _____

   _____

   _____

4. I can keep the conversational ball rolling. I will try not to take turns with my child in saying things but will focus specifically on what my child has said. I will not state what my child already knows as if it is new information. I will

try to remember that I do not have to accomplish my ultimate goal in the first conversation, and I do not expect my child to know or to say right away what she needs from me.

Obstacles:

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_____

5. I will try not to succumb to such conversation stoppers as, "Dad, *no* teenager ever confides in her parents."

   Obstacles:

   _____

   _____

   _____

6. I will not fall into the gender gap by thinking that there is some natural law against females' confiding in their fathers and males' confiding in their mothers. The capacity to be open and above board in communicating is not gender based. All teenagers want and need privacy about specific issues but not necessarily about their eating disorders.

   Obstacles:

   _____

   _____

   _____

7. I will be clear with my child that I do not intend to control her life but only to live in harmony alongside it. My goal is not to have power over my child but to empower her.

   Obstacles:

   _____

   _____

   _____

8. I will use I-based statements to avoid giving advice and blaming ("I notice that you haven't eaten much dinner," rather than, "You didn't eat enough dinner.").

Obstacles:

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9. I will try to use objective rather than subjective statements ("I notice your clothes seem to be getting larger on you," rather than, "You are too skinny.").
   Obstacles:

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10. I will learn to expect and respect my child's resistance to treatment and recovery, knowing that this response, though misguided, represents her best effort to take care of herself and to survive.
    Obstacles:

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11. I will attempt to *create* occasions to interact with my child. I will make a point of wandering into her bedroom when she is not particularly busy and hanging out there, testing the waters for any inclination to chat.
    Obstacles:

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12. I know that I may eventually need to use my authority as her parent, through ultimatums or force, to get my child to treatment, at least initially. I know I can rely on the therapist to negotiate the resistance and anger between us. If my child walks out on me and the session, I can always stay and get help for myself.
    Obstacles:

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EXERCISE D Recognizing What Your Child Considers Supportive How do parents know what feels supportive to a child? How can parents feel confident that they are not overstepping the line between intervention and interference when offering support? Here are some of the things your child might say to you were she sufficiently self-aware and capable of articulating her needs. To help yourself overcome obstacles to communication, read each statement, and if you can imagine yourself doing what your child is asking, circle Y for yes. If you can't, circle N for no.

1. Y/N Don't tell me what to eat; ask me instead if something is wrong. Your policing my food intake is less helpful in the long run than my learning to control myself.
2. Y/N If you see me struggling, notice it, comment on it, ask if there is something you can do. Ask me if I want to talk about it, but respect my answer if I say no. Bring the issue up again in another way, at another time. It helps me to know that you are with me, that I am not alone.
3. Y/N Notice that *I* am struggling; your accent should not be on my food and eating, but on *me.* It's OK for you to wonder aloud what might be making things so hard for me.
4. Y/N Rather than supporting my decisions, it would feel more reassuring to me if you would ask me how I arrived at them. Ask me why I feel the way I do before commenting on whether or not you agree with me. Ask me if I have considered thinking about things differently. Remember you are supporting *me,* not my decisions.
5. Y/N Please take the initiative with me; don't wait until I come to you. Ask me whether I am feeling upset if I seem upset to you, even though I may not be aware enough of myself yet to be able to answer you.
6. Y/N Offer to make my lunch for school. That little brown sack of sustenance at the bottom of my book bag does a lot to say how much you really care about me.
7. Y/N Listen to hear me, not for an excuse to tell me what you think. Don't be impatient for me to be done speaking. I have a right to my opinions.
8. Y/N You think that by not saying certain things you are avoiding an argument, but when a conflict exists, it exists whether you and I discuss it or not; bringing it to light increases the odds that we can resolve it.

9. Y/N Don't feel that it is acceptable for you to say insensitive things to me because I am overweight. I am not this way by choice.
10. Y/N Refrain from commenting on my thinness; it sets off my anxiety and determination to become even thinner.
11. Y/N Don't sit by passively if others make fun of the way I look. My feelings are easily hurt, and I need your understanding and support.
12. Y/N Don't feel compelled to accommodate my requests to bring low-fat and lite food products and junk food into the house. These will not help me recover.
13. Y/N Honor your own needs. Don't go out of your way to make me special dinners or to change the family's eating lifestyle to accommodate mine. I'll make my own meal if I do not like what you are eating. Expect me to sit down at the table with you for communal dining. If I go overboard and eat up all of a certain food before the rest of the family has a chance to partake of it, expect me to replace it.
14. Y/N Don't try to take control of my life, my disease, and my recovery by disposing of trigger foods that I bring into the house. Don't take on my problems as your own; don't lose sleep, don't miss your vacation so you can stay home to watch over me, don't refrain from eating out at certain restaurants that may be a challenge for me, and so on. Such actions both impose and take away undue power, reinforcing my insecurity and my need for the eating disorder.

One of your goals as you learn more about eating disorders is to be able to answer yes to more of these supportive behaviors.

CONFRONTING YOUR CHILD CONFRONTING DISEASE

What do you *say* about a problem that makes its own rules, one of which is that it is not to be discussed? What do you *say* to a child who drops hints then retracts them in the next breath? What do you *say* to a child who claims of her disorder, "As soon as things come together in my life, I'll get rid of it"? What do you *say* to an anorexic child who claims that she really doesn't have an eating disorder at all, now that she has enough self-control not to fall below ninety pounds again, or to a child who says, "How can I be sick? I ate out with you at a restaurant, didn't I?"

even though she fasted all day in preparation for the occasion? In confronting your eating disordered child, you can count on confronting resistance—to recognizing disease, to accepting treatment, and to engaging in recovery.

Confronting Resistance

Resistance often appears as early in the recovery process as the stage of symptom recognition and disease acknowledgment, taking the form of disease denial. It accounts for the secretive nature of the disease and often looks and sounds like fear—of change, of failure, of success, of relying on oneself, of displeasing others. Resistance is about holding onto symptoms that work for the patient; the task of treatment is to find alternatives that serve the patient more effectively. In most instances the effort to resolve a problem begins with defining the problem. In the case of eating disorders, and as a result of resistance, efforts to resolve the problem often need to begin *before* the patient acknowledges that a problem exists. In fact the first goal of treatment is inevitably to help the patient understand that there *is* a problem.

Resistance appears too in the patient's difficulty with accepting and committing to the process of treatment. Patients may commit to treatment but then regress into ambivalence about recovery. One of the first requirements for confronting your child successfully is that you understand and recognize the many faces of resistance. Individuals resist giving up disease for a variety of "good" reasons. In one instance a teenager assumed that a diagnosis of eating disordered was forever. Concluding that her fate would be sealed with the admission of disease, she needed to remain outside the treatment process because she needed to live with the hope of being well one day.

Accepting recovery connotes accepting disease and, with it, accepting one's own failings and vulnerability. Some patients believe they cannot exist without their disorder. When the child's resistance is intense, treatment might initially focus on less threatening, more attainable goals, with food issues always present but perhaps tangential until trust is established in the therapy process. Particularly in those cases where resistance to food changes is high, regular monitoring by a physician is critical to watch for degeneration in the patient's physical health.

Parents may also be resistant to recognizing disease or assuming a role in recovery, and this can compound the child's resistance. Parents of today's adolescents, who are otherwise so accustomed to living proactive, entitled, and

empowered existences, in too many instances seem all too ready to abandon their take-charge stance in the face of their children's eating disorders.

EXERCISE E Recognizing Deterrents to Getting Better Here are some of the forces behind resistance to recovery, described in the words your child might use if she were sufficiently self-aware. To identify some of the forces behind your child's resistance, read each statement, and if you think it is something your child might tell you if she could articulate her resistance, circle Y for yes. If it is not, circle N for no.

1. Y/N Tomorrow I will undo the positive changes that frightened me today.
2. Y/N I don't need to gain back all of my weight in order to be recovered.
3. Y/N I will surely become fat if I eat normally.
4. Y/N I am afraid of food; as soon as I begin to eat, I feel completely out of control.
5. Y/N I am not responsible for the good things that have happened so far in treatment.
6. Y/N I can't live without my eating disorder.
7. Y/N Everyone will stop caring about me if I get well.
8. Y/N If I let go of disease, I will also have to let go of my self-control, self-discipline, good grades, nice appearance, being the envy of my friends, invitations to the prom, and many other great perks.
9. Y/N You may consider my eating disorder to be yet another indicator that nothing is right in our family.
10. Y/N This treatment may be too expensive for you to handle.
11. Y/N If you and Dad become involved in treatment, you might begin fighting with each other, which could lead to divorce.
12. Y/N My eating disorder is embedded in every cell of my body. It is as intrinsic a part of me as my hair and eye color.
13. Y/N I want to be "special," not just "average" and "ordinary."
14. Y/N Giving up my disorder would be like going through a death.
15. Y/N The therapist is encouraging me to accept "responsibility" for the part of my problem that is in my power to control, but what he really

means is that I am to blame for my disorder; he's trying to make me feel guilty.

16. Y/N Someday, when I have a husband and kids, a job and financial security, then I won't need my eating disorder anymore, and it'll go away by itself.
17. Y/N I can eat a meal, so I must be recovered.
18. Y/N I consider myself to be living a wellness lifestyle.
19. Y/N Any amount of failure feels total and irrevocable to me.
20. Y/N If you don't look at a problem, it's not really there.

As you look back at the statements you thought your child might make, consider how you might help her to overcome these specific resistances.

Recognizing Hidden Agendas

With as much nonchalance as she can muster, a daughter begins to interview her mother: "Mom, have you noticed that the entire bag of Snickers has disappeared?" It is likely that this child needs and is asking for something more weighty than a discussion about candy wrappers. What does she really want to say? What is her hidden agenda? My guess is that this youngster is attempting to say "Help me!" to break her silence about her disease in the only way she knows how—disguised and cryptic. She is probably asking her mother to take initiative and control where she cannot do so herself. Feeling tentative about putting herself in a position from which she cannot retreat, she probably feels safer asking for what she needs in the form of a riddle. She may also be fearful about broaching a topic that seems a shameful indictment of her character, suggesting that she might be "crazy" or out of control. She might be asking whether or not she is sick.

Her mother could respond in various ways. She might pretend not to know anything about the situation, pretend not to be concerned about the worrisome signs she *has* noticed, acknowledge that she is aware that something odd is up but express no curiosity to know more, or acknowledge that she has noticed and is all ears to hear what her daughter has to say on the subject.

If her mother plays dumb in this situation, it might say to the inquiring child that her mother not only doesn't know but doesn't *care* to know about the child's quandary or the unhappiness and fear she is experiencing. This would reinforce the misconceptions discussed earlier that having family secrets is preferable to knowing

unpleasant things, that ignorance and denial are viable alternatives to assuming responsibility, and that if one does nothing to stir up a problem, it might simply disappear of its own accord. Moreover, playing dumb will give the child the sense that she has once again put one over on her mother, increasing her sense of being overly powerful, self-destructive, and reliant on her eating disorder to control her otherwise out-of-control existence. This child might also deduce that her disease is too profound or serious for anyone to provide assistance. She might even get the message that her mother *prefers* her to be thin.

The more open a parent is to hearing the truth, the greater the chances the child will respond truthfully. This interchange was about a child asking for help. The best offer of assistance would take the form of the parent seeking further information from the child in order to understand her needs and her dilemma as fully as possible. In asking for this information and understanding hidden agendas, parents must practice the skills of active listening.

Active Listening

The beginning of wisdom is silence; the second stage is listening.

Hebrew proverb

If you want your child to be forthcoming with you about her disorder, you need to become a better listener. The parent with a genuine interest in listening to and understanding the things her child needs to share enables the child to look deeper into herself to observe and reveal additional thoughts or feelings. An active listening response also offers the child the assurance that she is not alone and that she has the parent's unconditional support in her every effort to find assistance. Active listening is a fearless and optimistic model for interaction that demonstrates the power of joining with others to bring about change.

How to Listen Actively

1. Hear the feelings underlying the child's statement.
2. Summarize the child's statement, making reference to her feelings.
3. Avoid criticism, contradiction, explanation, and judgment; reinforce conversational comfort through openness.
4. Describe what you see, feel, and believe needs to happen next. (This is not the same as advice giving.)

Here's an example of a mother using active listening with her child. Before you read the mother's response to the child's accusation, think for a moment about how you would be likely to respond.

MOTHER: Good morning. How are you this morning?

CHILD: Can't you ever stop watching me and questioning me every minute?!

MOTHER: Wow! You seem jumpy this morning. What's going on with you? You know, it seems that you feel I've been interrogating you about things lately. I'm not sure what I have done wrong. I feel badly that I made you feel that way, but I can assure you this has not been my intention. Can you give me some examples of when I made you feel like this?

Taking Stock Active Listening To use active listening with an eating disordered child, the parent

- Offers an open-ended but contained response that reassures the child the parent knows his or her own limits and is respectful of them and of the child's personal boundaries.
- Implies that he or she is content to wait for cues about the best pacing and timing for the child to disclose concerns.
- Role-models the child's capacity to ask others for what she needs in life. This is also known as assertiveness. A parent's comments and questions needn't be succinct, thought through, or even to the point. All they need to be is *expressed.*
- Demonstrates a sincere, unconditional readiness to assume responsibility where he or she can. The child is not alone with her feelings.
- Offers relief and an outlet to the child who asks a simple question (perhaps about a bag of candy) that may be a disguise for her interest in making a confession. By providing an opportunity for self-disclosure, the active listener helps the child to understand what motivates her own attitudes, behaviors, and responses.

Hearing What Has Not Been Spoken

Every communication is composed of two separate components: the *overt* (the literal content) and the *covert* (the unspoken feelings). An active listener tunes in

to the covert, underlying feeling messages and responds to them in such a way that the original speaker comes to recognize and understand her emotions, intentions, and self more fully.

EXERCISE F Learning to Listen Actively The following scenario contains an interchange that occurred between a young woman who was a patient of mine and her father after they had lunch together at a country club. As you read, consider the overt and covert meanings, and in the space provided, write down what you think the daughter and the father might have been trying to communicate.

DAUGHTER: Boy, did I do my share of eating today!
FATHER: Oh, come on! You hardly ate anything.

1. *What might the daughter have been trying to express?*

   _____

   _____

   What she wanted to express: her pride about how she had handled the challenge of eating lunch, emotionally and nutritionally. She felt it had been a real achievement that she had kept her meal down, and she wanted her father to notice her accomplishment and share her pride.
2. *What might her father have heard her say?*

   _____

   _____

   W*hat her father heard:* recriminations and fear about how she had overeaten in contradiction to her anorexic drive not to eat.
3. *What might she have heard her father say?*

   _____

   _____

   What she heard her father say: that he had not noticed how well she'd done. She felt abandoned and alone in her recovery efforts.
4. *What might he have been trying to express?*

   _____

   _____

   What he was trying to express: support and reassurance that she had not eaten anything that should have caused her grief, guilt, or weight gain.

Despite this parent's good intentions, he made his daughter feel that she had failed. An active listening, and more effective, response might have been: "You feel as though you ate a lot today. Tell me about that. It seemed like a normal portion to me. So what is that like for you?" This response would help this young woman to better understand herself and then better communicate her feelings and thoughts to her father. The active listening dynamic would ultimately enable her father to be as supportive of his daughter as he would have liked to be.

Troubleshooting Tip Identify Feelings When a child has difficulty identifying her feelings, parents can offer some assistance by suggesting that she try to identify feelings through four major emotional categories: (1) mad, (2) sad, (3) glad, (4) scared. Parents can also give the child some insight into her feelings by telling her what *others* might typically feel under the same circumstances.

EXERCISE G Recognizing the Feeling Content in Messages As you read each of the following statements, try to separate the content from the feelings that underlie it. Then, in the space provided, write down, first, what the listener might have heard and, second, what the speaker might have meant. Appendix A contains some sample answers; however, other answers are also appropriate. The object of the exercise is not to come up with the specific answers given in Appendix A but to practice the art of active listening.

1. Parent to child: "You have an adorable little figure."

   What was heard:

   _____

   _____

   What was meant:

   _____

   _____

2. Parent to child: "I am relieved to see that at least you're not so sick that you are fainting in school anymore."

   What was heard:

   _____

   _____

What was meant:

_____

_____

3. Parent to child: "You're looking so much better."
   What was heard:

   _____

   _____

   What was meant:

   _____

   _____

4. Child to parent: "No. I won't eat dinner."
   What was heard:

   _____

   _____

   What was meant:

   _____

   _____

5. Parent to child: "You can eat your cake only after you've finished your beans."
   What was heard:

   _____

   _____

   What was meant:

   _____

   _____

6. Parent to child: "Should you be eating that? I thought you were concerned about gaining weight?"
   What was heard:

   _____

   _____

   What was meant:

   _____

   _____

7. Parent to therapist: "How is my child doing?"

   What was heard:

   _____

   _____

   What was meant:

   _____

   _____

8. Parent to therapist: "I would like to become involved in treatment with my child."

   What was heard:

   _____

   _____

   What was meant:

   _____

   _____

In all your conversations with your child, the closer your responses come to addressing the *feelings* underlying the discussion content, the more effectively you will communicate. *No point can be made effectively and no dispute resolved when underlying feelings remain unaddressed.* The feeling message behind your intervention with your eating disordered child needs to be: "We'll get through this thing together. We are behind you all the way. This is a fine time to begin recovery. We are respectful of you and your courage for sharing your feelings with us and for starting to deal actively with the problem."

Coming Face to Face with Your Child

On a daytime television talk show, the audience was asked to suggest ways that parents might deal with their eating disordered youngsters. Many in the audience were able to mouth the right words, even without a clear understanding of how these methods would be effective. They knew not to "nag" their children by requiring them to eat or attempting to control their food. They knew that parents must offer their children "self-esteem, not food." "Just keep loving them," said one parent to the others. Yet can you just *love* your child back to health? Don't most eating disordered children first become disordered despite parents who

genuinely and actively love them? And can a parent just swallow the frustration and fear of watching a starving child avoid putting food to her lips?

As you prepare to talk about eating disorders with your child, you are approaching a volatile and uncertain situation. Remember that no interpersonal barrier is unbreachable as long as your intentions are good and your relationship is soundly based in love and mutual respect. Human interaction, particularly between parent and child, allows limitless room for error and damage control. Easily amended, rethought, or restated, miscommunications can be repaired during follow-up discussions—immediately afterward or three days, three weeks, or three years later.

Try not to be put off by your child's off-putting responses, such as, "It's none of your business." It *is* your business, and you have a right to ask because she is your child and you are her parent. You might respond in turn with a question like, "What is going on with you? Is there something happening between the two of us that I am not aware of?" Learn to avoid conversational sudden death discussion-stoppers such as "fine" or "whatever." These are idioms meaning, "I don't want to discuss this, so I'm blowing you and the topic off right now." Whatever it takes, do not let the conversation go until you are satisfied that you have said what you need to say and what your child needs to hear. Successful communication does not end till all parties feel heard. When conversations appear to be dead-ending prematurely, take the initiative to carry them through to their natural completion. Don't let statements like, "I don't feel like talking now," "You're one to talk!" and, "I've got it all under control" stop the conversation. Don't cut the conversation off yourself with remarks like, "I give up. I don't care anymore. You're on your own"; "If you don't eat, I'm taking away the car"; and, "Do it for *me*."

When you find you have slipped into a nonproductive communication pattern, make it your business to slip out of it. And as you interact with your child, keep in mind that you are under no obligation to be perfect or even correct. Your child needs to understand and respect that, as this concept is basic to her learning about herself as well. Furthermore, she is far more tolerant of mistakes and resilient than you might think and is becoming more so all the time in treatment. Whatever you ultimately can't change in yourself, she will need to learn to tolerate or accommodate as she matures through the therapy process. It is not critical that your child feels the way you do about things, as long as she remains open to seeing all options available to her.

Activity Offering Wellness as an Option: Preparing What to Say Mentally rehearsing a confrontation with your child can help you get ready to intervene by mapping out major points and goals for your dialogue. You may want to anticipate making active listening responses, recognizing and responding to resistance, and offering effective rebuttals. The following section is a sample script, or discussion outline, for a parent who sees symptoms of an eating disorder in her child that the child is refusing to acknowledge. It incorporates many of the ideas discussed in this chapter. Think about which aspects of the script might work for you. If some parts of the discussion feel less comfortable to you than others, try to understand why. You may use the script as a model for preparing your own outline of what you might say and how you might respond to your child's predictable display of resistance.

Sample Script for an Intervention

PARENT: I'm concerned about you. Here is what I've observed [*describes his or her observations*]. My hunch is that you may be needing some help now. What's your take on this?

CHILD: There's nothing wrong [*or,* You're imagining it, exaggerating; *or,* It's really none of your business; *or,* If there's ever anything to be concerned about, I'll let you know].

PARENT: I understand what you think, but it would be helpful for me to know more about how you've arrived at this conclusion. Because we see things differently, and because this might possibly be a matter of your health, maybe a professional should help us determine what, if anything, might be going on here.

CHILD: I'm not going to see anyone. I don't want to, and I don't need to [*or,* I can fix things myself whenever I choose].

PARENT: It's only natural to feel reluctant to investigate a situation that scares you or makes you feel out of control. A lot of people who don't understand eating disorders think all kinds of scary things about them, like once you have a disorder you've got it "for life" or that you have to be "psycho" to have an eating disorder or to go into therapy. You know that these notions aren't true, don't you?

CHILD: Of course. I also know there's nothing wrong with me. I'm just trying to keep my weight down so I can look good. All I want to do is lose ten pounds.

PARENT: What is so confusing about eating disorders is that they *appear* to be about food and weight, but they are *actually* devices that help people solve problems, cope with anxiety, and take control—not only of food, but of life. The odds are that if you are out of control with food and frightened about gaining weight, you are probably feeling out of control and fearful about other things in life as well. Eating disorders reflect how a person thinks, acts, and feels in general.

By the way, have you thought about why you feel you must engage in such extreme behaviors in order to lose weight? And are you absolutely certain that you'd be content to stop losing weight once you lost the initial ten pounds?

CHILD: OK, so let's say I have a problem and I went for help. What if things didn't get better for me even then?

PARENT: It's understandable that you might be concerned about that, because eating disorder recovery can be a real challenge and can take time. But you're up to it, and I'm behind you. You've done a lot of tough things in your life—you'll do this one, too. The changes you will need to make won't require you to totally revamp who you are; they will simply be a matter of fine-tuning some of the strengths and resources that you already have in place.

CHILD: What if I have to leave college [*or,* school]?

PARENT: There's a good chance that you could work on your recovery while in school, through various supports on campus. If the problem is too intense for you to stay at school, it will make sense for you to take a semester off, because there's not a lot of learning that can go on anyway when all you can think about is food.

CHILD: I'm not ready to get help now. I'll take care of this next week. Just give me a little time.

PARENT: Do you believe that waiting will help the situation go away? Initially, an eating disorder helps a person feel better, but the longer the disease goes on, the greater the damage it does to the body and the harder it is to fix. If you'd like to try to make a few changes on your own for a week

or so and then see what happens, that's OK with me. But let's plan to talk about it again in a week's time to see how things are going.

CHILD: I promise, I can do this myself. I don't need anybody's help.

PARENT: If you had diabetes and needed insulin, I'd be responsible, as your parent, to make sure you got the medical attention you needed. This situation leaves me no choice either. Why not take the week you are looking for, and let's say that if you haven't been able to make sufficient changes in that time, then I'll step in at that point to find help for you. That's the deal. I will offer you a hand temporarily, just until you are free to take control of things on your own again. So, what do you think?

CHILD: I guess that sounds fair. I just wish I could be good enough the way I am.

PARENT: You *are* certainly good enough. My intention is to help you *stay* that way.

Achieving an open exchange is the most important goal as you begin to dialogue with your child. Don't expect results immediately, but remain focused, confident that you are doing what needs to be done, and persistent.

Getting Started

By now, you have the essential information you need to confront your child. Think of an appropriate time to bring up the necessary conversation with your child, or resolve to take advantage of the next opportunity that presents itself. Decide whether you want to be with or without your partner when you talk with your child. If the two of you are to do this together, determine the things you and your partner should discuss prior to the dialogue with your child. Be sure that you are both of the same mind and that your child does not feel ambushed.

THE AFTERMATH

EXERCISE H Assessing How You Did After you approach your child with your concerns and statements of your position, an assessment of how the conversation went can be a helpful tool, giving you guidance for your continuing dialogue with your child. Answer each of the following assessment questions in the space provided.

1. Do you feel you chose a good time to engage in discussion? (What was right with it? What was wrong with it?)

_____

_____

2. How do you feel your child responded overall and were you surprised by her response?

_____

_____

3. Did your child's feelings change in any respect during your interaction? If so, how so?

_____

_____

4. What did you say that you felt best about?

_____

_____

5. What might you have done differently if you had it to do over?

_____

_____

6. Did you find yourself in what felt like a power struggle? (What was it about? How did you respond? What might have been a better response?)

_____

_____

7. If you were with your partner during the discussion, were you happy with who said what and when and how it was said?

_____

_____

8. Did you anticipate the trouble spots accurately? (Did your efforts to overcome these obstacles work for you? Did they backfire?)

_____

_____

9. Are you aware of changes in your relationship with your child following the dialogue? If so, what are they?

_____

_____

10. How are you handling these changes?

_____

_____

Activity Journaling Intervention Effects Record in your journal any indications that your intervention was in some way reassuring to your child. Keep track of power struggles that may develop so you can attempt to resolve them. Note whether anyone is getting angry now and for what reasons. Write down your ongoing assessments of the unfolding changes in the relationship between you and your child (and you and your partner) and your sense of whether or not you are responding to them effectively. What else might you do?

HITTING THE WALL

A king was saddened to learn that his beloved son, the prince, had decided it was time to leave the kingdom and make his own way. In bidding him farewell, the king said to his son, "Return as far as you can, and I will come the rest of the way."

Talmudic tale

In this section, I discuss a couple of problems you may well encounter during the moments, days, or weeks following your intervention.

Parents who find themselves up against a wall must consider this an invitation and a challenge to begin taking that wall down, one brick at a time. Your child's symptoms may be communicating something to you that even she does not understand. The rockiest periods in treatment are typically the most productive periods, stimulating both you and your child to add techniques to her survival bag of tricks. If you notice that your child feels pain in confronting disease and treatment, keep in mind that her eating disorder is a metaphor for other pain that she has not yet been able to conceptualize and deal with. Uncovering pain is the first step in eradicating it. See if you can help her to comprehend this and to identify her pain—all of it; this knowledge will make the recovery process much more gratifying.

"Anger, like a deep breath, cannot be held indefinitely."[3] When you approach your child about an eating disorder, it is safe to anticipate some anger on her part

as well as your own. Though unpleasant and often feared, anger can be a most empowering emotion when expressed effectively, as it leads to the definition and resolution of problems and personal needs. Author Terri Apter describes fighting between parents and children as parents' not learning what the child has to say.[4] So welcome your child's anger with facilitating responses like, "I see. What else? Tell me more." This will assist her to teach *you* a thing or two about what she lacks and craves from her relationship with you.

During the tough times, you can expect to be the target of your child's intolerance and frustration. Because parents' love is unconditional, children typically assume that parents are a safe haven and that the children will be wholly forgiven for their hurtful behavior—a dubious honor for parents but well worth recognizing and understanding. Where there is anger, you can be assured there are hurt feelings. By attending *first* to your child's hurt feelings rather than to the hostility, you will go far in reducing the depth of your child's defensiveness and rage. *The capacity to resolve conflict through an open expression of hurt feelings between parent and child can remove barriers to intimacy and deepen ties.*

Anger goes both ways; parents have the right to feel hurt and anger too. Don't be afraid to express honest anger toward your eating disordered child, communicating your needs and making appropriate demands, although always making it clear that your anger is with the eating disorder, not the child. This will help you be less critical and help her to feel more embraced and fully accepted. Anger and love coexist quite happily, though one might momentarily obliterate sight of the other. Active listening is a superb way to resolve anger.

Some professionals advise parents to let go of their own anger in an effort to avoid power struggles, to simply ignore their child's raging and refuse to fall into the *tantrum trap.* Emotional distance can be helpful momentarily; it can allow the parties to simmer down and think through why the problem occurred, how it might best be resolved, and how such a situation might be avoided in the future. I contend, however, that anger in any form *requires resolution* eventually, later if not sooner, and that resolution entails the mutual satisfaction of all parties involved.

Don't be fooled into believing the myth that your child's refusal to eat is her way of saying she is mad at you. Anger does not cause disease. It is cause for concern when your child's anger, among other feelings, *cannot be expressed freely and openly.* When an individual cannot recognize and express her feelings, her needs

cannot be met, her problems cannot be effectively resolved, and she feels out of control and unable to cope with life.

Remember that anger is a real, legitimate, acceptable, and very human feeling. Modeling the honest and fearless expression of human feeling, even if it means raising your voice, can only benefit your child—who will be learning to do the same through treatment.

Activity Reversing the Errors of the Past Think about any incident that has occurred between you and your child where you aroused her anger inadvertently. In hindsight, do you know why she became so irate? What might you have done differently? What can you do now, to reverse the errors of the past? What might you watch for as clues that the mishandling of anger is threatening to sabotage your relationship with your child? How can you prevent such problems from occurring?

If you regret some incident in the past between you and your child that slipped by without discussion, consider taking action now. It is never too late to undo such an event, to say: "You know, I have been thinking about something you did [or said] three weeks ago. It occurs to me, as I rethink the situation, there may be more to what is happening with you than I realized at the time. I'd like you to think back with me for a moment. Perhaps you could help me understand something that still puzzles me."

Rethinking Power Struggles

It is important to understand that the real struggle for power exists between the patient and her disease, not between patient and parent or patient and therapist. Nonetheless, by sacrificing their values on the altar of peacekeeping in their fervent efforts to avoid power struggles with their children, parents typically put too much emotional distance between themselves and their offspring or they create emotional distance too soon. In actual fact, *there is nothing wrong with engaging in struggles with your child if those struggles are part of a process leading to anger and conflict resolution.* By butting heads and locking horns, children find out who they are and where they stand in relation to others. They learn how to face and resolve problems constructively, thereby putting their eating disorder out of business.

Troubleshooting Tip **Don't Participate in No-Win Situations** When you believe a battle is being fought to achieve control rather than a negotiated resolution, disengage from the struggle. R*ecognize what the power struggle is designed to achieve* (your child's sense of power), and respond to *that.* Why is your child feeling powerless in regard to you? Asking, "Do I look fat?" is a typical means your child may use to rope you into a power struggle where you are defeated before you begin. It is a forgone conclusion that what you say will be misconstrued. If you respond affirmatively, your child will not forgive you. If you respond negatively, she will either distrust both you and your answer or feel elated that this is how you see her. You might explain your decision not to participate in this no-win bantering, however, and ask what she really wishes to accomplish by asking that question.

Soft power, the exertion of power over another by getting him or her to want the same thing as you do is always the better way. Obviously, no one can make another person eat. When your child digs in her heels and says no! when you have run all the bases and are still striking out, having done what you can to educate, persuade, and set clear limits, it may be time to play hard ball. Exerting your power and authority as a parent is always a legitimate option when it is based on the expression of a clear, appropriate and consistent system of values. Remember, while your child is still at home, you remain her primary means of support, providing the roof over her head, the bicycle she uses to overexercise, the car she drives, her tuition for college. Your child is sick. Do not be afraid to treat her that way. Through tough love and a united front, in these particularly difficult situations, you and your partner may begin to evaluate options you would have preferred not to consider. Though you cannot demand wellness, you certainly can hold out for a substantive and ongoing communication with your child—if not about the disease, then about other issues of great consequence to you both.

In the end, however, you cannot get around the now familiar formula: take control where you can and let it go where it is beyond your reach. Express your feelings, then back off and let reality enforce its inevitable consequences. If your child becomes weak enough, she will collapse and find herself in the nearest emergency room. If she refuses help long

enough, she will be forced to take a leave of absence from college or make some similar accommodation. But in the meantime, don't stop talking, no matter how defeated you feel. Your continued concern is worth more than you know.

Activity Liberating Yourself from the Need to Control In letting go of situations that are beyond your control, you will find yourself feeling liberated. Feeling a need to control people or life situations beyond your reach can cause great anxiety and despair. Think of other areas in your life where you feel pressure to be in control (you may wish to use your journal for this activity). How might your efforts in these other areas affect your need or wish to be in control of your child's disease? How much of your need to be in control is really about fear? How much is about anger? Helplessness? Powerlessness? Understanding these aspects of yourself can help you gain some perspective about your own struggles. Observing your own need to assume control helps you to better understand your child's motivation to remain involved with her disorder.

When Nothing Else Works

In the event that your resistant child becomes harmful to herself or others (that is, she attempts suicide or self-injury or she drives under the influence of drugs or alcohol), you must be prepared to remove her forcibly to a safe environment. If she resists, it is appropriate to call the police to assist you in committing her to a hospital setting. But such forcible commitment, though it can mark the acceptance of disease and the start, renewal, or commitment to recovery, is never in itself more than a temporary solution.

Bringing your child to a readiness to accept treatment is a major step toward her recovery. The next chapter presents the complex dynamics of eating disorder treatment itself.