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Communication Challenges Within Eating Disorders: What People Say and What Individuals Hear

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Additional information is available at the end of the chapter

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Abstract

Communication challenges are apparent in many different ways when working with individuals who struggle with eating disorders. These issues can include the influence of parenting styles to society's weight messages to comments by professionals as they interact with those struggling with eating disorders. Other challenges come from the skewed interpretations that individuals with eating disorders can place on messages that they receive. This chapter examines the literature on many of these issues, highlights challenges with clinical examples, and proposes potential tools to ameliorate some of the impact of these issues on communication.

Keywords: communication, eating disorders, anorexia nervosa, bulimia nervosa, binge-eating disorder, parenting, negative comments, media images, teasing

1. Introduction

Communication requires the exchange of ideas, which means that there is a communicator and a receiver. We need to consider communication as it relates to eating disorders from both sides. What is being said? And what is being heard? There are times that these two aspects are very different. For example, when a person tells another, "You look so healthy!" Most of us would accept this as a compliment. Individuals with anorexia nervosa often hear this exact comment as "You've gained weight". They hear and interpret comments through a specific filter that can distort messages. Yet there are times that messages communicated to individuals are heard just the way that they were meant, and it is the comment itself that is the issue. Such an example would include when a client of mine, who was finally recovering from her eating disorder and was doing well in college was criticized by her family for not having a job. This comment, clearly, meant that she was not meeting expectations. That is how it was heard.

This inability to please others, even when she was working so hard to recover and complete school started her back on the path of restricting and purging.

Other expectations are communicated by society through implied standards. Even the DSM 5 recognizes these messages when it defines certain risk factors: “Historical and cross-cultural variability in the prevalence of anorexia nervosa supports its association with cultures and settings in which thinness is valued” ([1], p. 342). “Internalization of a thin body ideal has been found to increase risk for developing weight concerns, which in turn increase risk for the development of bulimia nervosa” ([1], p. 348). These values are often communicated through the media, which can have a significant effect on individuals.

This chapter will examine communication challenges through a review of the literature and examples from clinical experience. In the end, recommendations to help improve communication will be offered. The eating disorders addressed in this chapter are defined by the DSM 5 and include anorexia nervosa, restrictive eating leading to a significantly low body weight with an intense fear of gaining weight; bulimia nervosa, recurrent episodes of binge eating and subsequent compensatory behaviour in an attempt to prevent weight gain; binge-eating disorder, recurrent episodes of binge eating, such that one eats until uncomfortably full, binges even when not hungry, eats this quantity of food alone because of embarrassment and feeling distressed or guilty after the binge, and finally unspecified eating disorder, which includes behaviour similar to the above categories but in which the symptoms do not meet all of the qualifications [1].

While the effects of different interpersonal interactions will be split out and examined separately, it is important to recognize that these influences work together to create an atmosphere that fuels the eating disorder. Many authors describe the “tripartite model of influence” with the primary core sources affecting body dissatisfaction being parents, peers, and the media [2, 3]. Attempts to understand these various factors have been made with the development of the CIMEC (Questionnaire of Influences on Body Shape Model), which measures the influence of different sociocultural influences [4].

2. Intrapersonal factors

While there are many challenges with the messages communicated via the media, society, family members, and peers, there are additional challenges related to how individuals with eating disorders perceive these messages. Individuals struggling with eating disorders when compared to asymptomatic controls are more likely to identify hostile intent in a series of social vignettes [5]. Adolescent girls were provided with social dilemmas, such as not being invited to a best friend’s birthday party. The control group described that they would talk with the friend or made positive assumptions, such as it must have been assumed that she would come. Individuals struggling with eating disorders, however, rarely picked the option of talking with the friend and brought negative assumptions to the interaction, such as assuming that the friend had only been pretending to like her. They most often picked avoidant coping strategies, including eating disorder symptom uses [5].

Those with anorexia nervosa (AN) and bulimia nervosa (BN) have a higher tendency to use suppression strategies to handle negative emotions as compared to healthy controls who use reappraisal strategies [6]. Individuals with eating disorders suppress the hurt rather than trying to reframe a situation or challenge their assumptions. With BN, avoidant coping strategies are more apparent when the individual is struggling with depression [7].

There is additional evidence that individuals with eating disorders are on high alert for threats. In a computer-driven test, women with a high level of bulimic symptoms were significantly more likely to identify a threatening word when it was present and less aware of it being absent, which suggested a bias towards always expecting a threat to be present [8]. Individuals with anorexia nervosa (AN) often think the worst when considering how others see them, and these experiences then negatively affect their body image, such that they feel themselves fat and believe others see them as ugly or disgusting [9]. One can see the challenge these negative perceptions and expectations have in interpersonal interactions.

Other studies have demonstrated engrained reactions that differ for individuals struggling with eating disorders (ED) as compared with healthy controls. For example, using a lexical decision task, individuals at risk of eating disorders were found to react more quickly to fat-related words than to words unrelated to fat; healthy controls had the opposite pattern [10]. In another study when compared with controls, eating disorder patients were quicker to identify body-related information and more distracted by food information [11]. At-risk individuals appear triggered by these types of words, which then affect how they attend to words and concepts in conversational settings. In addition, clients have described that if they restrict in a social setting then much of their focus is on food or body comparisons. They are not only primed for this focus, but also their ED behaviours fuel it.

Interpersonal interactions also rely on nonverbal communication. So while individuals with eating disorders may be overly attending to certain words, distracted by others, and reading negative meanings into many situations, what happens in the face-to-face contact with others? Individuals struggling with AN have less facial expression in response to positive and negative emotional stimuli and tend to look away while watching a negative film clip as if trying to avoid negative feelings [12, 13]. In particular, individuals with AN have less intense and shorter in duration spontaneous smiles as compared to individuals with BN and healthy controls within these settings [14]. This reduced expression of positive affect can maintain a pattern of social avoidance seen in individuals with AN [14]. Individuals with AN also have more difficulty imitating facial expressions of emotions [15]. They can appear distant and uninterested. Individuals with eating disorders, especially AN, have deficits in their own emotional awareness [16]. This challenge in expressing their own emotions can lead to a tendency to provide vague or over-generalized answers to questions about their emotional state [17]. One client described that she does not really know how she feels so she cannot put it into words. This has led to interpersonal conflicts with her spouse who wants to know how she is feeling and how he can help improve her mood.

Individuals with eating disorders also struggle in the opposite direction, that of being able to accurately interpret another person's emotional expression [16]. Individuals with high levels of eating pathology have a challenge in recognizing subtle expressions of emotion

and have a tendency to misidentify more intense emotions, reading fear as anger and anger as sadness [18]. As Ref. [19] describes, "Thus, if the experience of anger, disgust and rejection are usually linked to each other in people with AN, it may be that faces portraying disgust were experienced by people with AN as rejecting and thus were interpreted as 'angry'" (p. 40). This can relate to the previously described interpersonal situations and the tendency of individuals with eating disorders to interpret others' interactions in a negative light and see them as rejecting. Another study demonstrated that individuals with AN, especially those with strong obsessive-compulsive symptoms, had difficulty in recognizing sad facial affect [20]. Difficulties in these emotional spheres can have huge impacts on individuals with eating disorders as they work to make interpersonal connections. Helping individuals understand their misinterpretation of facial cues and the link to feelings of rejection may be very important in the treatment of individuals with AN [19].

In addition, anger and, at times, sadness are seen as toxic and a danger both for the individual and the others involved [21]. According to Ref. [21], "The analysis highlighted how people with anorexia often did not regard themselves as entitled to be an 'emotional' human being, or that being 'emotional' would lead to rejection from significant others" (p. 298). In the clinic setting, family members often provide this message to individuals struggling with eating disorders. Even as a brother was criticizing his sister and she was trying to defend herself, he told her to not get mad. In other situations, clients have been told by family members that they are "just too sensitive". These comments take away the power of these women to be able to react to criticism. It relieves the attacker of responsibility and hands it to the individual who is struggling with the eating disorder. It essentially says, "This is not related to what I said, this is all you. You are just too sensitive". This leads us into examining aspects of interpersonal interactions with family and peers.

3. Interpersonal factors: parents

Individuals with eating disorders, especially those struggling with anorexia nervosa, can misinterpret situations and emotions. However, are there times that interpersonal interactions could be fuelling the eating disorders? Overall, the majority of adolescents report valuing their parents' opinions and believe their parents care about them. Yet those adolescents who perceived a poor level of parental communication and caring were at a high risk of developing unhealthy weight-control behaviours, especially if they felt that their mother cared very little or not at all [22]. Ref. [23] used a projective test to examine family dynamics and found that patients with eating disorders expressed more discord within the family picture and described, in particular, cold and loveless relationships in the family, in which they did not feel validated. While perceptions may not always be the reality, within a group of adolescents those with binge-eating disorder (BED), as compared to controls, had higher levels of perceived maternal criticism and lower levels of perceived warmth [24]. Ref. [25] identified that, "Whether overt or perceived, negative verbal communications appear stronger predictors of eating disorders than those that are indirect in nature such as family conflict" (p. 209). Weight-teasing by family members has been found to be most strongly and most consistently

correlated with problematic weight issues [26]. Individuals who have more eating disorder characteristics often describe feeling less comfortable discussing their problems with their parents, feel that issues are not taken seriously and often feel lectured at rather than finding a collaborative stance [27].

Families in which the daughter is struggling with AN perceive their family functioning as significantly worse than matched controls and the daughters perceive the family functioning in a much worse light than the rest of the family [28, 29]. The most frequent parenting style in families where a child struggles with an eating disorder is low in care and high in control [30]. They do not feel cared for but feel as if they do not have any control or the ability to navigate the family situation. Individuals struggling with eating disorders who have a more positive perception of their family functioning generally had a more positive outcome, irrespective of the severity of their symptoms [29].

In one study, daughters and mothers of control families seemed to share similar views of family communication, but daughters with eating disorders often did not have a shared perception with either parent about the family's communication. This left them isolated and potentially participated in maintaining the eating disorder [28]. Evidence suggests that this difference in the daughter's perception is related to her distrust of people in general and to her feelings of inadequacy [31]. She feels isolated and not understood. Individuals who consider their mothers "neglectful" in the first 16 years of their lives often demonstrate a higher drive for thinness and more body dissatisfaction [30]. They may be trying to understand why their mothers are so withdrawn from them and are trying to find ways, through the messages of society, to make themselves into individuals who are loveable. When individuals experience neglectful parenting, they have lower self-esteem [30]. In clinic interactions, some of the young woman often describe a feeling of isolation in the family and relate that their eating disorder is the only thing that they can count on.

For individuals struggling with bulimia nervosa (BN), three family variables appear to be involved, including negative comments related to appearance, external control of food intake, and rules related to family mealtime [32]. Often family meals have been seen as positive and protective, but it depends on how the meals proceed. One client whom I worked with described that when she was growing up, her parents would not speak to each other but would argue through her. She was the conduit for all conversation and disagreement during the family meal. Afterwards, she would go to her room and binge and purge to try to relieve herself of this negativity. This clinical example reflects research findings that document a link between negative family food-related experiences and disordered eating [33]. Families who have poor problem-solving skills can spur increased bulimic symptoms because individuals need to relieve feelings of distress and frustration in that immediate point in time when a problem is being mulled over but not solved [34], whereas individuals who restrict often experience excessive cohesiveness in the family. This sense of over-control is a more global experience and not a discrete episode related to solving a problem. The response to this style of parenting typically leads to more restrictive behaviours because that is the only thing they can control [34].

While we will examine the effect of the media and peer interactions, it appears that parental comments have the largest impact on young adults and the development of body

dissatisfaction and eating disorders. Females can be influenced not only by negative comments, but also by positive comments, when the focus still fuels the pressure to stay thin; in males, only negative comments have been related to body dissatisfaction [35]. In addition, in females, eating disorder patients have lower self-esteem as compared to controls and are very sensitive to both positive and negative remarks, such that just one comment can have a significant effect [36]. Dissatisfaction with appearance, lack of regular meals and poor communication with parents increase the likelihood of eating disorder symptoms in both girls and boys [37].

An additional challenge within parent-child relationships is in families where communication between the father and child emphasizes conformity and sets very high standards, which are often unachievable [38]. This spurs self-perfectionism and can make the individual vulnerable to media and society standards, because of the message to conform and achieve. "Those fathers with a communication and conflict resolution style that promotes collaboration/compromise and therefore autonomy in their children help to minimize the risk of the child having significant problems around eating" ([39], p. 60).

A recent example in my program was a father whose daughter had just returned from an extended stay in a residential eating disorders program. She describes that her first morning backs that she was peeling a grapefruit because that is how they ate it at the program. Her father said, "Why are you eating it like that? Don't normal people cut their grapefruit in half?" This is a small example but it had a huge effect on her. She felt criticized, felt "not normal", and a failure despite trying to comply with the meal plan that she had been discharged on. While knowing this father, I do know that he cares deeply about his daughter. But controlling and critical comments can set a standard that seems unreachable and may end up leading to individuals not pursuing their goals since they feel that no matter what they do, they are going to fail anyway.

One challenge within the father-daughter relationship is that daughters want connection/closeness, but fathers often value separateness and independence in their children and so remain distant [40]. These male/female emotional distinctions can get played out within dysfunctional families. There is often a tendency to avoid conflict so communication is stunted. Girls may be aware of the underlying emotional tone but feel powerless to change it; boys, less concerned with family interactions, find support outside the family as they seek their independence [40]. This can leave daughters more vulnerable.

Daughters often model their mothers' relationships to food. This can be a significant issue if mothers have had their own challenges with food and body image. Ref. [41] identified modelling between mothers and daughters in their emotional responses to food and correlations between their eating disorder symptom scores. While daughters mimicking their mothers' eating behaviours may be important, parental comments on the daughter's weight and appearance have a stronger effect than modelling behaviour, such as dieting [42]. This stays true even as women move on into adulthood. The level of concern that adult women have about their weight and their overall body dissatisfaction is often related to comments that they remember their parents making to them when they were young girls [43]. The comments were weight-related or criticism of their appearance.

So how can parents help their children who may be overweight or obese? This is clearly a current societal challenge. The evidence suggests that the focus should be on healthy eating rather than focusing on weight or size. Even for non-overweight adolescents, having one parent engage in weight conversations was triggering, such that the prevalence of dieting went from 15.6% when neither parent engaged in weight conversations to 35.2% when one parent engaged in this talk and 37.1% when both parents engaged in this focus [44]. This is an important consideration because adolescents who report dieting end up experiencing (after 5 years) weight gain, becoming overweight and developing disordered eating [45]. Ref. [46] showed that in recollections of family meal times, comments about appearance/weight control and emphasis on mother's weight were significantly more present in women who were overweight as compared to those who were underweight. He suggests that "...emphasis on mother's weight may be the single most destructive factor mis-shaping a young girl's bodily self-esteem..." (p. 43).

Clinically, it is a challenge when mothers struggle with their own relationships with food and their body image. In working with clients, many describe their mothers' focus on calories or the nonfat nature of a food item, and they find this triggering. Unfortunately, many of these food-related discussions and observations are so engrained in our culture that women may not even realize that are making these comments. Mothers will also body check in front of their daughters, ask whether a certain pair of jeans makes them look fat, and other experiences, which can sometimes be seen as "bonding" but in fact can be extremely triggering to the daughter who may be struggling with her own issues.

This is further escalated if the mother has a clear eating disorder whether it has been diagnosed and treated or not. Often the untreated eating disordered behaviours can be extremely challenging. Daughters find it hard to comply with their meal plan when their mothers are only eating plain lettuce or not even sitting down to eat. Some mothers of patients in our program modelled that they do not eat when they are feeling stressed and often engaged in exercise with their daughters who were being treated in an intensive day program. These mixed messages communicate an ambivalence related to the eating disorder and recovery. How can the daughter value her complete nature and inner talents, when ongoing discussions focus on weight, diets and appearance? Many times, these interactions occur without the mother even being aware of the negative messages. For mothers who have clearly documented eating disorders, there are other ongoing struggles. They worry about being a negative role model, and they want to shield the child from an awareness of symptom use, but this becomes impossible, and in the end, many children end up as caregivers for their parents [47]. Mothers with eating disorders may, in particular, have more difficulty interacting with their daughters around food than their sons, with increased monitoring and food restriction and more appearance-related comments [48]. Difficulties in social communication have been observed in children at a high-risk of an eating disorder, particularly if they were exposed to a mother who experienced bingeing with or without purging behaviours [49]. Their findings suggested a possible shared liability for eating disorders, social anxiety and autism spectrum disorders and raised the possibility that maladaptive eating could result from social difficulties in these individuals [49].

Often certain shared traits in the family precede the eating disorder and can fuel symptom use. These traits run in family, such as anxiety and compulsivity. Family members clearly

become anxious when their family member is sick and that anxiety can make the individual more anxious, which can escalate symptom use, and this can fuel the cycle [50]. Overly analytic family members who focus on detail and continually try to argue the individual out of their eating disorder can often strengthen the symptoms because the patients have the chance to rehearse and state their beliefs over and over such they become even more entrenched [50]. These tendencies can have other effects. In one couple, the husband had the need to think through the pros and cons of every decision in a very compulsive way. He would then ask his wife for her opinion of the options. No matter what she answered, he provided the cons of her choice such that she always worried that she had made a mistake. She felt like she was never right and felt inadequate, and this escalated her restricting behaviour.

In addition to the difficulties within family dynamics that might be present prior to the eating disorder, there are challenges that can affect the family once the eating disorder develops, which can cause continual strain for the family and can exacerbate the eating disorder symptoms. Approximately, one-third of caregivers working with children struggling with eating disorders had moderate to severe levels of psychological distress, including depression and anxiety [51]. A review demonstrated consistent findings of psychological distress, expressed emotion, and accommodating and enabling behaviours in caregivers for people with eating disorders [52]. This can become understandable when we consider the stress that families can be under as they work to provide care to their loved one with an eating disorder. This burden can increase as the years of illness increase, and this can impact the caregivers' functioning, such that accommodating behaviours are more frequent, remains the longer the illness [52]. This is understandable if we consider that compromises with the eating disorder might be made as the individual becomes more ill, having them eat anything may be better than trying to engage them in the family meal. In addition, caregivers in the family can get worn down as the day-to-day arguments over meals and exercise continue. In most families, mothers spend 2–5 times as that of fathers in caregiving tasks [51]. In these interactions, mothers have demonstrated more accommodating behaviours, which are often used to decrease distress or anger in their child who is struggling with an eating disorder [51]. However, these accommodating behaviours lead to poorer social aptitude for individuals struggling with AN [51]. This can lead to more social isolation and an ongoing cycle of challenges.

4. Interpersonal factors: peers

Many clients describe that they were teased about weight-related issues during middle and high school either by family members or their peers. Ref. [53] found that among overweight children, three times as many as compared to non-overweight children were teased, and this teasing occurred more frequently, lasted for years, was more emotionally upsetting and was associated with bulimic behaviours. This predicted lower confidence in physical appearance and a tendency to isolate and participate in sedentary activities because the over-weight children were not avoiding just one bully, they were avoiding an entire peer group that teased them [53]. There is a clear association between teasing and body dissatisfaction and disordered eating [54].

Outside of teasing, the prevalence of “fat talk” (conversations pertaining to comments about appearance, dieting, and the need to lose weight) can also be an issue just as we saw with communication between mothers and daughters. College students both with and without an eating disorder discuss people’s shape and appearance, but those with an eating disorder engage in more fat talk and are more attuned to and preoccupied with eating and body image [55]. Fat talk is a way that the thin ideal is transmitted between individuals and can affect social connections, such that those who do not comply with this type of talk can be viewed more negatively [56]. Ref. [57] found that fat talk is common among young women and is associated with body dissatisfaction, body checking, negative affect and eating disorder behaviours; this is particularly true if individuals engage in the “fat talk” as opposed to just overhearing it. Body talk can also affect men, not only related to eating disorder behaviour but also the extreme drive for muscularity; however, in conversations with friends, men do express body satisfaction, a topic that is a rarity within women’s conversations [58]. It appears that there is a weaker association between fat talk and disordered eating in men as compared to women and in older individuals as compared to those who are younger [59]. The higher association between fat talk and eating disorders in women may be related to the fact that these messages reinforce broad societal messages related to women’s appearance [59].

There are also issues related to dieting and weight loss advice that is affected by an individual’s appearance. For young women athletes, individuals with higher a BMI received less anti-dieting advice than those with lower BMI, even though both groups had the same level of disordered eating symptoms [60]. This pattern has been present for non-athletes as well and has been seen in comments by healthcare providers, at times. There is often a focus on weight loss when individuals are overweight to obese and not an exploration of how this goal is being accomplished. Individuals may be using dysfunctional eating disorder behaviours, but this is not often confirmed until there is a physical evidence of low weight or other physical issues.

5. Interpersonal factors: online experiences

Individuals with eating disorders can have challenges with interpersonal connections. Some of this can be related to issues that have already been discussed. For example, they have a tendency to interpret interactions through a self-critical lens that often has them withdraw from these situations. Many of our cultural interactions revolve around food, which can be extremely challenging for individuals who struggle with eating disorders. In addition, many clients describe that their eating disorder makes them feel isolated. Often when they come into treatment they find a community. This can be supportive or can keep them stuck in their eating disorder because by recovering, they lose part of their identity and support.

Individuals sometimes turn to online groups to find a support system. Members of online forum groups perceive less support from others in their lives as compared with age-matched peers and describe receiving better support overall and specifically related to their eating concerns through the group conversations [61]. Communication within these forums can be helpful, providing advice of how to get help, or they can support the eating disorder behaviours. This is especially true related to online groups that function around disordered eating.

Ref. [62] evaluated online discussion groups related to general psychiatric issues, abuse or a forum for eating disorders. All of the forums provided users with constructive/positive responses to posts, which could be seen as encouraging social support. However “destructive” posts and topic threads, which encouraged negative behaviours, were more than twice as common in the eating disorder group as compared with the other two forums. In the thin focused culture that we live in, no one tends to encourage staying depressed or being abused, but positive feedback can be provided to encourage individuals to try and get thin.

This is evident in online discussion groups that are pro-ana (pro-anorexia nervosa) or pro-mia (pro-bulimia nervosa) and encourage eating disorder behaviour. Social support is most frequently communicated among pro-ana bloggers, which leads to intense friendships and bonds that can have both positive (encouraging seeking treatment) and negative effects (comments that encourage further weight loss) [63]. Interviews with pro-ana group participants demonstrated that each individual had significant evidence of disordered eating and had joined the group specifically to gather advice about weight loss and support for their symptom use [64]. While Ref. [65] found that groups that form a recovery focus can offer individuals much needed support, Ref. [61] describes that in addition to support, forums encourage eating disorder behaviours. Although pro-recovery activity has been found on Facebook, they attract fewer users than pro-anorexia groups [66]. Pro-ED websites do not necessarily imply “anti-recovery”, but users who come for information about seeking treatment may instead find validation of their eating disorder identities and tips about how to continue their symptoms use and hide it from others [67].

Individuals who receive extremely negative comments to their Facebook statuses experience higher shape, weight and eating concerns. These individuals often have a negative feedback seeking style that promotes critical comments, and this, in turn, increases their restrained eating [68]. How individuals ask for feedback can affect what is said, and their further negative interpretation of these comments can escalate the damaging effect.

6. Interpersonal factors: media

Messages from the media can influence eating disorders in a number of ways. First is the overall presentation of society’s “thin ideal” and unrealistic expectations, especially with the mixed messages about the indulgence on food yet with the need to still conform to a certain svelte appearance. “Whereas the ideal female has become progressively thinner over the last 30 years, the male ideal has become increasingly dense and muscular” ([69], p. 298). Media images of the “thin ideal” can have an immediate effect on women’s moods such that they feel angrier and more depressed after examining just 20 images; women who are more dissatisfied with their bodies or have feelings of ineffectiveness or interpersonal distrust are more vulnerable to these effects [70]. These images of unattainable thinness can influence some women to eat more, perhaps related to feeling one’s status as worse in a culture of thinness and exacerbating negative effect and lowered self-esteem [71]. In addition, magazine articles often focus on diet and weight loss and can contribute to negative weight control behaviours to help women meet their thin ideal [72]. Restricting calories and taking diet pills appear

to be influenced by reading fashion magazines [73]. The emphasis of the magazines of self-improvement is typically in the realm of physical beautification [73]. These are just some of the skewed messages that are being communicated.

Second is how the media portrays eating disorders since these messages can influence individuals as they consider pursuing help. Ref. [74] found that magazine articles tended to focus on unusually thin sufferers of eating disorders with a disproportionate focus on anorexia nervosa, such that readers can get the erroneous view that someone who is overweight cannot have an eating disorder. This concern seems to be merited as many times normal weight individuals who struggle with bulimia report that others have made comments to them that they do not look like they have an eating disorder. The articles often provide a superficial presentation of eating disorders, so that readers do not get a sense of the complex emotional issues that underlie eating disorders and the complex path for recovery [74]. Articles about eating disorders are typically placed in the entertainment-related sections, so are seen as “soft” news stories [75]. In addition “...profiles of individuals with EDs also understated the complexity of causes and outcomes associated with anorexia and bulimia and overstated the likelihood of an easy recovery” ([75], p. 48). These messages can be exceptionally hard for sufferers and their families. The messages communicated by the media are often that eating disorders are not that serious and can be easily overcome. When perfectionistic young women struggle with recovery, they view these messages as criticisms of themselves—they are not strong enough to recover—and families are lulled into expectations that this illness will be easy to treat. Since the response to individuals with AN is often, “Just eat!” one can see the pervasive harm of these superficial messages.

7. Interpersonal factors: healthcare professionals

While healthcare professionals should be more aware of the potentially negative effects of their comments and the health risk of eating disorders, this does not always seem to be the case. Clients have returned from referrals for bone scans to assess the possibility of osteoporosis and describe that the technician said, “I wish I could have anorexia for just a little while”. Doctors have not listened to the concerns of patients and families related to weight loss. There is such a focus on obesity that losing weight is not seen as a significant concern. This can delay necessary treatment for individuals and lead to a greater risk of complications. Ref. [76] quoted one patient who was being seen for binge-eating disorder (BED) as being told by her paediatrician “*to do my push-away exercise, meaning push food away*” (p. 58). Patients describe needing a safe environment where they can talk about their issues and a competent understanding of the illnesses by their providers. Often if providers do not have a good understanding of eating disorders, they minimize the problem [77]. This can affect the individual’s pursuit of treatment and level of shame. In addition, often individuals are not seeking treatment on their own but are being pushed to discuss treatment at the encouragement of someone else, and this can lead to intense anxiety over losing control of the eating and their life [77]. Practitioners need to be aware of this anxiety and engage individuals in the session so they can express their goals, their concerns and what steps they are willing to take.

Even in a field that should have compassionate professionals, when assessing BED, psychiatrists recommended that patients employ willpower to break the symptom use and often phrased questions in ways that patients felt judged. Despite patients wanting to explore factors that they felt were driving the binges, such as negative emotions, the psychiatrists often did not explore those areas, focusing instead on type of food eaten, amount, etc. [78]. A word cloud provided a stark visual as to how the psychiatrists and patients each viewed BED, with the psychiatrists focused on symptoms such as binge, weight, ever vomit, how much weigh as compared to the patients whose top words included depressed, stress, anxiety, sweet [78]. The word clouds highlighted the most frequent terms introduced by either the psychiatrist or the patient during their sessions. With such remarkable differences in viewpoints, one can see where communication might falter in these encounters.

Professionals need to be aware of not only what they say, but also of their body language. If they appear not engaged, bored and dismissive of the problem or violate the patient's safe space, individuals who are already ambivalent about seeking treatment may flee from an uncomfortable interaction and not pursue potential treatment. Attention to tone of voice, body language, etc. can help "...alleviate the patient's feelings of loneliness and make her feel safe and listened to" ([77] p. 220). When staff from a inpatient children's hospital were surveyed, nurses had more sympathy towards the ED patients than the paediatric residents (58.1 vs. 37.5%), but only 12.5% of the nurses felt rewarded caring for their ED patients and only 6.3 % of the residents [79]. This level of frustration has the potential to be transmitted to the patients and their families, which can affect their decision about whether to pursue or continue with medical care.

All frontline practitioners, including dentists, should increase their competence related to eating disorders. Dental fear is higher among women with ED as opposed to the general population, which can impact dental visits, even though purging can lead to dental erosion [80]. Ref. [81] offers an extremely useful sample dialogue to help approach patients about a possible eating disorder when dental signs are discovered. These guidelines can help other practitioners. They emphasize making certain there is enough time to discuss the issue, enough privacy, to start slowly with the observations that have been made and listen to the patient's thoughts as to what might be causing the damage, if they do not offer information suggest possible causes of the damage, explore the patients' relationship with food, body image and eating, and then offer referrals for help with the eating issue as indicated. The suggested dialogue in this article offers a comprehensive view of eating disorders and a compassionate approach that could be employed by all health professionals.

8. Recommendations

Considering this information are there guidelines that can improve overall communication with individuals who struggle with eating disorders?

- A. We need to understand that eating disorders are not only isolating for the individual, but also often for the family as well as they try to cope with the rules and expectations that

the eating disorder demands. Working with the patient and family to help them engage in food-related events will be important. However, it may be necessary for the clinician to help broker some of these experiences. Dining out can be hard for individuals with an eating disorder, but the meal can be planned ahead of time and a positive family interaction can occur. Yet taking the individual to a buffet may be so overwhelming that it can lead to a retreat from that experience back into the safety of the eating disorder. Families often do not understand how stressful everyday food events can be for someone struggling with an eating disorder. The extent of this challenge may need to be communicated by the healthcare professional.

- B. Family messages can unintentionally be provided that keep the symptoms in place [82]. One set of parents who were considering divorce told the staff and daughter that they were going to stay together until she was well. What incentive did she have to get better? Once she was well, her family would dissolve. Another patient described that her family was very involved and caring when she was sick, but then as she got well, they disappeared from her life because they were no longer worried about her health. The only way to keep them close and involved was by staying ill. Practitioners may need to decipher these messages.
- C. Families need help understanding the way that some of their behaviours reinforce the eating disorder so they can find alternatives. For example, do they incorporate all the eating disorder rules into the family just to keep peace? If either parent's behaviour is accommodating or enabling the eating disorder that will adversely affect recovery [83]. Are there ever negative consequences for the eating disorder behaviours or does mom just clean up vomit from the bathroom and not confront the issue? Families will need help with small steps that can help shift the dynamics within the family. They will need to working together, making small changes, such as working on more positive communication, openly and calmly discussing issues rather than avoiding the topic of symptom use, and working together against the eating disorder. In one couple in which the girlfriend was over-exercising, we had to help support the boyfriend to not feel obligated to go on long hikes with her. He was trying to keep her happy but was fuelling the eating disorder thoughts. Another individual's boyfriend would often buy her binge food so that she would not steal it, would not get angry, and sometimes as a reward for doing well in her recovery. This is a very mixed message.
- D. Families need information to help them understand eating disorders. Understanding the biological risk factors can help decrease some of the shame, blame and guilt. Understanding how their loved ones who struggle with an eating disorder process messages and struggle with perfectionism may help in interactions. Carers often describe that they want more information, practical advice and guidance [84]. Psychoeducation can help lower distress and create a more understanding perspective [85].
- E. We need to help parents as caregivers and focus on decreasing overprotection so their children can feel a sense of control in their lives [30]. With this comes the need to assist families to improve open communication and skilled conflict resolution. One aspect of this is for family members to listen to each other and not to interrupt so that everyone has an

opportunity to express their needs and opinions in a supportive atmosphere. Sometimes a “talking stick” or other object can be helpful. The person holding the stick gets to speak and cannot be interrupted.

- F. We need to help those struggling with eating disorders to become more assertive. A basic formula for expressing one’s self is “When you..., I feel..., because...” ([86], p. 145). If someone dismisses the individual’s feelings, they can say “‘That may be so...’ (You are neither agreeing nor disagreeing with them.)...’...But I want you to know how your behaviour affects me” ([86], p. 147). This pattern of expressing one’s self may need to be repeated before others will start to listen. The individual struggling with an eating disorder needs to be able to express their opinions without the use of their symptoms.
- G. Teaching families some of the tools that we as physicians should be using, such as summarizing what you think the other person has said. It is through these conversations, “So if I understand you, you feel...” that misinterpretations and assumptions can be clarified and corrected.
- H. Work to help families feel empowered because many family members may struggle with their own sense of low self-esteem [30]. Low self-esteem can cause individuals to use unfavourable comparison strategies, that is, that their daughter is sicker than others [87]. This can increase maternal stress and affect the family’s overall level of functioning. The child is seen in the sick role rather than as one able to recover. A recent clinic example included a mother who the daughter perceived as distant and neglectful. The mother spoke highly of a girl she knew who recovered from her eating disorder and was doing so well. Yet the daughter felt that the mother never acknowledged her own struggles. This comparison led to the daughter feeling like she needed to get sicker in order to get her mother’s attention. We need to help strengthen connections within families and work to help each member understand the hidden messages that words and actions convey.
- I. Help families understand that they need to engage in self-care behaviours so that they do not experience caregiver burnout. One way to discuss this is that family members need to be role models for healthy coping so that their children can learn from them [88]. Physicians need to help communicate these messages so that families take care of themselves. They need permission, and they need to understand that unless they care for themselves, they will not be able to help their child recover [88].
- J. Understand that the eating disorder can become such an engrained part of Individuals’ identities that they become fearful of whom they will be without the illness. As described in [89], p. 863, “The recovery process brought losses because in rejecting the illness, they were also rejecting a major part of their identity”. This concept is important so that friends, family and healthcare professionals can help individuals reconnect with interests prior to the eating disorder, help them discover new interests or work to understand what led to the illness—what function it serves—so that they can replace that function in a healthier way.
- K. Strong feelings of guilt and shame related to the eating disorder may make it difficult for individuals to ask for help and support with their recovery [89]. Families and caregivers need

to understand that a lack of communication does not mean that their loved one does not need their help. They may be fearful of being seen as a burden. In addition, there are times that individuals struggling with an eating disorder will feel when not being asked questions about the illness is an indication that the caregiver is no longer worried about them [90].

- L. At times, patients have difficulty expressing themselves. They do not really know how they feel or they fear expressing their opinions. Sometimes they communicate through their eating disorder. One patient told me that when the family was struggling with an issue, she let her body speak for her. When she increased her restricting, she was trying to let her family know her feelings. As described by a parent "...The unspoken words are more important than the spoken word" ([91], p. 423). The individual struggling with an eating disorder may put a good face on how things are going and say that everything is all right. If there is evidence to the opposite, do not ignore it!
- M. Physicians and other healthcare providers need to be more sensitive to issues of eating disorders and the potential effects of their comments. If a healthcare provider suspects an eating disorder, they need to ask about body concerns and eating habits in a compassionate style. Their assumptions and comments can have lasting effects.
- N. Improved education should also include school nurses, teachers and coaches. Often early signs of eating disorders can present in these different environments. Adults need to be able to recognize the warning signs and be able to initiate discussions in a compassionate and well-educated manner.
- O. While there may be family communication issues, which may suggest the need for family therapy, family members should not be made to feel guilty about the eating disorder. The goal should be for the family to align with and help the individual tackle the eating disorder.
- P. As parents or providers, if one is interacting with a child or young adult who may need to lose weight, the focus needs to be on health and not on dieting. Weight-related teasing only hurts the individual's self-esteem. Dieting only starts the individual on a futile cycle. When parents engage in weight-related conversations, they increase the risk that their children will diet, use unhealthy weight-control practices or binge-eat [44]. Capitalize focus instead on pursuing a range of fun activities!
- Q. We need to teach children to practice media literacy (and practice it ourselves). This can help blunt the impact of the messages that bombard us on a daily basis. We need to remember how images are created and photoshopped so that when we compete with the model in a magazine, we recognize that we are trying to match a fantasy.
- R. Families should also consider environmental cues, how many fashion magazines do they have in the house? What shows are they watching? What messages are being promoted? Consider the messages that are being provided—"unlike the media, parents are able to deliberately adapt their communication with their children" ([35], p. 148).
- S. We need to work with parents both of our patients and parents in general to examine the messages that they are providing to their children. A home environment needs to nurture positive feelings about one's body and one's self.

9. Conclusion

We live in a world that is focused on a thin ideal. The messages that we receive from the media can influence people's overall self-esteem and be especially triggering for individuals who are at risk for eating disorders. It is important that we practice media literacy and that we treat ourselves and others with compassion. Weight-related comments and teasing can escalate the risk of disordered eating. Families and professionals should instead focus on health and providing support. Excessive expectations can lead to perfectionism and disordered eating as a way to comply with unreachable goals. Within interpersonal interactions, all individuals, especially those struggling with eating disorders, need to be encouraged to express their opinions. If they are not allowed or encouraged to use their words, they will use their bodies and symptoms to let people know something is wrong. We need to be aware of what we say and what those who struggle with eating disorders hear. Let's work to ensure that there are positive messages filled with compassion and care.

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