

When Your Child Has an Eating Disorder

A Step-By-Step Workbook for Parents and Other Caregivers

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Chapter 2: Recognizing Signs of Disease

Does your child have an eating disorder or could he be in the process of developing one? Answering this question can be tricky, as indicators of the disease are generally disguised. Just as photographers see negative spaces and musicians hear rests, you must become sensitive to aspects of disease that may not be immediately apparent to most people. As a parent, you are in an ideal position to entertain a heightened awareness about what might be signs of a disorder in the making and to develop hunches about your observations. You may have heard of the several different kinds of eating attitude assessments, or diagnostic surveys, that could be administered to your child to determine the likelihood of disease. However, the results of such tests are difficult for parents to interpret accurately. The most accurate assessment will come from your own sensitive and knowledgeable observations of your child.

Exercise A: Observing Your Child's Attitudes and Behaviors

Here are some characteristics that in combination with others may be indicators of disease. To begin assessing your child for these various kinds of attitudes and behaviors, consider each characteristic. Does it pertain to your child? Circle Y for yes, N for no.

1. Y/N Has undergone excessive or rapid loss of body weight.
2. Y/N Has a poor self-image.
3. Y/N Feels fat even when thin; describes fat as a feeling.
4. Y/N Displays quirky eating habits; eats a limited variety of foods or becomes a vegetarian for purposes of food restriction.
5. Y/N Denies hunger.
6. Y/N Has lost her menses.
7. Y/N Exercises excessively.
8. Y/N Frequently weighs himself.
9. Y/N Has left indicators of laxative, diuretic, or diet pill abuse for you to find.
10. Y/N Dreams about food and eating.
11. Y/N Is reluctant to eat in front of others.
12. Y/N Uses the bathroom frequently during or following meals.
13. Y/N Compares his body to the bodies of others, such as models and athletes.
14. Y/N Is moodier and more irritable of late.
15. Y/N Lacks good coping skills; eats in response to emotional stressors.
16. Y/N Seeks to avoid risks; looks for safety and predictability as an alternative.
17. Y/N Fears not measuring up.
18. Y/N Distrusts himself and others.
19. Y/N Abhors the feeling of being full, which creates indescribable discomfort, bloating and nausea, along with fear that the discomfort will never go away.
20. Y/N Hates big family dinners at holiday times; becomes terribly anxious and upset prior to and during the meal.
21. Y/N Thinks that because he joins you occasionally at restaurants, he must not be disordered.
22. Y/N Avoids substantive connections with others.
23. Y/N Believes his life would be better if he were thinner.

24. Y/N Is obsessed with his clothing size.

If a cluster of these symptoms applies to your child, there is a good chance that he may be struggling with an eating disorder or may soon be developing one.

LOOKING FOR EXCESSES

It is important to understand that excess and extremism are at the root of eating disorders and also that excesses, whether they concern food, exercise, or any other passion, rarely occur in isolation. My goal here is not to make a crisis out of, or catastrophize, what could be minor problems nor to frighten you into finding eating disorders where they do not exist. It is to help you assess when a diet becomes a disorder and when otherwise healthful exercise becomes a compulsion.

Consider the behavior of this young woman and her mother. Trudy, a college student who sees herself as an athlete, trains hard daily to keep in shape for track, then runs an additional eight miles. Her mother is sure that she can't be disordered because, she says, "Trudy eats." Trudy has not had a menstrual period in years because she lacks the body fat to support production of the hormone estrogen. Running alongside her daughter daily, this parent sees no reason to think that her child is disordered in any way. Yet, if something acts like an eating disorder, feels like an eating disorder, and takes its toll on the quality of a child's existence as does an eating disorder, does it really matter what label defines it at the moment? Considering the excesses in her daily exercise, would you anticipate that Trudy is maintaining a functional balance in other areas of her life, including social activities, academics, and recreation? There might well be a benefit in addressing the emotional issues that underlie Trudy's situation even if she does not have a full-blown eating disorder. More to the point, if this were your child, this would be just the kind of situation that should make you look more specifically at exactly what and how your child is eating and how he feels about food, weight, and himself.

In considering Trudy's excesses, her mother flippantly quipped, "But we all have our excesses! You've just got to pick the right ones." True. But some take a greater toll than others. The issue here is not which excess you may see in your child but how excessive these behaviors are, and how that excess serves the child's personality. A behavior is extreme if it puts a person's life off balance emotionally or if it leaves a person functionally vulnerable and at risk, less capable of landing on his feet in times of crisis and, more poignantly, in the process of daily living.

People make positive changes on their own, and it's possible that your child might eventually moderate his extreme behaviors without your help. But you may be taking a gamble by ignoring the situation. These are vulnerable and formative years for your child, setting the stage for all the years to come. The kinds of questions to consider are these: Will the innocent excesses of your well-intentioned child remain as benign as he grows older and more set in his ways? How likely is it that timing, life circumstances, and emotional resiliency will come together favorably so that he can independently develop the strength and capacity to bring his imbalances into balance with the rest of his life functions?

SEEING BEYOND FOOD; SEEING BEYOND SMOKE SCREENS

Once again, eating disorders are not just about food. Don't be fooled by the smoke screens and barriers your child may be putting up to distract you from his behavior and from issues of food, eating, and weight.

Exercise B: Seeing Beyond Obstacles to Disease Recognition

You may not recognize an eating disorder simply because you have had no previous experience with this disease. Beyond that, there are many other deterrents to disease recognition. To begin looking beyond these obstacles, read each of the following descriptions and think about whether it pertains to your child. Write your observations and hunches in the space provided.

1. Evidence of disease is typically not overt. Eating disorders are highly secretive diseases and often go unnoticed by parents, physicians, therapists, and even the patient himself. Even blood tests fail to reveal eating disorders until the latter-most stages of disease, if at all. Eating disorders go unrecognized in clinical settings in up to 50 percent of cases.

This sounds like my child's situation because:

2. Symptoms vary dramatically. No eating disorder looks exactly like another; in fact, no disorder will exactly resemble any definition you will read in a book. There can be extreme variability in symptoms from individual to individual, as well as within the course of a single disease. Anorexics, for example, may restrict food maximally (becoming bony and skeletal), moderately (falling 5 percent to 15 percent below their personal healthy body weight), or minimally (perhaps skipping breakfast and having a salad for lunch, a pattern of calorie rearrangement that may ultimately promote bingeing). Anorexics eat normally, sparingly, ritualistically, or excessively on any given day. Bulimics typically alternate between being highly restrictive and bingeing on food, taking in, at times, from five thousand to ten thousand calories per day. Bulimic individuals may vomit thirty times per day or several times per week. Some individuals may take thirty to three hundred laxatives per day; others may take one or two or none at all and yet still have an eating disorder. An eating disordered child will probably gravitate toward friends who are very thin, some of whom will be disordered and others of whom will not be adding to the overall confusion.

This sounds like my child's situation because:

3. Behaviors alone are not reliable and accurate indicators of disease. Disordered behaviors seen in isolation from other symptoms may actually look healthy to the observer, resembling self-discipline and the capacity to be goal directed. Patients often look good and feel great, invigorated, energized. They tend to be overachievers and perfectionists. Their disease shows up definitively in discreet attitudes and thought patterns.

This sounds like my child's situation because:

4. Disease denial is common. Disease denial may take the form of resistance to acknowledging disease, nondisclosure of an acknowledged disease, or refusal to consider or heed the health risks of serious disease. It is surprising how many parents are reluctant to acknowledge disease in their children, making excuses for them and their behaviors or considering symptoms to be passing phases, signs of strength, or normal teenage obsessions. Some take comfort in calling the symptoms food disorders, a more benign term than eating disorders.

This sounds like my child's situation because:

5. Professionals sometimes err. Even the most competent physician can be misled by eating disorder myths. In response to a mother's concern that her inpatient anorexic youngster was refusing to eat protein, sugar, or fats, a doctor heading up a psychology unit in a hospital told her: "We could all take a lesson or two from your daughter. Did you know that Americans eat six times the amount of protein they actually need?"

This sounds like my child's situation because:

5. Weight alone is not an indicator of disease. Eating disorders are not just about food. To judge the significance of weight gain, loss, or stability, parents have to consider how quickly, through what intentions, and by what means it occurs. Eating disordered individuals can be malnourished even at normal weight.

This sounds like my child's situation because:

6. Feelings are masked. An eating disorder transforms anxiety, fear, anger, and sadness to anesthetized numbness, stuffing them into inaccessible recesses of the soul. When feelings are not recognized and expressed, the child's needs go untended and the parent's capacity to recognize the child's pain is greatly compromised.

This sounds like my child's situation because:

7. Family dinners are too often the exception, not the rule. If a child is not sitting down with the family to dine, it is hardly possible for parents to note odd eating behaviors. More important, if parents are not providing an occasion for the child to talk about his day, his thoughts, and his feelings, they will find it difficult to know him fully and to understand what he is going through.

This sounds like my child's situation because:

Subclinical Indicators of Disease in the Making

Subclinical indicators of disease are also known as soft signs. Falling short of clinical symptoms, soft signs are found in the feelings, attitudes, life perspectives, and behaviors that underlie disease or predisease states. They tend to be present when symptoms are still evolving, intermittent, or are noticed only as isolated events. Subclinical indicators of disease are to be distinguished from subclinical diseases (EDNOS), which, lacking some essential feature, severity, or duration of bona fide symptoms, fall short of the accepted clinical definitions of eating disorders, as described in Chapter One. Subclinical indicators are hard-to-see forerunners of clinical or subclinical disease, attitudes and behaviors found in individuals who share the eating disordered mind.

Eating disorders are progressive, gradually evolving diseases that develop along a continuum, giving parents a great deal of warning once they learn to read the signs. For example, a child might make a sudden commitment to an extreme form of vegetarianism in which he resists eating beans and other vegetarian proteins; has a proclivity to eating only foods frequently favored by anorexics, such as salads without dressing, frozen yogurt, cottage cheese, cereal, diet drinks, apples, and plain bagels; or has a growing propensity to miss meals because of being otherwise occupied.

A young man might refuse to go to lunch or for drinks after work with his peers at the office. Missing prime opportunities for office socialization and communication, he finds

himself alienated at work and ultimately out of a job.

A young woman might marry a man who is as unable to recognize feelings and confront problems as she is. They handle the natural transitions and challenges of their life together by choosing not to deal with them; stressors such as the wedding, job changes, financial concerns, and family relationships are simply not discussed, increasing her depression, affecting her eating patterns, and ultimately jeopardizing their relationship.

A college student who drinks too much and eats too little or too much might decide not even to try to balance his checkbook. Because he does not respect his abilities to regulate himself or his finances, he prefers to be ignorant of any problem he might be called upon to handle if he knew of it. He sees it as safer and more reliable to simply leave an excessive surplus of funds in the account, more than he would actually need or could ever spend.

Subclinical conditions and the soft signs that frequently characterize them harbor highly significant information about the individual's underlying emotional environment, vulnerability to disease, and physiological stressors. It is in the subclinical and early stage disorder that we find the key to early intervention, to effective and timely recovery, and most important, to disease prevention. In developing an eye for soft signs of disease, you learn to look for and to see what is not plainly visible. When you perceive possible problems, even in the absence of clinically definable behaviors, it may be wise to consult a professional who can help confirm or deny your hunch. Your child's emotional issues deserve attention, whatever their nature. A problem defined is potentially a problem addressed.

Activity Disorders

The term activity disorder, coined by Alayne Yates in her book *Compulsive Exercise and Eating Disorders*, describes an overinvolvement with exercise to the point of adverse consequences. Studies have reported that as many as 75 percent of eating disordered individuals use excessive exercise as a method of purging or of reducing anxiety.⁴ They appear unable to stop exercising even when their extreme regimen results in injury, exhaustion, or other physical damage or otherwise interferes with their health and well-being. Individuals with activity disorders lose control of exercise just as eating disordered people lose control of food and dieting. The term *anorexia athletica* describes an EDNOS "for athletes who engage in at least one unhealthy method of weight control, such as fasting, vomiting," or using diet pills, laxatives, or diuretics.

Eating disorders overall are more prevalent among athletically inclined subgroups in our society, such as dancers, skaters, gymnasts, equestrians, wrestlers, and track and field contenders. The demands of these activities parallel the demands of the disease. The rigors of achievement and performance require discipline, self-control, impassioned excellence, and the need to make weight and look good. The practice, practice, practice lifestyle involves such a commitment of time as to exclude ordinary amenities of life like mealtimes.

A Case Study

Todd, at seventeen years old, was an all A student and a gifted pianist as well as an accomplished skater. Having grown up in a loving family, he had good values and a strong sense of responsibility and discipline, which allowed him to hold an after-school job despite spending over twenty hours a week at the rink. Soon after he moved away to college, he was overcome by extreme anxiety. Suddenly paralyzed by fears, he found it difficult to concentrate and to sleep. He envisioned his parents divorcing and his own terminal illness. During the first week of school, he became nauseated whenever he ate

and so began refusing food. At the same time, he became too anxious to skate in competitions.

Todd's lifestyle had been quirky and extreme during his high school years. He stayed up till all hours of the night, and as a result his father had difficulty waking him for school. Because Todd generally missed the bus, his father drove him to school, frequently making himself late to work. Todd never ate breakfast, claiming that he wasn't hungry in the morning. After school he snacked continually before, during, and after work and skating until dinnertime, when he was no longer hungry for a meal. When the family went out together for dinner, he generally begged off, feeling fatigued after skating practice, having a stomachache, or not being "in the mood to eat." Though his mother tried to set limits on his out-of-control snacking, she felt that "what he puts into his mouth is really none of my business." Because he was "old enough to make his own decisions," his parents avoided discussing what was available for him to eat when the rest of the family went out to dinner leaving him behind. Feeling his emotional fragility, his parents kept news of other skaters' wins from him.

To the casual observer, and even to some psychotherapists, Todd would not appear to have an eating disorder, not even as a secondary diagnosis. His weight was normal and stable. His presenting problem was anxiety. His difficulty eating might have been due to nerves or depression. But with a history of addiction and depression in his extended family; of an excessive, imbalanced lifestyle as an athlete; of anxiety; and of personal issues about control, there is a likelihood that his eating quirks are signs of an eating disorder in the making. I would encourage parents to become sensitive to this possibility, particularly in light of the statistic that only 25 percent of individuals with eating disorders ever gain access to treatment, and the remaining 75 percent are never clinically evaluated.

Exercise C: Detecting Soft Signs of Predisease

To diagnose some hard-to-detect predisease signs, complete the following diagnostic questionnaire, circling the word that best describes the frequency of the behavior in your child: never, rarely, sometimes, often, always.

1. My child's eating lifestyle is unbalanced, extreme, or erratic and so are some of his other behaviors, such as his patterns of studying, talking on the telephone, watching television, socializing, sleeping, shopping, gum chewing, drinking, cigarette smoking, or musical instrument practicing.
Never Rarely Sometimes Often Always
2. My child gets dizzy and has fainted in school, but claims this is "stress-related."
Never Rarely Sometimes Often Always
3. He seems anxious before eating, guilty afterwards, and is uncomfortable eating in front of others. Hiding food or empty wrappers is not unusual.
Never Rarely Sometimes Often Always
4. My child feels that I am too controlling, though I feel I give him lots of freedom.
Never Rarely Sometimes Often Always
5. He constantly seeks approval and avoids risks and confrontation.
Never Rarely Sometimes Often Always
6. He exercises too intensively, for too long and too often, and feels anxious and out of sorts if something comes in the way of his exercise routine.
Never Rarely Sometimes Often Always
7. He does not adapt well to transitions and changes.
Never Rarely Sometimes Often Always
8. He is a black-and-white thinker, catastrophizing life events; if he has a bad day, he feels as if he's blown the whole week.

- Never Rarely Sometimes Often Always
9. He thinks people create and reinforce problems when they discuss them openly.
Never Rarely Sometimes Often Always
10. He always has good excuses for not eating a meal. Either there is no time, he is not hungry, he has already eaten, he doesn't feel like it, or he'll eat later.
Never Rarely Sometimes Often Always
11. He often pre-eats dinner before going out to dinner so as not to look like he eats a lot.
Never Rarely Sometimes Often Always
12. He refers to fat as a feeling. He feels "fat," "huge," "big," and so forth, in place of feeling distressed, sad, anxious, or angry.
Never Rarely Sometimes Often Always
13. When disappointed or upset, he engages in self-destructive behaviors.
Never Rarely Sometimes Often Always
14. He feels he is "masquerading as a thin person." He believes he is a fat person at heart, despite his physical appearance or what the scale reads.
Never Rarely Sometimes Often Always
15. He sometimes misses school because of "not feeling well." (This might be due to taking laxatives or to wanting to stay in bed so as to be away from, and not tempted by, food.)
Never Rarely Sometimes Often Always
16. He needs to know the contents of foods before he'll eat them. He's been known to interview restaurant bakers and chefs before eating a meal, and he studies food package labels for fat content.
Never Rarely Sometimes Often Always
17. He lives for the future, when "things will be better."
Never Rarely Sometimes Often Always
18. He eats the same foods over and over again, at the same time every day and in the same order.
Never Rarely Sometimes Often Always
19. He has left his diary or journal out in places where it has been easy for me to find it. It seems as though he wants me to notice what he is experiencing, despite his apparent secretiveness.
Never Rarely Sometimes Often Always
20. He avoids reading books or newspapers because he has problems concentrating.
Never Rarely Sometimes Often Always

Did any patterns emerge in your responses to these diagnostic questions? If most of your answers are often or always, you may be looking at signs of disease or imminent disease. It might be instructive to ask your child to respond to this questionnaire after you have completed it. Much can be learned from comparing answers. If there is a discrepancy in perception, what might be causing it? What can you do about it? How might you and your child go about discussing it together? These discrepancies can become a jumping off point for a dialogue between you and your child.

We Are All a Little Eating Disordered

Of the many smoke screens clouding disease recognition, the most insidious is that we all, to some extent, straddle the fine line between normalcy and pathology. During times of great stress, people frequently lose their appetites. Who isn't on some sort of dietary vigil in this era of health and fitness consciousness? How many people have said, even with tongue in cheek, that they "wish they could be just a little anorexic," if only until the unwanted pounds come off?

New projections promise a life expectancy of 120 years for people who "take care" of

themselves by eating less and staying fit. According to the American Dietetic Association, at any point in time 45 percent of women and 25 percent of men are on diets, driving an industry that sells \$33 billion worth of weight control products and devices each year.⁷ One might assume that it is a young girl's distortions that lead her to believe she will become more popular as she grows thinner. But then she explains that "everything did change for me when I lost weight. I started getting phone calls, boyfriends, party invitations.... It never happened before!"

Youngsters observe their camp counselors choosing to forgo lunch in the interest of looking good in their swimsuits. A teen camp counselor reported that her six- and seven-year-old campers routinely inspected the nutritional labels on the items in their lunch sacks before eating. Food restriction is becoming synonymous with glamour and fame; revered and emulated women such as Princess Diana are less reticent about discussing their disorders publically.

As our computer-oriented lifestyles make us increasingly sedentary, it becomes imperative to watch what we eat and engage in regular exercise routines to remain healthy. The behaviors that characterize eating disorders can in certain contexts be seen as healthful accommodations to a changing lifestyle. Typically, the transition from normal behaviors and attitudes to diseased ones is so subtle and gradual as to go unnoticed.

The true distinction between normalcy and pathology lies in the quality of behavior-its extent, its purpose-and in the capacity of the individual to exercise free choice in connection with that behavior. When behaviors that should be autonomous are no longer under your child's voluntary control and when once benign behavior begins to interfere with his life functions and roles, he is displaying the distinctive hallmark of pathology. As you look for such distinctions in your child's behavior, ask yourself if he appears to be using food for purposes other than

- Satiating hunger
- Fueling his body
- Fostering sociability

If so, it is a good bet that something is up.

PREPARING YOURSELF TO DISCOVER YOUR CHILD'S EATING DISORDER

Gleaning a diagnostic hunch can be particularly difficult if your own attitudes and behaviors involving food get in the way. Behaviors that appear normal and even healthful in your eyes could be fueling an eating disorder in your child.

Exercise D: Analyzing Your Own Attitudes Toward Food

To reach a greater degree of self-awareness about your own attitudes toward food, consider the following questions, and write your answers in the space provided.

1. Has your child ever run out the door to school in the morning in a big hurry and without breakfast? If so, do you know his reasons why?
2. Consider your own views about the importance of meals, particularly breakfast. Do you eat breakfast regularly? If not, why not?

3. If your child is racing out the door without breakfast, he may not be remembering to take a lunch either. What is your policy about lunch? (Have you ever considered making it for him? Do you send him to school with money to buy lunches? Have you ever inquired about whether or how that money gets spent?) Is lunchtime simply not your concern? If not, why not?

4. It would be a good idea to plan to ask your child about his breakfasts and lunches. Can you be persistent when you ask your child about the motivations for his actions? How aware do you think he is of his own motivations? Do you see your child as defensive?

5. When confronting your child about potentially touchy issues, can you tell if he is being open and honest with you? (What if he were to turn those questions back to you to discover why you don't eat breakfast; how would you respond?) Do you feel your child values himself enough to make it a priority to do what is best for himself?

6. Are you tuned in sufficiently to notice if he is fearful about becoming fat from eating nutritious foods that fuel the body? Does he become irritable at the very mention of food and meals?

7. Might he be willing to eat if good food were more readily available to him at home or if you were to join him at the table for breakfast before his day begins?

8. If you are typically absent during the morning routine because of your work, sleep, or exercise schedule, what could you do to make it easier for him to eat breakfast and lunch (such as making lunches or setting the breakfast table the night before)?

Your Own Resistance

Most parents feel unprepared to diagnose their child's eating disorder. Moreover resistance to acknowledging disease or participating in recovery can be as strong for some parents as it is for some children. Resistant parents may be responding to their own uneven problem-solving skills and capacities to handle difficult interactions, their varying tolerance for the expression and acceptance of conflict or anger, and their varying ability to accept responsibility to make personal changes. Parents may secretly (or not so secretly) envy their child's thinness and self-discipline, wishing themselves the same capacities. Many believe that issues not acknowledged or discussed may disappear by themselves. Another often-unsuspected form of resistance is a defeatist attitude about their own effectiveness, which prevents parents from intervening proactively.

The greatest reinforcement to parental resistance is today's confusion about what truly constitutes healthy eating. Is fat-free and low-fat eating invariably healthy? Parents often lose sight of the fact that even the healthiest food attitudes become unhealthy when imposed too stringently or carried to extremes. In moderation there are no bad foods.

The question of what constitutes healthy parenting pervades this book. Misconceptions about what adolescents need and the myth that parents must defer to adolescents' requirements are destructive and all too commonplace assumptions that have the power to derail and undermine any parent-child relationship.

Much of what you will need to do to prepare yourself to recognize disease and mentor your child's recovery involves gaining an awareness of your own feelings and attitudes toward food and problem solving and understanding their significance for your child. Here are two exercises designed to give you further insights into yourself and your

attitudes, how these attitudes came to be, and how they may skew your perceptions and responses to your child. These exercises will help you identify the areas in which you might consider making some changes. It is critical that you understand yourself before you try to understand or communicate with your child on this topic.

Exercise E: Assessing Your Attitudes About Food and Weight, Then and Now

How you were as a child affects who you are now. To review and assess your early childhood attitudes and experiences with food and eating, read the following questions and write your answers in the space provided. When you were a child:

1. How did you feel about your body?
2. Were you ever teased or criticized by others because of the way you looked? If so, why?
3. Did you live with rituals concerning food? If so, what were they?
4. Was food ever used as a device to threaten or motivate you? If so, how?
5. What kinds of eating behaviors and meal patterns did you see in your role-models (your parents, older siblings, camp counselors, coaches, and so forth)?
6. How did these childhood events affect your attitudes and values then? Today? (If food was used as a bribe or if you were threatened with a week of no desserts if you didn't eat your peas, there is a good chance that you might have some residual dysfunctional food attitudes.)

Exercise F: Assessing Your Family Background

The attitudes of your family of origin (the family you grew up in) continue to influence your attitudes today and how you interact with your eating disordered child in your nuclear family (the family you created together with your partner and children). To develop your insights and facilitate family discussions about these influences, complete the following two assessments.

Assessing Your Family of Origin

Read the following questions about your family of origin and write your answers in the space provided.

1. What messages did you get from your parents about how people were supposed to look?
2. How did your parents perceive you physically? How do you know?
3. Who made dinners for you as a child? Who ate with you?
4. What were dinner times like? What kinds of things were discussed?
5. Draw a picture of your family dinner table. Who sat where? Was anyone often absent?

6. What were your family's food traditions, rituals, and quirks?
7. How were troublesome issues handled? Were problems resolved? Give examples.
8. Could people express themselves honestly and openly? Explain.

Assessing Your Nuclear Family

Respond to the following statements by circling the word that best describes the frequency of the behavior described: never, rarely, sometimes, often, always.

1. I tend to be an overly controlling parent. This leads to an out-of-control child.
Never Rarely Sometimes Often Always
2. I tend to be an overly permissive parent. This leads to an out-of-control child.
(Your answers to the first two questions may reflect the fact that parents may be overly controlling and overly permissive at once.)
Never Rarely Sometimes Often Always
3. At times I give my child too many choices; at other times I do not give him enough.
Never Rarely Sometimes Often Always
4. I am excessively conscious of body size. I praise or criticize my children for their appearance.
Never Rarely Sometimes Often Always
5. My partner and I do not present a united front; we generally do not agree on how to resolve problems.
Never Rarely Sometimes Often Always
6. The members of our family typically keep secrets from one another.
Never Rarely Sometimes Often Always
7. I feel there is not enough privacy in our family.
Never Rarely Sometimes Often Always
8. There is alcoholism or drug addiction or both in our family.
Never Rarely Sometimes Often Always
9. There is abuse (verbal, physical, or sexual) in our family.
Never Rarely Sometimes Often Always
10. The members of our family are always trying to make each other happy and to avoid conflict and sadness at all costs. In our effort to be the Brady Bunch, the truth goes by the wayside.
Never Rarely Sometimes Often Always

The greater your number of often or always scores, the greater the likelihood of eating disordered attitudes and issues in your family. Further, it would not be unusual for you to see similar patterns in your nuclear family as in your family of origin .

Activity Thoughts to Ponder

Did you know that as individuals grow older, their basal metabolism rate drops 4 to 5 percent with each decade? That as estrogen levels drop, women need fifty fewer calories per day at age fifty than at age forty? That as you grow older, to maintain your weight, you may have to eat considerably fewer calories daily and exercise more? Did you know that after you give birth to a child, your set point weight (the weight your body tries to maintain) may change, along with your shoe and blouse size?

How do you feel about these normal changes as they occur in your own body now? How are you accommodating these changes? Could your personal responses be negatively

influencing your child? Are you aware of any rules you may be following about food and eating? Are you aware of your child's rules? Are they similar to yours? (You may want to record your thoughts in your journal.)

Self-Assessment

Having gotten to this point, don't be discouraged if you are not feeling entirely prepared yet to deal with your child or this disease. An increased consciousness of the issues involved and a heightened self-awareness will be sufficient to get you through. Bringing problems to light should be an incentive for problem resolution, not guilt. Your proactive problem solving will provide incomparable role modeling for your child, in recovery and in all aspects of his life.

Some of the potentially problematic qualities you may have uncovered in yourself, such as a need to be in control or a drive toward rigorous self-discipline, are in many respects strengths, not weaknesses, enhancing the quality of your life and your child's. It is only in their extent and in their impact on your child that they may need modifying. Though the nature of your commitment to care for your child changes as he grows into adulthood, you will never stop being your child's parent -- and he will never stop needing you to be.

Once parents come to better know themselves, their children, and eating disorders, they are ready to take action to confront the eating disordered child. Chapter Three suggests practical ways to begin a dialogue with the child who needs a parent's help.