A GUIDE FOR FAMILY & LOVED ONES

# Understanding Eating Disorders

Recognising the person behind the eating disorder, responding to food and body distress, supporting treatment and recovery, and protecting the wellbeing of loved ones too.

**Eating disorders are serious mental-health conditions**

They are not diets, vanity or attention seeking. They can affect people of any age, gender, body size or background and may involve restriction, binge eating, compensatory behaviours, intense fear, sensory or interoceptive difficulties, rigid rules, body-image distress or combinations of these. A person's appearance alone cannot tell you how medically or psychologically unwell they are.

## The person and the eating disorder

Families often describe feeling as though the person they know has changed. Food may dominate conversations, routines become rigid and previously ordinary meals can trigger fear or conflict. It can help to separate the person from the illness without treating them as powerless: the eating disorder may influence thoughts and behaviour, but the individual still deserves dignity, collaboration and a voice in recovery.

## Different eating disorders can look very different

**Anorexia nervosa** can involve restriction, fear of weight gain and behaviours intended to prevent weight restoration. **Bulimia nervosa** involves recurrent binge eating with compensatory behaviours such as vomiting, fasting or excessive exercise. **Binge eating disorder** involves recurrent binge episodes without regular compensatory behaviours. **OSFED** describes clinically significant eating-disorder presentations that do not fit another category exactly. **ARFID** involves restricted intake for reasons such as sensory sensitivity, fear of consequences or low interest in eating, rather than weight or shape concerns.

Other presentations and overlapping difficulties exist. Avoid trying to diagnose from a checklist; encourage specialist assessment when eating, weight, body image or compensatory behaviours are causing distress or impairment.

## What it may feel like from the inside

Food can become associated with fear, guilt, disgust, loss of control or rules that feel impossible to break. Hunger and fullness cues may become difficult to interpret. The person may feel watched at meals and judged when eating, while simultaneously feeling frightened when nobody notices how much they are struggling.

Shame can make honesty difficult. Hiding food, eating secretly, minimising behaviours or denying severity may be part of protecting the eating disorder, avoiding conflict or managing overwhelming fear. Respond firmly to risk without turning every interaction into an interrogation.

## Why 'just eat' is rarely enough

A meal can represent much more than food: feared weight change, loss of control, sensory overwhelm, nausea, choking fears, moral rules or intense anxiety. The practical act of eating may be simple; the internal experience is not. Recovery therefore needs nutritional rehabilitation alongside psychological and, when indicated, medical care.

## Warning signs families may notice

Changes can include skipping meals, rigid food rules, avoiding eating with others, frequent bathroom visits after meals, secrecy, binge episodes, food disappearing, compulsive exercise, body checking, weighing, sudden dietary exclusions, wearing clothes to hide the body, dizziness, faintness, feeling cold, sleep changes, irritability, social withdrawal or increasing preoccupation with calories, weight and shape.

None of these proves an eating disorder by itself. Patterns, distress, physical changes and functional impact matter.

**Do not wait for somebody to 'look ill enough'**

Eating disorders can be medically serious at many body sizes. Rapid change, severe restriction, purging, dehydration, fainting, cardiac symptoms, significant weakness or other concerning physical signs require medical assessment. Weight alone should never be the family's only measure of severity.

## How to raise concerns

Choose a calm, private moment rather than confronting the person during a meal. Use observations instead of accusations: 'I've noticed meals have become very stressful and you seem exhausted. I'm worried about you.' Avoid debates about whether they 'look thin', compliments about weight loss, or arguing over calories.

Expect ambivalence. Part of the person may desperately want help while another part fears what treatment will require. A defensive response does not mean your concern was wrong.

## Supporting meals

If a treatment team has provided a meal plan or family-based approach, follow that professional guidance. In general, keep meals as predictable and calm as possible. Avoid calorie talk, diet discussion, commenting on portion sizes or scrutinising every mouthful. Neutral conversation can reduce the sense that the meal is an examination.

After meals may be particularly difficult. Depending on the person's presentation and treatment plan, supportive company or a planned activity can help with distress and reduce opportunities for compensatory behaviour. Do not improvise surveillance strategies without clinical guidance.

## What not to say

Avoid: 'You look healthy now', 'I wish I had your willpower', 'Just have one bite for me', 'You don't look anorexic', 'Why can't you eat normally?', 'You ate loads yesterday', or comparisons with other people's bodies. Even well-intended appearance comments can be interpreted through the eating disorder.

Try focusing on the person: 'It's good to hear your laugh again', 'You seem more able to concentrate', 'I know this meal is difficult and I'm staying with you', or 'What would make this conversation less focused on your body?'

## Binge eating

Binge episodes are not a failure of discipline. Shame and restriction can intensify the cycle. Avoid policing cupboards, humiliating the person or prescribing a diet. Encourage evidence-based assessment and regular, adequate eating as advised by clinicians. Compassion and structure are more useful than punishment.

## Purging and compensatory behaviours

Vomiting, laxative misuse, fasting, driven exercise or other compensatory behaviours can carry medical risks. Families should not provide detailed 'tips' about how behaviours are performed. Seek clinical advice, particularly where behaviours are frequent, escalating or accompanied by physical symptoms.

## Exercise

Movement can be healthy, but in an eating disorder it may become rigid, compulsive or compensatory. Warning signs include exercising despite injury or illness, distress if a session is missed, secret exercise or using movement to 'earn' food. Treatment teams may recommend temporary limits or a graded return.

## Body image and body checking

Repeated mirror checking, measuring, weighing, pinching skin or asking 'Do I look bigger?' can maintain distress. Avoid becoming a body-reassurance service. Acknowledge the emotion without judging appearance: 'I can hear how uncomfortable you feel in your body today. I don't think analysing your size together will help.'

## Social media and diet culture

Weight-loss content, transformation images, calorie tracking and 'clean eating' messages can reinforce eating-disorder rules. Families can reduce diet talk at home and consider whether particular accounts or apps are supporting recovery or feeding comparison and compulsion.

**A family principle**

**Do not make every conversation about food, weight or recovery.** The person still needs relationships, humour, interests, privacy and an identity beyond the eating disorder. Recovery is helped by rebuilding a life worth returning to.

## Treatment and recovery

Eating disorders deserve proper assessment. Treatment may involve a GP, specialist eating-disorder service, psychological therapy, dietetic input and medical monitoring. The exact approach depends on diagnosis, age, medical risk, severity, duration and individual needs.

NICE guidance includes disorder-specific psychological treatments. For children and young people with anorexia nervosa, family therapy focused on anorexia is one recommended approach; family involvement can also be important in other presentations. Treatment should not blame families for causing the disorder.

## Medical monitoring

Eating disorders can affect cardiovascular, gastrointestinal, hormonal, bone and metabolic health. Clinicians may monitor observations, blood tests, ECGs and other measures depending on risk. Families should follow professional guidance rather than attempting to interpret medical stability from appearance.

## Medication

Medication is not a standalone cure for most eating disorders, though it may be used for particular conditions or co-occurring depression, anxiety or other difficulties. Prescribing decisions belong with clinicians who understand the person's eating-disorder and physical-health context.

## Recovery is rarely linear

Progress may involve eating more consistently, reducing behaviours, tolerating feared foods, improved concentration, returning to relationships, challenging rules and becoming less dominated by body checking. Anxiety can temporarily rise when eating-disorder behaviours reduce; distress does not automatically mean recovery is going wrong.

## Relapse signs

Early signs may include renewed meal skipping, food rules, weighing, body checking, secrecy, exercise changes, withdrawing from meals, increasing diet content or statements about needing to 'get back in control'. Agree in advance how loved ones should raise concerns and who to contact.

## ARFID needs different understanding

ARFID is not driven by a desire to lose weight or change body shape. Sensory differences, fear of choking or vomiting, previous aversive experiences and low appetite can be central. Pressure, hiding foods or assuming the person is simply fussy can worsen distress. Because ARFID deserves detailed condition-specific guidance, it is covered separately in this family series.

## When urgent help is needed

Seek urgent medical advice for collapse or fainting, chest pain, severe weakness, dehydration, inability to keep fluids down, blood in vomit, significant confusion, severe deterioration or other concerning symptoms. Eating disorders can also carry increased suicide and self-harm risk. Seek urgent mental-health help for suicidal intent, serious self-harm or inability to stay safe; call 999 or attend A&E; for immediate danger.

If you are uncertain about physical risk, use appropriate NHS or clinical advice rather than waiting for the person to appear visibly unwell.

**Recovery is about more than weight**

Physical restoration can be vital, but recovery also means reducing fear and compulsions, restoring flexibility, reconnecting with hunger and fullness where possible, rebuilding relationships and identity, and learning that food and the body do not have to dominate every decision.

## Safeguarding yourself as a family member or supporter

Eating disorders can pull entire families into vigilance. You may watch meals, monitor bathrooms, attend appointments, hide scales, worry about exercise, check food supplies and lie awake wondering whether the person is medically safe. This can become exhausting and frightening.

## You are not the eating-disorder team

Family involvement can be essential, especially for children and young people, but loved ones still need professional guidance. Do not carry medical risk assessment alone. Ask the treatment team exactly what you are responsible for, what warning signs require contact and what belongs with clinicians.

## Conflict at meals

The person may become angry, distressed or pleading when eating-disorder rules are challenged. Try not to personalise every reaction. At the same time, illness does not mean family members must accept threats, violence or abuse. Follow the treatment plan, keep communication calm and prioritise safety.

## Support versus collusion

Support validates distress while still supporting recovery. Collusion changes family life to protect the eating disorder: preparing an ever-narrower range without clinical reason, joining diet rules, cancelling treatment, helping conceal behaviours or agreeing that weight loss is necessary when clinicians are concerned.

## Boundaries

Examples include: 'I won't discuss calories or whether you look bigger.' 'I will support the agreed meal plan, even when the eating disorder is angry with me.' 'I can attend this appointment, but I need the team to help us understand what happens next.' 'I will not buy laxatives or weight-loss products for you.'

## Partners and intimacy

Body shame, malnutrition, hormonal changes and anxiety can affect sexual desire and physical closeness. Partners should avoid pressure. Talk about consent, comfort and forms of closeness that do not centre the body. The partner's loneliness and needs also deserve a safe place to be discussed.

## Siblings and children

Siblings may feel invisible when family life revolves around meals and appointments. Children should not become monitors or be given responsibility for whether another family member eats. Protect ordinary routines, individual attention and age-appropriate explanations.

## Your own relationship with food and body

Supporting somebody can make you hyperaware of your own eating and appearance. Avoid starting restrictive diets or frequent weight talk in the shared environment where possible. If the situation activates your own history with food, body image or an eating disorder, seek support for yourself.

## Carer burnout

Warning signs include constant checking, sleep loss, irritability, social withdrawal, neglecting your health, dread before meals and feeling that one person's eating has become your entire life. Respite, carers' support, counselling and sharing responsibilities are not signs of giving up.

## Seven practical coaching tools

**1. Person-versus-disorder map.** What does the person value? What does the eating disorder demand? Where are they currently aligned, and where is there already a small gap that recovery can strengthen?

**2. Meal-support agreement.** Before a difficult meal, agree who is present, what conversation helps, what comments are unhelpful, what happens afterwards and when professional advice is needed.

**3. Warning-sign tracker.** Note changes in meals, secrecy, exercise, mood, body checking, social withdrawal and physical wellbeing. Use patterns to support clinical conversations, not to interrogate the person.

**4. Reassurance boundary.** Agree a response to repeated body questions: acknowledge distress, avoid judging size or shape, redirect to the recovery plan or a non-body activity.

**5. Recovery evidence.** Track more than weight: flexibility, concentration, warmth, sleep, relationships, spontaneity, reduced rituals, returning interests and the ability to eat with less negotiation.

**6. Supporter wellbeing plan.** Who can share practical support? What time is protected for me? Who can I speak honestly to? What signs tell me I am burning out? What respite is realistic?

**7. Identity rebuilding.** List five things the person was, enjoyed or valued beyond food and body, and five things they may want to discover. Recovery needs somewhere meaningful to go.

## Common myths

**'You can tell by looking.'** You cannot reliably judge severity from body size. **'Eating disorders are about vanity.'** They are complex mental-health conditions. **'Families cause eating disorders.'** Blame is unhelpful; families can be important recovery partners. **'Just eating fixes everything.'** Nutritional recovery is crucial but psychological recovery matters too. **'Binge eating is greed.'** It is a recognised eating-disorder behaviour, not a moral failure.

## Recommended reading

**Skills-based Caring for a Loved One with an Eating Disorder** - Janet Treasure, Anna Crane and colleagues, specifically designed to help carers respond effectively. **Survive FBT** - Maria Ganci, a practical family-oriented resource particularly relevant to family-based treatment. **Hope with Eating Disorders** - Lynn Crilly, written for people affected by eating disorders and their families. Choose books that fit the diagnosis and treatment approach.

## UK resources and clinical sources

Useful UK starting points include NHS information on eating disorders, NICE guideline NG69 on eating disorders: recognition and treatment, Beat eating-disorders charity, GP and specialist eating-disorder services. For urgent medical concerns use NHS 111 or emergency services as appropriate. Samaritans can be contacted on 116 123 for emotional support.

### Clinical note

This guide is educational and does not diagnose an eating disorder, prescribe meal plans or replace specialist assessment. Individual nutritional and medical needs vary significantly. Avoid using generic weight, calorie or exercise targets without appropriate clinical guidance. ARFID, eating disorders in children, pregnancy, diabetes and significant physical illness may require particularly tailored care.

## A message from Maggie

*When somebody you love has an eating disorder, food can stop feeling ordinary. A meal can become something everybody anticipates, watches and worries about. You may find yourself studying what is left on the plate, listening for the bathroom door or wondering whether a comment you made has made things worse.*

*It is incredibly hard to see somebody struggle with something that appears, from the outside, as though it should be simple. But eating is not simple when fear, sensory distress, shame, compulsions or the need for control have become attached to it. Understanding that does not mean giving the eating disorder everything it asks for.*

*Try to keep seeing the person. The eating disorder may be loud, but it is not their whole identity. Talk about the things they love. Remember their humour, interests, relationships and hopes. Recovery needs more than something to move away from; it needs a life worth moving back towards.*

*And please look after yourself. You may be frightened, angry, exhausted or confused. You may sometimes dread mealtimes or wish you could have one day when nobody mentions food. Those feelings do not make you uncaring. They mean this is affecting you too, and you deserve support rather than carrying it quietly.*

*You are not expected to cure an eating disorder through the perfect words or the perfect meal. Your role is to offer steady support, follow appropriate professional guidance, protect safety, hold boundaries and keep believing that the person is more than the illness. Recovery is possible, and neither of you should have to face it alone.*

**Maggie Learoyd**
**Space to Breathe Therapy**

### Final reflection

If the eating disorder has become the loudest voice in the household, what could help the family hear **the person's own voice, values and future** a little more clearly this week?