

# Supporting Someone with Atypical Anorexia Nervosa

A practical, compassionate guide for parents, partners, friends and carers | Space to Breathe Therapy

Atypical anorexia nervosa is a serious eating disorder that can involve the same restrictive behaviours, intense fear of weight gain and psychological distress seen in anorexia nervosa, without the person being below the expected weight range. Someone may have lost substantial weight, be medically unstable and need urgent support even when they do not appear underweight.

The word “atypical” describes a diagnostic distinction, not a milder illness. Weight, appearance and BMI cannot tell you how unwell someone is or how much support they deserve.

## 1 | Understanding what the person may be experiencing

The person may feel compelled to restrict food, follow strict rules, avoid eating socially or compensate for eating through excessive activity or other behaviours. Food can be associated with fear, shame or a loss of control. They may feel exhausted, cold, irritable, dizzy or unable to concentrate, and may still believe they are not “ill enough” for help.

Changes in body size are not a reliable guide to severity. Rapid or significant weight loss, inadequate nourishment and eating-disorder thoughts can have major effects on the heart, blood pressure, hormones, digestion, concentration and emotional wellbeing regardless of starting weight.

## 2 | Signs to notice without policing

- Eating patterns: increasing restriction, skipped meals, rigid food rules, distress around ordinary meals or avoidance of eating with others.
- Thoughts and feelings: fear of gaining weight, harsh self-criticism, guilt after eating, body checking or withdrawal from relationships.
- Physical wellbeing: dizziness, fainting, fatigue, feeling cold, sleep changes, impaired concentration or menstrual changes where relevant.
- Behaviour: compulsive movement, secrecy, repeated reassurance seeking about bodies or foods, or increasing distress when routines change.

None of these signs alone establishes a diagnosis. Their presence is a reason to ask caring questions and encourage assessment, not to interrogate or accuse.

## 3 | Start the conversation with care

Choose a calm, private moment, away from a meal if that feels less pressured. Describe what you have noticed without mentioning weight, clothing size or appearance. Use curious questions and listen more than you speak.

You could say: “I have noticed meals seem stressful lately, and I am worried about how you are feeling. I care about you and would like to understand what is difficult.”

If they say they are fine, avoid arguing over whether they look unwell. You can reply: “You do not have to convince me that you are struggling. I am here, and I would like us to find support together.”

## 4 | What helps — and what can make things harder

- Helpful: validating distress, checking what support they want, protecting their dignity, following treatment guidance and keeping connection beyond food and exercise.
- Less helpful: comments about weight or shape, praising weight loss, comparing bodies, labelling food “good” or “bad”, threatening or bargaining, and insisting they must look thinner to need help.
- At meals: offer a calm setting and predictable support. Some treatment plans involve supported eating or supervision; work with the clinical team so kindness is not confused with avoiding necessary nutrition.

## 5 | Support eating and rest safely

Do not independently prescribe calories, target weights, intensive exercise or a refeeding approach. An eating-disorder service or qualified healthcare professional should assess nutritional needs and any medical monitoring required. For someone who has been eating very little, increasing intake may need supervised care because of refeeding risks.

Encourage breaks from weight-focused conversations and social-media content that fuels comparison. If movement is driven by fear or compensation, help the person discuss exercise safety with their clinician. “Just exercise less” may underestimate how distressed they feel, but continuing strenuous activity when medically unwell may be unsafe.

## 6 | When medical help matters

Arrange a prompt GP assessment or contact the person’s existing eating-disorder team if restriction, rapid weight loss, purging, fainting, marked dizziness, weakness or worsening symptoms are present. Ask for a physical assessment alongside psychological support. Eating-disorder risk assessment should not depend only on BMI.

Urgent: Fainting, chest pain, palpitations, severe weakness, confusion, dehydration or inability to eat or drink safely requires urgent medical advice. In the UK use NHS 111 for urgent advice; call 999 for immediate danger, collapse, severe chest pain or serious breathing difficulty.

## 7 | Helping someone seek professional support

Offer to help book an appointment, sit beside them while they call, accompany them if wanted or prepare a short written account of symptoms. They may need help communicating openly, especially if shame, anxiety or neurodivergent communication differences make appointments difficult.

A GP can assess physical health and refer to specialist services. Evidence-based treatment may involve eating-disorder-focused psychological therapy, nutritional rehabilitation, regular medical monitoring and support for family or carers. The appropriate approach depends on age, risk and clinical assessment.

## 8 | Boundaries without abandonment

Caring for someone does not mean you must become their therapist, monitor every bite or be available at all hours. Agree what you can realistically provide: for example, help with appointments or meals according to a shared plan, but not participate in repeated body-checking or weight reassurance rituals. Set boundaries calmly rather than as punishment.

You could say: “I want to help you feel safe, but I cannot keep checking whether your body looks different. I can listen to what is frightening you and help you contact your support team.”

## 9 | Neurodivergence and individual needs

Autistic and ADHD individuals may also experience sensory difficulties, interoceptive differences, demand sensitivity, executive-function challenges or distress from unpredictable routines. These can coexist with anorexia-related fears; neither should be dismissed. Ask which accommodations make meals, appointments and communication more accessible while still supporting essential nutrition and treatment.

## 10 | Support for the supporter

Families, friends and partners may experience fear, frustration, guilt and exhaustion. These feelings deserve support. Share responsibilities, protect your own eating and sleep, seek carer support and ask the treatment team what role you should play. You can be compassionate without taking sole responsibility for recovery.

### A simple shared support plan

- What I notice: changes in food, activity, mood or physical symptoms, written without judgement.
- How I will approach them: one calm opening sentence and space to listen.
- What they would welcome: practical help, accessible communication and agreed mealtime support.
- Who we can contact: GP, eating-disorder team, a trusted person and urgent services if necessary.
- My boundaries: what I can offer, where I need help and how I will care for myself.

### Further help and a final reminder

In the UK, the eating-disorder charity Beat offers information and support for people affected by eating disorders and their loved ones. Your GP and local NHS eating-disorder service can advise on assessment and treatment. For additional supportive resources, visit [spacetobreathetherapy.co.uk](https://spacetobreathetherapy.co.uk).

A person does not need to be visibly underweight to be seriously unwell. Believing them, taking symptoms seriously and helping them access appropriate professional care can make an important difference.

Educational information only. This article is not a diagnostic tool or a substitute for individual medical advice.