



# Eating Disorders in the Workplace

A guide for employers

Produced in association with Beat



**Incorporating:**

Employers  
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## 1. Introduction

This guide will give you a thorough understanding of eating disorders from an employment perspective. At the end of the document there is additional information to support you, including case studies and personal stories provided by members of the public wishing to share their experiences to help others.

Eating disorders are a range of conditions that can affect someone physically, psychologically and socially. They are serious mental illnesses and include anorexia nervosa, bulimia nervosa and binge eating disorder. Over 725,000 men and women in the UK are affected by eating disorders (2% of the working population). This figure means that you are likely to have employees who are affected by eating disorders and/or care for or have someone in their family that has an eating disorder.

Anorexia nervosa claims more lives than any other mental illness and the mortality rates from bulimia nervosa and atypical eating disorders are also high. Although serious, eating disorders are treatable conditions and full recovery is possible. The sooner someone gets the treatment they need, the more likely they are to make a full recovery.

Anyone can develop an eating disorder, regardless of their age, sex or cultural background. You cannot tell by looking at someone whether they have an eating disorder. However, young women are most likely to develop an eating disorder, particularly those aged 12 to 20. Children as young as seven can develop anorexia and there is a greater proportion of boys in this younger age group.

Eating disorders are complex and there is no one single reason why someone develops one. A whole range of different factors combine such as genetic, psychological, environmental, social, interpersonal, life events and biological influences. A number of risk factors need to combine to increase the likelihood that any one person develops the condition.

We still do not know enough about the causes of eating disorders or effective treatments. There is world class research going on - much of it in the UK and involving collaborations with centres of excellence across the globe. The latest research is showing us that the causes are much more biologically based than was previously thought.

Eating disorders are complex and not everyone will experience the same symptoms. There are a variety of treatments available. People will respond differently to treatment and can take different amounts of time to recover. Some people can be affected by more than one type of eating disorder or find their symptoms changing type as they recover.

## 2. Types of eating disorder

### 2.1 Diagnosis of an eating disorder

Doctors and healthcare professionals use internationally agreed criteria to make a diagnosis of an eating disorder. Diagnosis is usually essential to be able to access treatment. Diagnosis is made by 'taking a history' which means talking to the person, rather than just by physical tests or medical checks. They might use 'The SCOFF Questionnaire' which contains the five simple screening questions below. A score of two or more positive answers should raise suspicion of an eating disorder:-

1. Do you ever make yourself sick because you feel uncomfortably full?
2. Do you worry you have lost control over how much you eat?
3. Have you recently lost more than one stone in a three month period?
4. Do you believe yourself to be fat when others say you are too thin?
5. Would you say that food dominates your life?<sup>1</sup>

The two main classification systems are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD). Both cover eating disorders and are very similar in the criteria they use. The latest version published in 2013 is DSM-5.

The eating disorders listed in the DSM-5 are anorexia nervosa, bulimia nervosa and binge eating disorder (BED) and other specified feeding and eating disorders (OSFED).

The next version of the ICD is due to be published in 2017 and will almost certainly include binge eating disorder as a separate eating disorder as the DSM-5 has done.

Appendix 6 gives detailed information on the signs and symptoms of each type of eating disorder.

## **2.2 Anorexia Nervosa**

Anorexia nervosa is a serious mental illness where people keep their body weight low. They may do this by seriously restricting the amount of food and calories they consume, vomiting, using laxatives or excessively exercising. The way people with anorexia nervosa see themselves is often at odds with how they are seen by others and they will usually challenge the idea that they should gain weight. For example, they often have a distorted image of themselves, thinking that they are fat even when they are severely underweight. People affected by anorexia nervosa often go to great attempts to hide their behaviour from family, friends and colleagues.

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<sup>1</sup> 'The SCOFF Questionnaire'. King's College London. [Online] Available at: <http://www.kcl.ac.uk/ioppn/depts/pm/research/eatingdisorders/resources/THESCOFFQUESTIONNAIRE.pdf> . Last accessed 5<sup>th</sup> February 2016.

Often people with anorexia nervosa have low confidence and poor self-esteem. They can see their weight loss as a positive achievement that can help increase their confidence. Losing weight and maintaining a low weight can be associated with a sense of 'feeling in control', either over body weight and shape or in general.

As with other eating disorders, anorexia nervosa can be associated with depression, low self-esteem, alcohol misuse, self-harm and a number of other mental health conditions.

Anorexia nervosa can cause severe physical problems mainly because of the effects of starvation on the body. This can lead to loss of muscle strength and reduced bone strength; in older girls and women their periods often stop. Men can suffer from a lack of interest in sex or impotency.

The illness can affect people's relationship with family and friends, causing them to withdraw; it can also have an impact on how they perform in education or at work. The seriousness of the physical and emotional consequences of the condition is often not acknowledged or recognised and people with anorexia often do not seek help. Anorexia in children and young people is similar to that in adults in terms of its psychological characteristics. But children and young people might, in addition to being of low weight, also be smaller than other people their age, and slower to develop.

### **2.3 Bulimia Nervosa**

Bulimia nervosa is a serious mental illness where people often feel that they have lost control over their eating and evaluate themselves according to their body shape and weight. People with bulimia nervosa are caught in a cycle of eating large quantities of food (called bingeing), and then vomiting, taking laxatives or diuretics (called purging) or severely restricting intake at other times, in order to prevent weight gain. This behaviour can dominate daily life and lead to difficulties in relationships and social situations. Usually people hide this behaviour pattern from others and their weight is often in a healthy range. People with bulimia tend not to seek help or support very readily and can experience swings in their mood as well as feeling anxious and tense.

People with bulimia may also have very low self-esteem and self-harm. They may experience symptoms such as tiredness, feeling bloated, constipation, abdominal pain, irregular periods, or occasional swelling of the hands and feet. Excessive vomiting can cause problems with the teeth, while laxative misuse can seriously affect the heart. Bulimia nervosa in children and young people is rare, although young people may have some of the symptoms of the condition. Bulimia usually develops at a slightly older age than anorexia nervosa. In some, although not all instances, bulimia nervosa develops from anorexia nervosa.

### **2.4 Binge Eating Disorder**

Binge eating disorder (BED) is a serious mental illness where people experience a loss of control and overeat on a regular basis. People diagnosed with BED regularly consume very

large quantities of food over a short period of time (called bingeing) and they often eat even when they are not hungry. Binge eating disorder is not about eating extra-large portions.

Binges are can be planned like a ritual and can involve the person buying "special" binge foods. Binge eating usually takes place in private. People will often have feelings of guilt or disgust at their lack of control after binge eating. Unlike those with bulimia nervosa, people who binge eat do not purge or fast in an attempt to control their weight.

Binge eating episodes are associated with eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not physically hungry, eating alone through embarrassment at the amount being eaten and feeling disgust or extreme guilt after overeating. If someone binges at least once a week over a period of three months or more, they could have binge eating disorder.

People with binge eating disorder may also have low self-esteem and lack of confidence, depression and anxiety. Many people with binge eating disorder are overweight or obese which can lead to complications such as high blood pressure, high cholesterol, type 2 diabetes and heart disease.

Unlike anorexia nervosa and bulimia nervosa, BED tends to affect a more equal number of men and women and the condition is usually more common in adults than in younger people.

Obesity is not an eating disorder but some people can become overweight because of emotional difficulties and being overweight can lead to emotional difficulties. Low self-esteem, feeling guilty or ashamed and socially isolated can all be part of the picture. The relationship between weight, size and health is a complex one.

## **2.5 Eating Disorder Not Otherwise Specified**

Some people with an eating disorder may have received a diagnosis of Eating Disorder Not Otherwise Specified (EDNOS). This was used in the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system until 2013. Around 50% of all people diagnosed with an eating disorder were diagnosed with EDNOS and studies suggested that a significant percentage of people with this diagnosis actually had binge eating disorder. The aim of the changes to the classification system in 2013 were to ensure more people with eating disorders have a diagnosis that accurately describes their symptoms and behaviours.

A diagnosis of EDNOS would typically have been given to someone whose symptoms didn't meet all of the criteria for anorexia nervosa or bulimia nervosa or where their symptoms were a mix of those for anorexia and bulimia. EDNOS is not a less serious form of an eating disorder. The latest diagnostic criteria no longer uses this term and people would be diagnosed with anorexia, bulimia or binge eating disorder.

People with a diagnosis of EDNOS may find it more difficult to access treatment as they may not fit into one particular "category".

Further information on disordered eating/eating problems is in Appendix 1.

### 3. Facts - UK

Beat, the UK's leading charity supporting anyone affected by an eating disorder state that:

- Research tells us the majority of people with eating disorders are female. However studies suggest that up to 25% of all those suffering could be male. Eating disorders can affect anyone in our society, with people from all backgrounds and ethnic groups being equally vulnerable. Myths and stereotypes can often prevent some individuals from coming forward to seek help.
- In the working population, eating disorders are most likely to be found in the 16 to 30 year age range; although it is possible to have an eating disorder for many years, even for life, so older employees may also be affected. The average age of onset for an eating disorder is in mid-to-late adolescence, so employees with children may also be affected.
- 725,000 individuals in the UK are diagnosed with an eating disorder. Though it may be presumed that anorexia nervosa affects the most, this is not the case.
- Around 1 in 250 women and 1 in 2,000 men will experience anorexia nervosa at some point.<sup>2</sup>
- Bulimia nervosa is more common than anorexia nervosa, studies suggest that as many as 8% of women have bulimia at some stage in their life.<sup>3</sup>
- Two per cent of adults in the UK also meet the criteria for full blown Binge Eating Disorder.<sup>4</sup>
- Eating disorders are more likely to be found in a predominantly young female workforce, as the incidence and prevalence is higher in this group. However, anyone can be affected by an eating disorder. There are also certain occupations which tend to attract people who are vulnerable to eating disorders, such as jobs in the food industries, sport, fashion, nursing and the caring professions."

Beat commissioned PricewaterhouseCoopers to conduct a survey of 435 individuals diagnosed with a range of eating disorders and 82 carers across the UK. According to PricewaterhouseCooper's report "The cost of eating disorders – social, health and economic impacts" (February 2015):

- The number of people being diagnosed and entering inpatient treatment for eating disorders in England alone has increased at an average rate of 7% year on year since 2009.

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<sup>2</sup> 'Eating Disorders'. NHS Choices, June 2015. [Online] Available at:

<http://www.nhs.uk/Conditions/Eating-disorders/Pages/Introduction.aspx>. Last accessed 5<sup>th</sup> February 2016.

<sup>3</sup> 'Eating Disorders'. NHS Choices, August 2014. [Online] Available at:

<http://www.nhs.uk/Conditions/Bulimia/Pages/Introduction.aspx>. Last accessed 5<sup>th</sup> February 2016.

<sup>4</sup> Deanne Jade. 'Compulsive Eating & Binge Eating Disorder'. National Centre for Eating Disorders, 2010. [Online] Available at: <http://eating-disorders.org.uk/information/compulsive-overeating-binge-eating-disorder/>. Last accessed 5<sup>th</sup> February 2016.

- Eating disorders represent a total cost of over £15 billion to the UK's economy with £6.8 to £8 billion in terms of lost income to the economy.
- Seventeen per cent of people lost income. In relation to time off work and education - c£650 per annum was recorded for sufferers under the age of 20 and c£9500 for sufferers over the age of 20 and c£5,950 per annum for carers.
- Almost half of sufferers will wait longer than a year after recognising symptoms before seeking help.
- Access to treatment is inconsistent and inequitable
- For more than half of sufferers the recurring cycle (of waiting, treatment, recovery and relapse requiring repeat treatment) lasts for more than six years
- The responsibility in early identification and treatment should not lie with the health services alone. It must involve community organisations and peers to provide a proactive approach.
- Early interventions improve recovery rates and reduce overall prevalence of eating disorders.

Beat conducted a survey of its members in January 2016 and there were 653 respondents:-

- More than 30% of people felt they were stigmatised or discriminated against because of their eating disorder at work.
- Nearly two out of five people said their employers' impact on their recovery was 'unhelpful'.
- Two thirds of people were unable to access either formal or informal support for their eating disorder at work.
- 38% told us they were forced to or felt they had to use their annual leave to attend medical appointments for their eating disorder.
- More than four out of five said they didn't think or didn't know whether their employers and colleagues were 'informed' about eating disorders.

Appendix 2 details worldwide statistics and Appendix 3 covers myths surrounding eating disorders.

## 4. Impact of eating disorders in the workplace

Employees with eating disorders often present little difficulty at work and excel at their job. Whatever difficulties they have, they are likely to make strenuous efforts to keep their illness to themselves to avoid their disorder being noticed at work. The work situation does not, in itself, cause someone to develop an eating disorder. Anyone can be affected whatever their level in an organisation.

There are generally three ways that an eating disorder may be brought to the attention of an employer:-

1. The employee will tell their manager personally. This is unusual but is a positive sign as it shows a realisation of the problem and may suggest a readiness to address it.

2. Outward signs and symptoms - for example, extreme and noticeable weight loss or weight gain, which is maintained over a period of time, or marked change in behaviour as detailed in section two of this guide over an extended time period.
3. Colleagues become concerned and inform the employer of their anxiety about a fellow worker. This is the most commonly encountered situation.

Employees who develop or have an eating disorder may require lengthy treatment or absence to attend appointments. They may need to have their working arrangements in terms of hours or responsibilities altered to take their health needs into account. Employees with managerial or supervisory responsibilities will benefit from understanding how best to support someone with an eating disorder. Eating disorders are mental illnesses and policies and procedures around employee illness will be relevant.

If your business involves the media, fashion or retail side of food, clothes, sport, or exercise – you could consider the impact of eating disorders on your customers and clients. Working in these areas will not directly cause an eating disorder but could make someone vulnerable.

## 5. The legislation

Eating disorders are classed as a mental disability and disability is a Protected Characteristic under the Equality Act 2010. Eating disorders are unusual in that they show both physical and psychological symptoms. People who have a disability, or who have had a disability in the past, are protected against:-

- Direct discrimination, including their association with other disabled people
- Indirect discrimination
- Discrimination arising from disability
- Harassment and
- Victimisation.

Non-disabled people are also protected against direct disability discrimination based on their association with a disabled person or a perception that they have a disability.

Discrimination arising from disability arises where a disabled person is treated unfavourably because of something connected with their disability. This type of discrimination is unlawful where the employer or other person acting for the employer knows, or could reasonably be expected to know, that the person has a disability. This type of discrimination is only justifiable if an employer can show that it is a proportionate means of achieving a legitimate aim.

Discrimination against a disabled person also occurs where an employer fails to comply with the duty to make reasonable adjustments to ensure that they can access and progress in employment. The Act also makes it unlawful, except in certain circumstances, for employers to ask about a candidate's health before offering them work.

An employer must not directly or indirectly discriminate against, harass or victimise a person:

- When deciding who to offer employment;

- In the terms on which an applicant is offered employment;
- By not offering the candidate employment;
- In the way they are given, or not given, access and/or opportunities for promotion, transfer or training, or for receiving any other benefit, facility or service;
- By dismissing them (including constructive dismissal and the expiry and non-renewal of a fixed term contract); or
- By subjecting them to any other detriment as a result of their disability.

There are provisions in the Act, which will allow:

- Objective justification of indirect discrimination and discrimination arising from disability;
- Discrimination based on occupational requirements;
- Positive action to enable people of a particular disability to overcome a disadvantage.

Reasonable adjustments may need to be made to an individual's role in order to accommodate their disability.

## 6. Implications of non-compliance with legislation

More than ever, attracting and retaining sought after skills makes great business sense for your organisation and as a manager you want to get the best out of each and every employee who works for you so ensuring their welfare should be at the top of your agenda. Obviously there are penalties for non-compliance with the Equality Act 2010 at Employment Tribunal.

In addition, you have legal obligations to ensure not only the health, safety and welfare of all employees is protected but also to make changes, or reasonable adjustments for people who might be disabled by their mental health condition.

You could also be liable to personal injury claims from employees – not just from physical injury but also psychological injury as well as claims for disability discrimination under the Equality Act 2010.

## 7. What an employer can do

Food nourishes the body and provides energy, so it is vital to work performance that all staff are eating healthily and regularly. Above and beyond productivity concerns, there are more important reasons for HR managers and OH practitioners to be vigilant about employee eating disorders; an individual's mental health is at stake.<sup>5</sup>

HR, line managers and OH practitioners should seek guidance from legal and health professionals, as well as relevant safety at work regulations. In addition, the two

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<sup>5</sup> Nicola Davies. 'Managing Eating Disorders at Work'. Personnel Today, August 2015. [Online] Available at: <http://www.personneltoday.com/hr/manage-eating-disorders-work/>. Last accessed 26<sup>th</sup> January 2016.

factors discussed below should be taken into consideration prior to approaching an employee in an official capacity regarding concern about a perceived eating disorder.<sup>5</sup>

## **7.1 Colleagues**

Colleagues can provide an enormous amount of support to someone with an eating disorder. They are also more likely to notice a problem in a fellow worker than a manager or senior employee. In many workplaces, particularly those with a predominantly female workforce, food, weight and body shape are common topics of conversation. This can be difficult for people with an eating disorder to deal with. It does, however, indicate that colleagues may also be experiencing concerns around food, eating and body image, although not to the same extent that a person with an eating disorder will feel.

If other employees express concern about an employee, encourage them to contact line managers or HR directly. Likewise, HR staff should refrain from discussing the details of individual cases with other employees. It is imperative that HR and management encourage a professional and respectful atmosphere at work.

People with an eating disorder can become the focus of other people's anxieties causing them to feel pressurised and their privacy invaded. Colleagues may feel such a strong duty of care that they attempt to take control of the situation, including control of the person with the eating disorder, and may decide to inform the line manager or employer of their concerns. It is important that colleagues understand the person's need for help and support and that intervention and control may not be appropriate or helpful.

In the majority of cases, unless the employee's work performance is affected, or there is serious detrimental effect on the work of the team, a person's eating disorder does not need to become "workplace property" and will probably require minimum intervention, if any, from the employer. It is helpful if you can make this clear to other employees, whilst also relieving their anxiety about the health and well-being of a fellow worker.

## **7.2 Communication**

Understanding more about eating disorders will increase awareness of their existence in the workforce. Reading this guide or seeking information and knowledge from Beat's website or support services can help. It is important, however, not to make assumptions about people and their behaviour and to attempt to "diagnose" an eating disorder. We all experience difficulties and problems in life which may affect our work performance. It is only when this work performance is compromised or adversely affected for a period of time that intervention may be required. In the majority of cases, people with an eating disorder will make strenuous attempts to ensure that their work is not affected by their disorder. It is unusual, therefore, for a person with an eating disorder to be unable to do their job, to create problems for other people, or for it to be brought to the attention of a manager.

People with an eating disorder will have the same needs as other employees. They need to be valued and accepted, to feel useful and that their contribution is appreciated, they need respect and support and to be given feedback on their performance. An eating disorder is a health problem, but it is not necessary for it to be treated differently to any other health

problem experienced by employees. It is important therefore to remind colleagues that an eating disorder is not an attention seeking device or tactic; it is a symptom of underlying emotional turmoil and distress. People who are experiencing difficulty at work often find it helpful to be given clear guidelines about what is expected of them and regular managerial support and feedback. If this does not prove adequate to enable them to continue at work, additional assistance or sick leave may be required.

### **7.3 Recruitment**

The main aim of any recruitment process is to recruit people based their ability to do a job. A person's present or previous history of an eating disorder is in no way an indication of their suitability or otherwise for a particular post. Not to recruit an otherwise good applicant, solely because of a declaration of an eating disorder, would be discriminatory. A person with an eating disorder deserves equal consideration for recruitment or promotion as any other candidate. It is more common for people to declare a history of an eating disorder when they are recovered or well-established in treatment.

### **7.4 Work performance**

Even if it appears obvious that a person may be affected by an eating disorder, employers should not jump to conclusions. Eating disorders are serious medical conditions that require diagnosis by a medical professional. Rather than accusing a member of staff of having an eating disorder, it is more appropriate to focus on their job performance.

If it becomes obvious that the employee has health problems that are impacting their job performance – perhaps the individual is weak to the point of fainting, taking excessive bathroom breaks, or work quality has reduced – speak to the employee in private. Perhaps there is another reason for their behaviour that has not been considered.

Be sure to offer support while respecting the person's privacy. Again, this should be framed in terms of addressing a work-performance issue, not as an attempt to diagnose or label the person.

In the situation where an employee's work or behaviour is giving cause for concern, it may be appropriate to arrange a meeting or supervision session where these concerns can be addressed. It is helpful if this can be organised so that it does not cause alarm or suspicion either to the employee or amongst other employees. People with an eating disorder often feel very vulnerable and are afraid that their eating disorder may be discovered and about what the consequences of this might be. A work based approach to a work problem is often, therefore, more successful. At this session, it is helpful to demonstrate support and understanding, highlighting your concerns and worries and encouraging the employee to speak openly and freely.

Often people will be reluctant to admit to difficulties for fear of losing their job, being stigmatised or having their confidentiality compromised. Often an individual with an eating disorder will not realise or cannot come to terms with the suggestion that they are unwell. Eating disorder behaviours are often present to provide coping techniques for the individual – they can fear what the consequences of stepping away from this short term relief will be.

Even if the person denies any difficulties, saying they are fine and that nothing is wrong, you will have acknowledged that something is potentially amiss. If they have recognised they need to find support they may not know that treatment or recovery is possible or they may not feel that they are worthy of getting better. It is beneficial to maintain an open communication between both employer and employee so that either can return to the issues and further discussion if the situation does not improve or change.

## **7.5 Support**

In the situation where discussion has led to the acknowledgement and identification of an eating disorder, help and support from a variety of sources will often be required. This can be broadly defined as internal support, i.e. from within the organisation and external support - provided by outside agencies.

### **7.5.1 Internal support**

This includes that offered by line managers, occupational health employees (where available), human resources employees and fellow colleagues.

Firstly it is of great benefit to develop open communication and co-operation between the employee and the organisation. The help and support offered by an organisation can play a key role in recovery from an eating disorder and, therefore, it is helpful to establish the guidelines of the relationship at the outset.

A person's eating disorder does not have to be disclosed to other employees although frequent absence may arouse curiosity. It is useful for some agreement to be reached between employer and employee on how much or how little can be disclosed. It is preferable to avoid conversations about food, diet and body shape. The most helpful dialogue is one where the illness is overlooked and remarks are made that build and restore a person's confidence, their sense of purpose and belief that they have trustworthy friends who do not judge them. For those undergoing treatment, the support and understanding of an employer is invaluable. A flexible approach to work hours, which enables the person with an eating disorder to attend medical appointments, is extremely helpful.

### **7.5.2 External support**

External support in terms of treatment, can take a variety of forms depending on the severity of the disorder and what services are available locally. No single treatment is suitable for everyone; where some people respond positively to a self-help approach, others will need to take extensive time off work for medical and/or psychiatric care. For a person with an eating disorder, managing weight and eating should occur in conjunction with psychological help to treat the underlying problems.

## **7.6 Treatment**

Treatment for an eating disorder will vary for each individual and will be based on the needs of the individual and the type of eating disorder they have been diagnosed with.

### **7.6.1 Outpatient treatment**

Treatment for eating disorders is usually offered on an outpatient basis at weekly, fortnightly or monthly intervals. Treatment can last for many months with the time between appointments increasing as progress is made. Those with eating disorders will already have many barriers to treatment; giving employees the opportunity to make up time lost to ensure they are able to accommodate regular treatment appointments will help to reduce the number of people avoiding or dropping out of treatment. Facilitating access to treatment will enable a person with an eating disorder to remain at work, will enhance their feelings of self-worth and will be perceived as supportive.

### **7.6.2 Inpatient treatment**

A small minority of people will require inpatient treatment. This is usually lengthy, with NHS England specifying an average length of stay is 18 weeks and good practice would be to follow this treatment with subsequent day and outpatient care. An employee who is admitted to hospital may be absent from work for a considerable period. Some people may find it helpful and supportive to receive an occasional telephone call or letter from work whilst others would prefer to get on with their treatment.

### **7.6.3 Other treatment approaches**

Some people find other forms of therapy and support helpful. These include counselling, complementary therapies such as aromatherapy and reflexology, self-help groups and self-help manuals. Beat provides a series of self-help support options.

## **7.7 Help for relatives/carers**

It may be that an employee does not have an eating disorder but is caring for and supporting a close family member or friend with an eating disorder. This can be very demanding, cause a high level of domestic stress and many carers may blame themselves for the development of an eating disorder or feel like they can do nothing to help their loved one. The work situation can be a refuge for some people, offering relief from overwhelming problems and an area of life where an eating disorder does not intrude.

In a situation where the partner, child or sibling of an employee requires hospital or outpatient treatment, it is common for family members to be involved in the assessment and treatment of the person with an eating disorder. Enabling employees to attend by granting limited time off work or by offering flexible working hours will be hugely beneficial to the individual with an eating disorder and also can help the carer to feel as though they have a purpose in their loved one's recovery. Employee counselling services, where they exist, can also be very beneficial to employees in these extremely stressful and anxiety-provoking situations.

Being the parent or partner of someone with an eating disorder is a very demanding situation and can take its toll on their physical and mental wellbeing too. Being able to

accompany a child or partner to attend appointments or family therapy sessions is vital, and flexible working practices that can accommodate this are also extremely beneficial.

## **7.8 Return to work**

A period of sickness absence presents the person with an eating disorder with a number of dilemmas. For some, having a job to go back to is a real incentive and source of motivation for recovery. For others, it may cause immense concern and feelings of vulnerability. They may feel under scrutiny and that they have to prove themselves and may even feel it would be unwise to return to their original job. It is under these circumstances that good, structured management and, if available, occupational health support can prove invaluable.

A return to work interview offers a positive and constructive way forward. This will enable the employee to discuss their needs and if appropriate, to agree a change to work hours, (part-time may be beneficial initially) or a move to a different area of work. It is also helpful to agree what information that the person returning to work is happy to have disclosed to their colleagues.

An employer can greatly facilitate the return to work by ensuring that someone within the organisation is designated to provide ongoing support and supervision to the employee; someone with whom they can talk honestly and openly. On returning to work the employee will often make a huge effort to prove themselves, offering to take extra hours and/or extra work very quickly. This should be monitored and measures taken to address their fears and concerns.

Some people recovering from an eating disorder may find it difficult to be flexible about eating; they may wish to eat in a separate room and it may take them longer to eat and therefore they may not be able to make up for lost time if meetings or appointments erode their lunch breaks. It will help them if the need for meal breaks can be respected and comments about what is being eaten are avoided.

## **7.9 General wellbeing**

Making sure staff know that medical support is available, and promoting a healthy lifestyle through such activities as health fairs, health assessments, and lunchtime talks about nutrition and healthy eating is increasingly important for employees who suffer from being over or underweight.<sup>6</sup>

Providing information about the health risks of being underweight could also help in demonstrating an organisation's commitment to its employees' health and wellbeing.<sup>6</sup>

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<sup>6</sup> Natalie Cooper. 'Anorexia in the workplace'. Personnel Today, March 2007. [Online] Available at: <http://www.personneltoday.com/hr/anorexia-in-the-workplace/>. Last accessed 26<sup>th</sup> January 2016.

## 8. What an employee can do

It can be incredibly difficult for an employee to disclose their eating disorder – not just to their employer but to anyone. Sometimes, the reason for an employee to disclose their illness is that the physical symptoms become so apparent to others in the workplace. Those with an eating disorder must be honest with their employer in order for them to receive support in the workplace. It may be they identify someone they trust to disclose to who will help with informing their line manager. The employer and the employee can then work together on the best course of action for the employee, which may include:

- reasonable adjustments in the workplace
- time off for medical appointments and support
- help identifying the appropriate source of support
- financial support with treatment options if that is needed (such as a private medical plan).

The employee must agree clear targets for their performance with their employer, whilst balancing this with a clear treatment plan. Scheduled review meetings will ensure there is regular communication on how things are progressing. The employee may also wish to propose if they would like colleagues to be informed or not.

It is essential for the employee to ensure that the employer is kept fully up to date in order to ensure the employer can best support them.

## 9. Top tips for employers

**9.1 Know the signs.** Even if you have never dealt with an eating disorder first hand, many of the signs are clear: weight loss or gain, obsession with food and/or exercising, retreating into their own world, low self-esteem, distorted body image, mood swings, lack of concentration, bingeing then purging, and excessive sick days.<sup>7</sup>

**9.2 Open communication.** The ideal office is an environment in which all employees feel at ease in expressing not only their concerns about one another, but their struggles. Setting a precedent of a caring workplace where your coworkers have your back is the first step in opening the lines of communication between all employees.<sup>7</sup>

**9.3 Offer resources.** Do your research before approaching a coworker or employee with an eating disorder. Have hotlines, treatment centers, counselors and websites – every possible resource out there to help the person get better (details in section 10).<sup>7</sup>

**9.4 Be firm.** Denial and secretive behavior around an eating disorder is common for an individual struggling. It may take time for the sufferer to admit to the problem which can

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<sup>7</sup> Amanda Chatel. 'Eating Disorders in the Workplace: How to approach it'. The Grindstone, May 2011. [Online] Available at: <http://www.thegrindstone.com/2011/05/12/work-life-balance/eating-disorders-in-the-workplace-how-to-approach-it/>. Last accessed 26<sup>th</sup> January 2016.

make initial conversations difficult. If you believe there is an issue be firm but remember to focus on the problem behind the eating disorder. Beat's website holds tips for approaching someone you are worried about.<sup>7</sup>

**9.5 Follow up.** After the illness is out in the open, take the time to check in and follow up. Ask questions on a comfort level that doesn't pry, but shows that you're just looking out for their well-being. They need to know that a support system exists.

## 10. Sources of support

### Beat

Beat is the UK's leading charity supporting anyone affected by eating disorders. They provide information and support through:

- The Beat Helpline – 0345 634 1414, [help@b-eat.co.uk](mailto:help@b-eat.co.uk)  
The Helpline is available for anyone suffering or anyone worried about someone they know.
- Online support: [www.b-eat.co.uk](http://www.b-eat.co.uk)  
Join our message boards or find details of online support groups
- Helpfinder: <http://helpfinder.b-eat.co.uk/>  
And online directory of support services in your local area
- Training on 'Understanding Eating Disorders'

### Overeaters Anonymous

[www.oa.org](http://www.oa.org)

Overeaters Anonymous provides insight into eating compulsively, strength to deal with it, and a very real hope that there is a solution.

### MIND

[www.mind.org](http://www.mind.org)

**08457 660163**

MIND has over 230 local associations which provide a wide range of different services from counselling to housing projects, for people with mental health problems and their families and friends.

### SANE

[www.sane.org.uk](http://www.sane.org.uk)

**08457 678000**

SANE provides confidential support, information and help to anyone coping with mental illness. Operates every day of the year.

### Young Minds

[www.youngminds.org.uk](http://www.youngminds.org.uk)

**0800 018 2138**

YOUNG MINDS aims are to increase public awareness of the mental health needs of children, young people and their families. It also promotes the provision of a network of the professional mental health services for young people and their families.

## Appendix 1 - Disordered eating/eating problems

- 1 Pica
- 2 Rumination disorder or chew and spit
- 3 Night eating syndrome
- 4 Prader-willi syndrome
- 5 Selective eating disorders

### **1. Pica**

Pica involves someone eating objects which are not suitable to be eaten and have no nutritional value. These can include chalk, plaster, paint and clothing. Whilst some objects pass through the body without harm, pica can be very dangerous. The causes of pica are unknown however it can be linked to certain mineral deficiencies (like iron or zinc) and it is possibly associated with certain psychological disturbances and social deprivation. People with learning disabilities sometimes have pica. Complications can include lead poisoning, malnutrition, abdominal problems, intestinal obstruction, hypokalemia (low levels of potassium), hyperkalemia (high levels of potassium), mercury poisoning and dental injury.

### **2. Rumination disorder or chew and spit**

Rumination disorder involves a person repeatedly regurgitating food. Regurgitated food may be re-chewed, re-swallowed, or spat out and is not due to a medication condition (eg gastrointestinal condition).

### **3. Night eating syndrome**

Night eating syndrome involves eating the majority of food late at night or when waking from sleep or excessive food consumption after an evening meal. Often people with this problem skip eating at the beginning of the day.

### **4. Prader-Willi Syndrome**

Prader-Willi Syndrome is a complex genetic disorder which is present from birth. People with Prader-Willi Syndrome have an insatiable appetite because of a defect in a part of the brain (the hypothalamus) that results in them never actually feeling full. People are often overweight, may steal food (including pet foods) and spoiled items in a bid to feed their appetite. Children born with Prader-Willi Syndrome may have early feeding problems that lead to tube feeding, and often also have a degree of behavioural or mental health problems and learning disabilities. Physical problems associated with the Syndrome are delayed motor development, abnormal growth, speech impairments, stunted sexual development, poor muscle tone, dental problems, obesity and Type 2 Diabetes.

### **5. Selective eating disorder (SED)**

Selective eating disorder (SED) is often thought to be associated with food phobia.

## Appendix 2 - Worldwide statistics

- According to eating disorders statistics estimated by the National Eating Disorder Association, in the USA up to 30 million people suffer from an eating disorder such as anorexia nervosa, bulimia nervosa or binge eating disorder. Worldwide the figure is more like 70 million sufferers.<sup>8</sup>
- Anorexia Nervosa has the highest mortality rate of any mental illness. An estimated 0.5 to 3.7 percent of women suffer from anorexia nervosa at some point in their lifetime. Research suggests that about 1 percent of female adolescents have anorexia.<sup>8</sup>
- An estimated 1.1 to 4.2 percent of women have bulimia nervosa in their lifetime. Lifetime prevalence of binge eating disorder is 3.5% in women, and 2.0% in men.<sup>8</sup>
- Onset of anorexia nervosa is most commonly around the same time as puberty.<sup>8</sup>
- Binge Eating Disorder was found to usually start during late adolescence or in the early twenties.<sup>8</sup>
- A study in 2003 found that people with anorexia are 56 times more likely to commit suicide than non-sufferers.<sup>8</sup>
- Alcohol and substance abuse are four times more prevalent amongst people that suffer eating disorders.<sup>8</sup>
- Hospitalisations for eating disorders in children under the age of 12 years old increased by 119 percent between the years of 1999 and 2006.<sup>8</sup>
- Twin studies show that there is a significant genetic component to eating disorders.<sup>8</sup>
- In childhood (5-12 years), the ratio of girls to boys diagnosed with AN or BN is 5:1, whereas in adolescents and adults, the ratio is much larger – 10 females to every one male.<sup>8</sup>
- Young women with anorexia are 12 times more likely to die than are other women the same age that don't have anorexia.<sup>8</sup>
- The most common eating disorder in the United States is binge eating disorder (BED). It is estimated that 3.5% of women, 2% of men, and 30% to 40% of those seeking weight loss treatments can be clinically diagnosed with binge eating disorder.<sup>8</sup>

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<sup>8</sup> Tabitha Farrar. 'Eating Disorder Statistics'. Mirror Mirror, May 2014. [Online] Available at: <http://www.mirror-mirror.org/eating-disorders-statistics.htm>. Last accessed 26<sup>th</sup> January 2016.

## Appendix 3 - Myths and facts

**Myth:** Eating disorders are just about food.

**Fact:** You might think if you could just sort out your eating you would be fine. You might think if you could convince your loved one to 'just eat more' or 'just eat less' then everything would be ok. An eating disorder is an expression of pain. Addressing that pain is the path to recovery. Of course we all have to have a relationship with food for the rest of our lives so it is important to work on that too, but food issues are a symptom – emotions are the cause. Some people turn to food for comfort. Most people with eating disorders are using food to try to regain a sense of control. Sometimes focusing on food, weight and calories enables people to block out or numb painful feelings and emotions. But it doesn't work.<sup>9</sup>

**Myth:** Bulimia nervosa is a good way to lose weight

**Fact:** Bulimia is an ineffective and dangerous weight control method. Over time, individuals with bulimia tend to gain weight.<sup>9</sup>

**Myth:** Bulimia nervosa is only true of those who consume huge amounts of calories in one go and then throw up afterwards

**Fact:** Binges can vary in size and one does not need to vomit to have bulimia nervosa. Bulimia nervosa also includes severe restriction of food and calories at other times or purging through use of laxatives and counteracting binges with exercise.<sup>9</sup>

**Myth:** Compulsive overeating isn't as serious a problem as anorexia nervosa or bulimia nervosa

**Fact:** Compulsive overeating or binge eating disorder can be as serious a problem as anorexia nervosa or bulimia nervosa. Heart disease, high blood pressure, diabetes and depression are only a few of the potential consequences of compulsive overeating. Furthermore bingeing is just as clear a signal as restricting or purging that a person is in pain and needs compassion and professional support.<sup>9</sup>

**Myth:** Those with eating disorders, are easy to detect and can therefore be easily helped to recover from their condition.

**Fact:** The vast majority of people with eating disorders suffer in silence, believing they cannot confide in anyone about their condition. Eventually, most individuals with eating disorders will reveal their eating problem to someone else. However, without confiding in someone, it is impossible to receive help for any problem, including an eating disorder.<sup>9</sup>

**Myth:** Those of a 'healthy weight' cannot suffer from eating disorders

**Fact:** Eating disorders and body dysmorphia are characterised by a complex relationship with food, weight, exercise & the body. These complexities can apply to anyone regardless of their size and shape.<sup>9</sup>

**Myth:** Achieving normal weight means an eating disorder is cured

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<sup>9</sup> '6 Facts and 6 Myths about Eating Disorders'. The Recover Clinic, February 2014. [Online] Available at: <http://www.therecoverclinic.co.uk/ed-facts-and-myths/>. Last accessed 26<sup>th</sup> January 2016.

**Fact:** Weight recovery is essential to enabling a person with anorexia nervosa to participate meaningfully in further treatment, such as psychological therapy but recovering to normal weight does not in and of itself signify a cure, because eating disorders are far more complex.<sup>9</sup>

## Appendix 4

### Case Studies

#### 1 Recruitment

Joan is 28 years old and has applied for a nursing post. Her occupational health screening asks about history of illness. Joan had anorexia nervosa when she was 17 years old. She was admitted to hospital at 18 and had two years of treatment. She was able to resume her education and has not had any time off for sickness in relation to her eating disorder since then. She is wary of declaring her history of anorexia nervosa. However, she does not want to lie, so she declares it on the form. Joan is successful at interview and discusses her situation at her pre-employment medical screening. Joan has a good employment history and is able to talk about her illness and its effect on her in a mature and sensible way. The Occupational Health physician recommends that Joan's job offer be confirmed. Joan takes up the job, does well and has no significant health problems during her employment.

Many excellent employees will not declare a history of an eating disorder if they believe that this may be prejudicial to their employment prospects. It is important for each individual to be considered for employment on his/her merits. A history of an eating disorder does not necessarily indicate current or future problems. Employers can help by indicating non-discriminatory practices in recruitment literature and advertisements.

#### 2 Employee management

Jan is an office manager, in charge of ten secretarial and administrative employees. Clare, one of the senior secretaries comes to see Jan because she is worried about one of her clerks, Shamilla. She is concerned that Shamilla seems underweight and rather unhappy and withdrawn. She says that she never goes to lunch with the other employees and avoids any social events that are organised in the office, although she does sometimes bring food in for everyone to share. She does not know whether to say anything to Shamilla but is concerned about the effect on other employees, who are speculating about her eating and her weight and tending to 'mother' her.

Jan discusses the situation with Clare. It is clear that Shamilla's work is of a good standard and that any difficulties she might be experiencing are not impacting on her work performance. She relates reasonably well to other employees but is shy and lacks confidence. Jan and Clare discuss ways of supporting Shamilla and decide to offer her regular supervision at work with feedback and appraisal. Clare offers Shamilla more structured appraisal to set goals and gives positive feedback on her work. After six months, Shamilla seems more confident and takes a more active role in the office, although her weight and eating behaviour remain the same. The employees in the office are less concerned and protective and seem to treat her more as an equal.

## Appendix 5

### Personal stories – from Beat in their own words

#### Jessica

“Everybody at the school where I work knows that I had been in hospital for intensive treatment and not been at work for 6 months. The likelihood of my colleagues expecting me to resume my everyday tasks, without asking any questions and without making an error was extremely small. I also reminded myself of how incredibly supportive and patient they were whilst I was struggling before my hospital admission and consistently throughout my time off work.

As soon as I walked through the door, I was hit with a complete mix of emotions. Excitement, happiness and joy to see all of my colleagues and hear some lovely comments that confirmed just how much progress I had made. I have kept in regular contact with my colleagues throughout my time in treatment, and I have been overwhelmed with their support and acceptance of my situation. Amongst the emails, I also enjoyed a few hospital visits from them, which was lovely, and way beyond what I would have expected from an employer.”

#### Suzie

“A brief overview of my situation is that I was in my 2nd year adult nurse studies when I had to drop out in the summer 2015. Since then I've been in intensive day patient. My employers have been beyond accommodating. When I had to cancel a shift in the summer due to a hospital admission they were understanding, compassionate and accommodating. I opened up to a few members of staff on a need to know bases and I've never looked back. When I was admitted to the day patient unit they once again accommodated my needs immediately (literally!). They had no issue with the days I would not be able to work and put it into effect with no hesitation. They kindly asked what my availability was; and more importantly what I felt able to do.

They continue to compassionately support and ask how I am which is a beautiful support network. I actually love going to work because they are so caring but equally so funny. They make me laugh and smile whilst also giving me advice on difficult situations I may have found myself in during the week eg, panic attacks at dinner. They are just lush!”

#### Charlotte

“I personally have struggled as the place I work at, provides a staff menu (which we don't have to pay for) for less senior members of staff to have for their free staff meal, when we have worked over a certain amount of hours. There are around five options, four of which involve pizza and pasta, jacket potatoes etc, and one of which is a salad for the healthy option. As the choice is limited and I struggle to eat the certain types of food on the menu, other members of staff find it difficult to understand why I get so worked up and anxious every time I am supposed to choose something off of the staff menu to eat each day when I have a break, resulting in senior members of staff getting frustrated with me when I can't make a decision because of the choices I have to pick from, are foods I had problems with

(refused to eat under any circumstances) when I was at the worst point of my eating disorder. Which in turn makes me upset and I just pick something I do not want to eat and most of the time will end up wasting and putting it in the bin, which also annoys members of staff if they see me do this, so this involves in me choosing to eat and eating something to please other people which in turn makes my problem worse.

And the other main time I find a lack of understanding would be again when I am eating, and should I be able to afford to buy myself something off of the main restaurant menu, I will be able to afford to sit and eat something that I want, and something that won't cause me anxiety. I find that senior members of staff will come up to my dinner plate and using their hands, will take food off of my plate and eat it, this is something I have a big problem with as I can't then eat the piece of food they have touched, which is frustrating when the food is something I finally want to eat. This is where the lack of understanding comes in as I have explained to senior members of staff, that this is something that causes me a problem, and why I would kindly ask them not to do it, which they have ignored and continue to do so. And then do not understand why I waste my food and go on the rest of the day being hungry having not been able to finish my meal, even when I've paid it.

On other occasions I have had small misunderstandings with other staff members who are aware of my eating disorder, trying to trick me into drinking a food replacement/diet milkshake (just as I was about to drink it they told me what it was so I didn't drink it) , then finding my reaction of horror, rather over the top. Other members of staff trying to coax me into eating chocolate and not understanding my reluctance to do so. So when I want to eat a cereal bar/chocolate bar on my own accord I feel embarrassed and feel like I have to eat it in private or so that no one sees me do so.

And a list of specific comments that I can remember of the top of my head include;

1. "When you were at the height of your eating disorder you still weren't as bad or as thin as my sister when she had a problem". (This comment was from a colleague I hadn't known for very long at the time).
2. "You've put weight on so you must be ok now".
3. "It's been almost a year so you've bound to have recovered by now?"
4. "That's a lot of food to be eating"
5. "You should eat more, that can't possibly be filling enough".
6. "Why don't you ask the chefs to do you more food?"
7. "Did you really not notice you had a severe problem even when you were so thin?".
8. "How could you starve yourself for so long like that? I could never do anything like that?".
9. "I wish I had an eating disorder so I could lose weight more easily".
10. "I could do with an eating disorder to make me lose weight.
11. "CAN YOU GIVE ME ANY TIPS?!" (I felt that I had to write this one in capitals as it's one of the comments, out of all of the ones I've received, that I found more offensive, even though they're all quite thoughtless and hurtful)."

## **Rosie**

"I have had an eating disorder for many years - and have had 4 jobs throughout this time. My first job was in retail, and I have to say, my eating disorder was pretty much ignored. I was made fun of by some members of staff for being 'negative', when I was just very sad and having a really hard time. I knew for a fact that one of my duty managers used to talk about me behind my back also. No one mentioned anything to do with my weight until I had to hand in a sick note (needing to go into hospital as I was so poorly), and it wasn't that well received. I left that job a couple of months after I came out of hospital.

I then went into another job, doing some freelance work for a media company - it was around this time that I began bingeing. Not once was I ever asked if I was okay. They knew how much I was eating, they saw how stressed I was, but I felt so ignored. This happened at my subsequent job also - I would break down into tears regularly - I was never asked if I was coping okay with anything (they just piled more and more work on top of me) - it got to the point where I had to go to the doctors to get another sick note for stress. Whilst I was off on this sick note, I was sent a letter firing me - they told me that I'd had warnings (I actually hadn't) about my work and dismissed me. I then tried to get my job back in retail, but was told that they didn't want me back because of the time off I had taken (for my eating disorder) - I had had that job for 4 years and only been off on two occasions before my admittance to hospital.

The job I am in at the moment is in retail - and I have to say that although I have spoken about my eating disorder to my manager, this doesn't seem to help people understand. During a back-to-work interview with her, she once said to me that she 'didn't know how to handle me' (in reference to my mental issues). She told me that she would be contacting HR about me and my problems and that they would ring me at some point to discuss/support me - I am still waiting for that call, 4 months on."

## **Holly**

"Having suffered with anorexia nervosa for a number of years now I have been in and out of in-patient admissions. During the times I have been discharged I have been working for a large multi-national company where I have now achieved a management level position. It is tough trying to juggle a demanding job with weekly doctors' appointments and the mood swings these can bring (due to anxieties caused by the lead up to being weighed). My first boss was quite understanding although I realised he had no idea about the illness he did try to understand how he could help me. I tried to keep it quiet at work the first time as I thought rather naively that no one would know but it was long before the whispering around corners turned into out right questions and so I had to try to explain my situation and dispel the stigma, stereotypes and pre-conceived ideas that they had already created. Eventually it ended up as a bit of a joke, but I decided I'd rather have a bit of a light hearted laugh with my new friends about my situation than have them ignorantly gossiping behind my back. When a promotion came along I moved to a new store however my new boss wasn't quite so understanding however after a long chat I realised it was because he had never actually heard of 'eating disorders' or 'anorexia' before so had no idea what I was talking about. He is not of British origin and explained to me that in his home country, although they recognise

many mental illnesses, eating disorders are not one of them. He even mistakenly thought it was just a taste preference, assuming that I didn't want to eat because I didn't like the taste. Now all my colleagues know about my situation and do try to be supportive in any way that they can though I still face daily struggles in my work place. Whether it be idle comments from customers, team building events or simply awkward questions like 'why can't you wear the normal uniform' can make work difficult. Particularly when it comes to staff nights out as due to my illness I am unable to eat out in restaurants or drink alcohol. So when my boss explained I was expected to go for a meal and when out in our local town for the night I just about had a panic attack. Once again, I had to sit down with him and try to explain WHY I couldn't do these things. It can make life extremely awkward at work and it always worries me that now I have a team to lead, do or will they take me seriously as a manager? Can you take 'the one who doesn't eat' or 'the one that got sectioned' seriously in a position of authority?

Fortunately most seem to acknowledge the strengths I have in my role at work rather than judge my personal weaknesses. I'm not saying it's easy but I think as time goes on I am learning and adapting to confronting the issue with new colleagues and bosses before it becomes the 'elephant in the room.'

### **Peter**

"Growing up as a high-achieving and ambitious teenager, I had no problems with work. Academic work and volunteering for charity came naturally to me and I had high hopes for a successful career path that like my school life, would be without barriers. So when I developed anorexia at the age of 15, I came to realise just how much I had taken my health and ability for granted. I struggled to attend school and eventually had to leave when the impact of the eating disorder took its toll on my body, isolated me from my peers and became my one and only way to cope with life. At this stage, the successful high-flying future I had always expected seemed an impossibility. Getting into employment wasn't a priority compared to the real hard work of getting well again, and during the bleakest times I couldn't see a future at all, never mind one where I could hold down a job.

Over the following years my eating disorder was a constant companion. Changing its face from anorexia to bulimia, my private battle became even more invisible and like the anxiety and depression it often came with, hard for others to recognize. Later, when it came to trying to get a job, I approached my applications being honest about my mental health problems and explaining why I had gaps in employment and education. Whilst I put the fact that I was rarely invited to interview down to the tough economic climate, I couldn't help but wonder whether I was being judged as unsuitable based on a health condition that wasn't my fault. So I left out my diagnoses and skimmed over occupation health questionnaires, and suddenly doors opened.

The trouble with this was that whilst I now had the opportunity to show employers face-to-face that I had a whole host of skills to offer, I also became deprived of the chance to be supported in work in the ways that my health required. It seemed that between the black and white choices of telling my employer everything or not letting them know anything at all, it was easier to keep quiet. This way, not only was I more likely to get a job in the first

place, but when I did finally tell my employer that I was becoming unwell, I was met with such a limited understanding of what eating disorders even were that I wasn't at all confident in their ability to support me.

Even when I became very unwell, the responsibility was always on me to explain the symptoms I was going through and how they impacted on my work. I was even told when I finally disclosed my history of ill health that I could face disciplinary action for not having done so at the outset. What we need is a climate without this fear of being discriminated against if you have an ongoing health problem, where there is no risk of being seen as unable to fulfil your job just for lack of appropriate support. Even though this wasn't the case for me, I believe that campaigns such as Eating Disorders Awareness Week, better training for managers and improving consciousness of eating problems throughout the workplace and wider society will mean that people who are well enough to work will get the support that they need.

In my case, it's not as though I needed intense professional help. There were plenty of small actions that my employers could have taken to make life easier for me and to potentially prevent me from slipping further into my eating disorder. Offering a quiet place to eat during the lunch break or making sure I had time to have snacks; being flexible about working times so I could attend appointments or offering someone to talk to from time to time about how I was coping – these were all quite insignificant things. Yet they could tip the delicate balance between my job being manageable and enjoyable, or being a struggle that would ultimately drive me to use my eating disorder even more.

As well as working together to change attitudes towards eating disorders in society, being open at the outset – even though it may seem daunting and may still get a negative response - is a key way for employers to be aware of the needs of someone with an eating disorder. Unfortunately, it may also be a way of recognizing those employers who continue to struggle to alleviate barriers facing sufferers at work.

At my worst, maintaining a severe eating disorder was more than a full-time job, and embarking on the road to recovery became the hardest but most worthwhile occupation I have ever had. Anyone experiencing an eating disorder or working to overcome one has shown their ability to work hard, and in the right conditions with the right support there is hope that one day, changing attitudes to eating disorders will mean that employers effectively support the work that people *can* do, rather than focussing on what they can't."

## Appendix 6

### Detailed signs and systems of eating disorders

#### 6.1 Anorexia Nervosa

##### Behavioural signs:

- Fear of fatness or pursuit of thinness
  - Pre-occupation with body weight
  - Distorted perception of body shape or weight, for example they think they are overweight when actually they are underweight
  - An underestimation of the seriousness of the problem even after diagnosis
  - Telling lies about eating or what they have eaten, give excuses about why they are not eating, pretend they have eaten earlier
  - Not being truthful about how much weight they have lost
  - Finding it difficult to think about anything other than food
  - Strict dieting
  - Counting the calories in food excessively
  - Avoiding food they think is fattening
  - Eating only low-calorie food
  - Missing meals (fasting)
  - Avoiding eating with other people
  - Hiding food
  - Cutting food into tiny pieces – to make it less obvious they have eaten little and to make food easier to swallow
  - Taking appetite suppressants, such as slimming or diet pills
  - Rigidity
  - Obsessive behaviour
  - Excessive exercising
  - Vomiting or misusing laxatives (purging)
  - Social withdrawal and isolation
  - Ritualised eating
  - Chewing and spitting of food to avoid calorie consumption
  - Avoidance of reflections or mirrors
  - Wearing oversized clothes to hide body shape
  - Experiencing mood swings
  - Setting high standards and being a perfectionist
  - Difficulty concentrating
- 
- **Physical signs** Severe weight loss
  - In girls and women, periods may stop or are irregular (amenorrhoea)
  - Lack of sexual interest or potency
  - Difficulty sleeping and tiredness
  - Feeling dizzy
  - Stomach pains
  - Constipation and bloating
  - Feeling cold or having a low body temperature

- Growth of downy (soft and fine) hair all over body (called Lanugo)
- Hair falling
- Weakness
- Loss of muscle strength
- Effects on hormones
- Swelling in feet, hands or face (known as oedema)
- Low blood pressure

### **Long term effects**

- Physical effects of starvation and consequences of purging behaviour. Starvation affects every system in the body
- In children, puberty is delayed and growth and physical development is usually stunted
- Loss of bone density (osteoporosis)
- Purging can result in erosion of tooth enamel
- Difficulty conceiving (subfertility), infertility
- Irregular periods

## **6.2 Bulimia Nervosa**

### **Behavioural signs:**

- Bingeing – eating large amounts of food
- Using compensatory behaviours: for example purging after bingeing, vomiting, over exercising, using laxatives or diuretics, fasting
- Being preoccupied with thoughts of food and life may be organised around shopping, eating and purging behaviour
- Visiting the toilet after meals
- Secretive
- Mood swings
- Feeling anxious and tense
- Having a distorted perception of body shape or weight
- Feeling of loss of control over eating
- Feelings of guilt and shame after bingeing and purging Isolation
- Can be associated with depression, low self-esteem, misuse of alcohol and self-harm
- Feeling pre-occupied with body weight and/or shape

### **Physical signs**

- Vomiting
- Excessive exercising
- Misuse of laxatives and diuretics
- Disappearing soon after eating
- Fatigue, lethargy
- Feeling bloated
- Constipation
- Stomach pain
- Swelling of the hands and feet
- Periods may stop or are irregular (amenorrhea)
- Enlarged salivary glands

- Calluses on the backs of the hand from forcing down throat to vomit
- Electrolyte abnormalities/ imbalance
- Gastric problems
- Regular changes in weight

#### **Long term effects**

- Physical effects of excessive purging behaviour. This can affect a range of systems in the body
- Dental problems due to acid damage to the enamel on teeth
- Poor skin and hair
- Swollen glands
- Difficulty conceiving, infertility
- Irregular periods

### **6.3 Binge Eating Disorder**

#### **Behavioural signs**

- Feeling very self-conscious eating in front of others
- Eating much more rapidly than usual
- Eating alone or in secret because of the embarrassment about the quantities of food consumed
- Eating until feeling uncomfortably full
- Eating when not hungry
- Shame, depression and guilt after bingeing
- Hiding food wrappers

#### **Physical signs**

- Weight gain
- Bloating
- Feeling sick
- Poor skin
- Difficulties sleeping
- Stomach pains

#### **Long term effects**

- High cholesterol and high blood pressure which can increase risk of cardiovascular diseases
- Diabetes
- Osteoarthritis
- Weight gain which can lead to obesity



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