Eating Disorders in Religious Life

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The front page of a leading Catholic publication shows a group of younger women in religious life, two-thirds of whom are significantly overweight. At a weeklong spiritual retreat, half of the sisters and priests attending are markedly overweight. At a national meeting of vocation directors, the number of overweight men is striking. In a residential treatment program for priests and religious with a range of psychological difficulties, more than a third of the clients are considerably overweight. At a gathering of major superiors, several men and women in leadership seek out the psychologist presenter and, in hushed tones, express their concern about the increasing number of obviously overweight members in their congregations. In a women's community, a novice regularly excuses herself after meals, goes to the bathroom, and then rejoins the group. A young priest often misses meals and exercises vigorously several times a day, despite being very thin; he becomes irritable and anxious if anything interferes with his exercise schedule.

Eating disorders may well be what alcohol abuse and dependence were forty or fifty years ago: the unmentionable addiction that was exacting a huge toll on the health and ministry of many men and women in priesthood and religious life. Now, several decades later, it hardly raises an eyebrow to learn that Father or Sister or Brother is in recovery from alcohol addiction or has taken a leave to get help for an alcohol problem. Religious life, like the larger society, has acknowledged the problem of alcoholism and fully supports and affirms those who struggle to overcome it. There is little shame or secrecy in addressing the problem of alcoholism openly. Indeed, one can say that the language and ethos of Alcoholics Anonymous (and of all twelve-step programs generally), of "recovery," of healthy "sobriety" versus white-knuckle "abstinence," have become part of the fabric of priesthood and religious life in many settings. This means that individuals in recovery from or addressing alcohol problems readily find support and affirmation.

Eating disorders seem to be now where alcohol abuse and dependence were several decades ago: the problem is there, most people see it's there, many people struggle personally with it, but no one acknowledges it openly, no one talks about it, and everyone seems to avoid mentioning the issue out of fear of intruding on another person's privacy or being indiscreet. Meanwhile, thousands of men and women suffer silently and, often, alone.

This article provides a brief introduction to the problem of eating disorders in priesthood and religious life (which, for the sake of brevity and flow, I will henceforth refer to as "religious life," while being

well aware of the numerous differences between the realities of diocesan priesthood and religious life). It begins with a description of the phenomenon, continues with consideration of several factors that contribute to eating disorders in society at large and in religious life in particular, and then looks at some of the psychological dynamics underlying eating disorders. This article simply hopes to name the problem and begin opening the door for constructive reflection on and response to it.

DESCRIPTION OF THE PHENOMENON

Bulimia nervosa, anorexia nervosa, and binge-eating disorder immediately come to mind when we hear the expression "eating disorder." Each of these conditions involves distorted attitudes about eating, shape, and weight, mood symptoms such as depression and anxiety, and, often, personality disorders. An eating disorder centers on a disordered relationship with food whereby an individual consistently engages in a particular pattern of behavior around food in order to alter his or her mood. For example, the caloric restriction and compulsive exercising of anorexia nervosa and the bingeing and purging of bulimia nervosa are patterns that produce an experience of control and of temporary relief from the stress of low self-esteem and relational difficulties. Similarly, compulsive overeating, particularly of "comfort foods" (sweets, carbohydrates, fast foods), is experienced as a way to soothe and fill the emotional "hunger" and emptiness inside without having to go to relationships for this "nourishment." The pattern of consistently managing mood by turning to a substance or a pattern of behavior that reliably produces the desired "fix" is the hallmark of any addictive process. It can thus be useful to think of eating disorders as addictive relationships with food, in which food symbolizes and comes to function as much more than metabolic fuel for one's physiological system. Obesity has been the subject of considerably less research and clinical attention than anorexia nervosa, bulimia nervosa, and binge-eating disorder, despite the fact that obesity accounts for far more morbidity and mortality than these three eating disorders combined. Writing in *Monitor on Psychology* (March 2002), psychologist Eric Stice points out that because body mass is a direct function of caloric intake relative to caloric expenditure, and because obese individuals consume more calories and exercise less than nonobese individuals, it is reasonable to conclude that a medical condition caused by excessive eating relative to caloric needs is a disorder of eating. I will therefore include obesity in the group of eating disorders. Although all the eating disorders occur in priests and religious, this article will focus on obesity as the most prevalent and serious eating disorder among people in religious life.

Having said this, it is important to remember that not all cases of weight gain or obesity are indicative of an eating disorder. It is important to note that some medical conditions can cause obesity or significant weight gain (e.g., hypothyroidism, Cushing's syndrome, depression, certain neurological problems) and that certain medications, including steroids and some antidepressants, can cause significant weight gain. However, in my clinical experience and that of many colleagues, the majority of cases of obesity in men and women religious cannot be attributed exclusively or even primarily to medical conditions; rather, they appear to involve eating disorders.

OVERWEIGHT VERSUS OBESE

For the sake of clarity, it is important to distinguish between the terms "overweight" and "obese." Clinically speaking, being overweight means that one's weight is 25 to 30 pounds over the recommended weight for height; being obese means that one's weight is 30 or more pounds over the recommended weight for height. A more precise clinical measure of relative weight for height is body mass index (BMI), which is a measure of body fat based on height and weight. It is obtained through some simple calculations. BMI for normal weight is between 18.5 and 24.9, BMI for overweight is between 25.0 and 29.9, and BMI for obesity is 30.0 or greater.

Given the sensitive nature of this topic, especially outside of clinical settings, we often speak about people being overweight and may find it awkward to speak about obesity. In light of the definitions just given and your own experience, consider whether, in the first several sentences of this article, it would perhaps have been more accurate to use the term "obese" instead of "overweight." Also, ask yourself if your reaction to reading those first several lines would have been different had I used "obese" right away. This brief reflection may give you some clues about how hard it is for us to find words to introduce comfortably the difficult issue of eating disorders, including obesity.

Some numbers may help put this issue into perspective. Recently released results from the National Health and Nutrition Examination Survey (NHANES) estimate that 61 percent of adults in the United States are either overweight or obese. Of importance, the findings further point out that whereas the number of overweight adults in the

Observation, experience show eating disorders are a significant problem among men and women religious

United States increased by only 2 percent (from 33 to 35 percent) between 1980 and 1999, the number of obese adults nearly doubled (from approximately 15 percent to nearly 30 percent). This means that almost a third of the adult population in the United States is clinically obese. Further research indicates that seven out of eight individuals with bulimia nervosa, anorexia nervosa, and binge-eating disorder are women. Nearly equal percentages of men and women in the general population are obese. At present, there are no statistics specifically defining the problem of obesity and other eating disorders in religious life. Nonetheless, observation and years of experience in clinical and educational work with priests and both men and women religious unmistakably point to a widespread and significant problem.

Before leaving office, former Surgeon General David Satcher issued a "call to action," saying that in the United States some 300,000 deaths a year are related to obesity (a loss of American lives comparable to nearly 100 World Trade Center disasters every year). It is urgent, as a society, that we acknowledge and confront this major health crisis head on. We must move beyond reaching for the "quick fixes" touted by the booming diet industry and seriously explore the lifestyle issues at the root of the pervasive struggle with eating disorders. Satcher began by calling for the removal from schools of all fast food — a key contributor to eating disorders, particularly obesity.

FACTORS CONTRIBUTING TO DISORDERS

The pace of our culture, the ready availability of fast food and junk food, widespread poor eating habits, and the culturewide breakdown in healthy intimacy and relationality in society at large as well as in religious life are some of the primary factors that leave so many people at risk for developing eating disorders. Ours has become a workaholic and nonreflective culture in which people rarely slow down long enough to take stock of what is happening with their emotional, spiritual, and relational well-being. The unrelenting intensity of the pace of daily life for everyone (working men and women, families, even overscheduled toddlers and children) — combined with the incessant bombardment of stimulation from all kinds of electric and electronic media — keeps people from slowing down and thus protects them from finding out what's really going on inside themselves. In this climate, in which there is so little time to feel, to notice, to be aware, to make genuine affective connections with oneself and others, food has become for many a "language for feelings." Food often ends up being used to numb the pain of difficult feelings or to fill the hole created inside by loneliness, isolation, lack of healthy relationships, and lack of intimacy. This sets the stage for food's being used in addictive ways — that is, as a substance that reliably produces a change in mood and is intentionally used for this purpose — which in turn sets the stage for eating disorders.

In trying to understand eating disorders, and especially what has been called the current epidemic of obesity, some people have focused on the genetic factors (i.e., the inherited tendency to gain weight), almost as if to say, "It's in your genes, so there's not much you can do about it." There is no disputing that some individuals have a genetic predisposition that makes them more likely than others to gain weight. Some clarification is in order, however, lest readers join those who think that obesity is entirely programmed by the genes. As Stice notes, the fact that the obesity rate in United States adults has risen from 4 percent to 30 percent in the past century suggests that genetic effects are being behaviorally modulated. That is, behavioral and lifestyle factors are mediating the expression of genes, which normally do not change so dramatically and quickly. Thus, when trying to explain the exponential increase in obesity over a few decades, we are left looking at the unhealthy lifestyle that has taken hold in our society: a far more sedentary existence for most people (despite an intense focus on exercise for some), the consumption of more calories than necessary to fuel this lifestyle, and the pursuit of taste and convenience ahead of nutrition, as encouraged by the fast-food industry.

Researchers agree that consumption of fast food is one of the biggest factors in the prevalence of obesity today. Eric Schlosser, journalist and author of *Fast Food Nation: The Dark Side of the All-American Meal* (2002), points out that United States residents

spend more on fast food each year than they do on movies, books, magazines, newspapers, videos, and records combined. Consumers in this country spent more than $110 billion on burgers, fried chicken, and the like in 2000 alone, compared with $6 billion in 1970. Schlosser contends that the fast-food industry has changed the way Americans eat. I would add that this shift in American eating patterns and the increased reliance on fast food have become possible thanks to the interaction of several factors, including (1) the fact that in more families, both parents (or a single parent) are working full-time and thus have less time to cook regular meals for their families; (2) the increasing push (often compulsive) to "do" more and more things and to be involved in more and more activities, on top of increasingly time-absorbing work schedules, leaving even less time for families to gather around a shared, home-cooked meal once a day; and (3) the increasing fragmentation of family life, with each family member, even in "intact" families, rushing off individually to pursue this activity or that sporting event, diminishing their time together, especially at mealtimes.

FACTORS SPECIFIC TO RELIGIOUS LIFE

These general cultural factors seem to interact with several specific characteristics of contemporary religious life to increase the risk of eating disorders among men and women religious. First, socialization (from the general culture and from religious life itself) affects how religious are expected to cope with feelings. Our culture has typically socialized men not to express their feelings, not to appear vulnerable or in need emotionally, to appear strong and in control. Women have often been socialized to be caretakers and nurturers and not to pay much attention to their own needs for healthy nurturance. This social conditioning can make it difficult for people to recognize and express their own needs, especially for intimacy and connection. The problem is compounded when these individuals enter the context of religious life, which often instills a tendency to suppress negative affect, such as anger, frustration, and sadness. Also, religious life often fails to create an environment that provides much in the way of positive affect, including healthy experiences of intimacy, friendship, joy, shared laughter, closeness, support, and a sense of being on a shared faith journey. Finally, the "spiritual" expectation of what being a "good" religious or priest means often leaves individuals feeling unable to express openly what they really feel, experience, and need. This makes it much harder to develop a genuine spirituality grounded in honesty and healthy intimacy with God, others, and oneself. In many religious life settings, the combination of cultural and religious socialization contributes to a situation in which neither negative nor positive affect is handled in a healthy way. This opens the way for food to be used as the language for emotions that are unexpressed or lacking.

Second, the fear of intimacy is often encountered in religious life, especially in individuals who have not developed good relational skills or who have an unhealed history (as many do) of being significantly hurt or betrayed in interpersonal relationships. Usually, fear of intimacy leads to avoidance of situations in which good relational skills could be developed, which means that the unrequited need for healthy intimate connecting grows, forming a hole inside, and opening the way for food to fill some part of that inner emptiness.

Third, a combination of overwork and lack of self-awareness is increasingly characteristic of many priests and religious. Everywhere one looks, sisters, brothers, and priests are extremely overworked, trying to cover positions that would require several individuals instead of one, trying to contribute within their own religious communities, and also trying to be present in the larger community, particularly as voices for justice and peace in troubling times. These overworked men and women typically come home exhausted, often too tired to exercise or even to cook a healthy meal. Frequently, they end up sitting and watching television and ordering out for food, or eating a take-out meal picked up on the way home, or grabbing a burger or slice of pizza at a drive-through en route between work and an evening meeting and not eating a proper meal once they get home. This scenario is repeated countless times every evening, among individuals living in community, and especially among priests and religious living alone (of whom there are more and more). Because of their hectic pace and excessive workloads, these people rush through the days with hardly a moment to notice the overall impact of their lifestyle on themselves and others. Several priests and religious have shared with me that they were hurtling along this destructive path of overwork, stress, poor diet, no exercise, and inadequate support, quite unaware of what was happening to them, until something significant — a heart attack before age 40, a diagnosis of cancer, serious back surgery, or the sudden loss of a close friend brought to an early grave by a similarly unhealthy lifestyle — finally grabbed their attention, caused them to open their eyes and look at themselves, and set them on a path of establishing a different kind of life. Sometimes the pattern of overworking, especially if

combined with a poverty of healthy intimacy in one's life, leads to a slide into genuine workaholism — a huge occupational hazard in religious life. In genuine workaholism, work is used to "fill" the inner hole and manage one's painful feelings, including sadness, isolation, anger, frustration, exhaustion, disappointment, and grief. Clinically, we know that when one addiction is present in an individual, a second one is often present. Among men and women religious, it is not unusual to see addictive relationships to both work and food, which serve as a way to "numb out" — to avoid sitting with the tiredness, loneliness, and pain and thus to avoid having to make changes in one's life. Addictive relationships to sexuality (including acting out with others and involvement with pornography, particularly on the Internet), to alcohol, and to spending are some other commonly observed responses to the stressful lifestyle typical of many priests and religious.

Fourth is the fact that, increasingly, diocesan priests are experiencing a disastrous degree of isolation because of their geographical distance from brother priests, the generational and ideological distances within rectories, and the burden of being alone to handle the needs and problems of hundreds of parishioners with little or no support, not even from their bishops. The profound sense of loneliness and disconnectedness takes a huge toll on these men, who inevitably seek some way to numb the pain — and who often find comfort in food, which is sometimes provided in excessive amounts by overzealous housekeepers or parishioners eager to "feed Father."

Finally, an impoverished or altogether absent spiritual life can contribute significantly to the risk of turning to food in an addictive way. When a man or woman, involved in relational ministry on behalf of a relational God, is not being nourished and sustained ("fed") by a primary relationship with God, the hole inside is bound to grow, painful feelings and questions like "What's the point?" are bound to multiply, and the risk of using food to manage the pain and needfulness is likely to increase.

DYNAMICS OF EATING DISORDERS

Research has shown that emotional distress may be the key to a number of metabolic problems related to food consumption. I would add that emotional distress, which typically has a relational basis, seems to be at the root of all disordered relationships with food. Research has shown that individuals' responses to significant emotional or environmental distress can affect their body chemistry in ways that alter normal mechanisms of food metabolism and of absorption and depletion of crucial nutrients. Clinical nutritionist Nancy Appleton, in her book *Healthy Bones*, points out that we all experience stress and stressors, and that it is not the stress per se that can alter our body chemistry. Rather, it is how we perceive the stressors and how we deal with them that determine whether they become distress for us. The more we become angry or depressed, put ourselves in a victim role, hold judgments against others, or try to get back at people, the more the stress in our lives becomes distress — and it is this distress that causes us problems.

Some important sources of stress and, often, distress — especially for individuals in religious life — are the areas of intimacy and nurturance, boundaries around self-care, and sexuality. In society at large and in religious life in particular, there is a tremendous hunger for nurturance and intimacy. One often sees individuals in religious life needing and seeking a lot of nurturance, having come from backgrounds in which it was not provided to them, and in which they did not learn adequate skills in this area. Add to this early deprivation the loneliness and isolation so many of them encounter in the course of their ministries, and you have a situation that would be challenging even for the most relationally skilled person, let alone for someone who has never learned to identify intimacy needs or to address them in healthy ways. Some have remarked that the widespread craving for sweets is an expression of an underlying craving for the sweetness of healthy intimacy. Sadly, many individuals in religious life do not know how to go to a place of healthy intimacy in their lives, or, because of the formation they received, misunderstand what healthy intimacy is and think they simply shouldn't go there. Yet they continue to crave it deeply. Judi Hollis, a psychologist with a specialty in eating disorders and the author of *Fat Is a Family Affair*, writes that individuals with eating disorders need to "relate to recover." She points out how unhealthy eating patterns become a substitute for true intimacy and for taking the risk of relating. An eating disorder thus becomes "a symbol of how we relate in the world." Issues of control and vulnerability are central in the lives of those who struggle with eating disorders. Contemporary life, including religious life, often leaves people feeling overwhelmed, out of control, isolated, and afraid of being vulnerable. Increasingly, people turn to food as a way of coping. As Hollis puts it, "the only way to get nurturance without being vulnerable is with food." Relating to food (or work, or alcohol) is always easier than relating to other people.

A second source of stress and distress, especially

for individuals in religious life, is in the area of boundaries — specifically, in holding healthy boundaries around one's own physical, emotional, and spiritual needs and limitations. This involves having the humility and courage to recognize both one's gifts and one's limitations and being able to say no when necessary: "No, I'm not able to take on another project in the parish, but I can direct you to someone who would be excellent for this." "No, I cannot stay up and edit this paper tonight, as much as I'd like to; I really need to get some sleep." "No, I will not agree to a last-minute invitation to speak to a local group this Sunday afternoon. I really need to honor my afternoon of prayer and retreat." How difficult it is to speak these words — especially for hard-working ministers who have never learned or been encouraged to set limits and boundaries on their time, energies, and availability and who are accustomed to doing extra things that they really do not want to be doing, losing sight of their own needs, limits, and boundaries in the process. As a religious priest friend recently said to me, "Many of us have a great relationship with our yes, but absolutely no relationship with our no." Establishing healthy boundaries is not about selfishly refusing to be of service; it is about being free to serve better by honoring the particular instrument God has made one to be. A lack of boundaries around self-care and respecting one's own reality inevitably leads to an accumulation of frustration, anger, resentment, exhaustion, and sometimes self-blame, which can easily lead to reaching for food as a way of comforting and rewarding oneself — especially when one feels unable to rescue oneself by starting the challenging work of setting good boundaries.

UNDERSTANDING SEXUALITY

A third area of frequent stress and distress is that of sexuality, which often ends up getting linked to food — especially for religious, and particularly for women religious. Often, the expression of affection, caring, and desire, which is particularly important for women, somehow ends up being labeled inappropriate or unnecessary. There is a definite connection between the denied need for affective, sensual warmth and for being deeply touched in relationship (not only or even primarily at a physical level) and the use of food as a substitute source of gratification, pleasure, comfort, and distraction from the unmet needs. In addition, some individuals have received the message that, as religious or priests, they are simply not to be sexual persons. Those who hear this message and who lack a good understanding of what sexuality is primarily about (healthy relational living) and whose own sexuality is not well-integrated may be highly uncomfortable with the possibility of being seen as an attractive, sexual person and may end up "hiding" behind a great deal of excess weight. As clinicians, many of us have heard our religious and priest clients say that they would prefer not to lose weight in order to avoid dealing with sexual-attractiveness issues. Many people still enter religious life perceiving it as a safe haven where they can altogether avoid the issue of sexuality, especially if they have had painful past experiences around sexuality. Consider that at least 40 percent of women religious have a history of sexual abuse, and that many men do as well, and consider that shame is a powerful and tough emotion often associated with histories of abuse (especially when healing work has not yet been done). When individuals begin using food to manage the shame associated with their sexuality, the conditions are ripe for an addictive spiral of numbing the pain with food, feeling more shame because of the food addiction, eating more to numb the shame, and so on downward.

An additional psychological dynamic to bear in mind in understanding eating disorders in religious life is the high prevalence of compulsive and dependent personality styles among priests and religious. Individuals with a markedly compulsive personality style have a strong need to do things right, to have the correct answer, to make sure everything is in order (at least externally), and to accomplish assigned tasks immediately and well; they often show some lack of flexibility in how situations are understood, directives implemented, and change introduced. Individuals with a markedly dependent personality style have a strong need to please others (especially authority figures), to be guided and told what to do, and to be reassured and affirmed in what they are doing; they often struggle to take a stand on their own, to express an opinion that diverges from the commonly held one, or to take risks of any sort that might jeopardize their relationships with those on whom they rely for support.

A moderate degree of compulsive and dependent traits is actually quite adaptive and helpful to individuals in religious life; people who lack these traits in moderation would find it difficult to function comfortably in the culture of religious life. When these traits are strongly present, however, they can contribute to unhealthy patterns of functioning. In relation to eating disorders, individuals with compulsive styles are more likely to engage in compulsive overeating (or compulsive food restriction, in the case of anorexia nervosa) in order to cope with the

kinds of emotional issues discussed earlier. Not surprisingly, when these same individuals enter programs to treat their obesity and related emotional issues, they often set out to lose more weight than they should, faster than they should, in their need to be "good" patients and to do the program the "right" way. Similarly, individuals with a dependent style may successfully keep weight off for a while after treatment, in their need to earn the approval and affirmation of their superiors. However, both compulsive and dependent individuals may struggle to sustain weight reversals (loss or gain) attained in therapy when the external reinforcement of others' approval and affirmation is no longer as readily available because of a change in situation or assignment. Recovery work for these individuals needs to include their becoming aware of how their personality style contributes to their difficulties and how to take it into account in developing effective strategies for healing and long-term recovery.

Clearly, some of the major psychological dynamics that contribute to eating disorders include ongoing experiences of lack of intimacy and nurturance, struggles to maintain healthy boundaries around self-care, and difficulties in finding ways to live a healthy sexuality in a vowed celibate context. These struggles can lead individuals to the painful and disappointing conclusion that other people will not always be there for them or meet all of their needs in perfect ways, and that at times they may even be let down or hurt by others. When this conclusion causes individuals to live as if they could nurture themselves adequately without needing others, an illusion of emotional self-sufficiency emerges, setting the stage for a disordered use of food to meet emotional needs. As Hollis points out, the key to recovery from any eating disorder is finding ways to meet one's needs (for emotional nurturance, affirmation, healthy sexual expression, good self-care) without relying on food. This frees one to redefine one's relationship to food, to return to healthy socializing around meals, and to allow food to "just be food" again — primarily a source of metabolic energy for living and, occasionally, a source of culinary pleasure. The way out of eating disorders is to face interpersonal disappointments and hurts, to express one's feelings about them instead of holding in those feelings and managing them through food, and to realize that others do and will care, albeit imperfectly, and will provide support and nurturance even if they don't solve one's every problem or fill one's every need. Hollis states that facing disappointments is a way to grow up. Recovery is a lot about growing up by confronting those areas of one's life that are most painful and challenging. For some, undertaking this work of "growing up" relationally may seem too daunting until they understand that it is work to be undertaken with plenty of support and care. In fact, it needs to unfold in the context of healthy relationships, which help one to address the pain and to come through it rather than persist in trying to numb it. Wilkie Au and Noreen Cannon beautifully express the nature of this important work of healing and growth in their book *Urgings of the Heart: A Spirituality of Integration:*

> In close, intimate relationships, the best and worst in us are brought to the fore, providing us with a unique opportunity for transformation in the give-and-take that such encounters involve. [Intimate relationships] force us to grow up, challenging us where we are stuck in old but familiar self-images and patterns of self-centeredness. Intimacy brings us face-to-face with those shadow parts of ourselves that we tend to deny and project onto others, revealing to us "that which we have no wish to be." When intimacy is accompanied by love, it can become a crucible for our wholeness, stirring up what needs to be integrated and holding us in love as we meet those parts of ourselves which we have feared and hated. (p. 114)

Thus, the addictive relationship to food that is so widespread becomes a symptom of what has gone terribly wrong in the past few decades, in our society and in religious life, in the areas of healthy intimacy and relational living. The key to preventing and recovering from eating disorders is to redefine not only one's relationship with food but also one's relationships with oneself, others, and God.

RESPONDING TO THE PROBLEM

The following recommendations are offered to help readers, especially those in leadership and in formation work, address the problem of eating disorders.

Start to name the reality of eating disorders (particularly obesity) courageously and gently, as an important step in acknowledging the seriousness of the issue, in supporting individuals in need of healing in this area, and in assessing ways, as a group, to respond to it — for the sake of the physical, emotional, and spiritual health of members and of the group as a whole. Speaking plainly, directly, and compassionately helps to normalize the problem for those who may be struggling with it. By breaking the silence around the issue and addressing it openly, you can help others recognize they are not alone in their struggle and implicitly give them permission to seek help.

Assess the "health" of your system. Research has shown that eating disorders are most usefully understood in systemic terms — as the "patient" with the disorder expressing something on behalf of the "family" system as a whole. It would thus be opportune for religious communities, formation communities, dioceses and deaneries to take stock of the health of their own systems: of the extent to which there is healthy support and nurturance that goes around, of the degree of isolation among ministers, of the extent to which overwork is exacting a toll on individuals.

Provide opportunities for education on eating disorders, their prevalence, issues related to them, resources available for addressing the problem, and on ways to develop healthy intimacy and good relational skills. It is important to begin providing this kind of input early in formation, in order to instill as soon as possible habits that will support a healthy religious or priestly lifestyle.

Challenge your members, students, and peers to strive for wholeness and "un-numbing," to move into the fullness of life God intended for them, and to come fully into their gifts and talents. These gifts may never fully emerge unless they are called forth in supportive, encouraging, and positively challenging ways. Of course, if leaders and formators are to call others to wholeness and even to greatness, they must first confront, and humbly commit themselves to addressing, the areas of numbness within their own lives.

Renew your commitment to prophetic gospel witness. Consecrated men and women are called to be prophetic — and, thus, often countercultural — witnesses to gospel realities in the midst of a world in great need of alternative, life-giving messages. It would be worth reflecting on the prevalence of eating disorders in religious life as one symptom (the problem of sexual misconduct being another) of the extent to which, in certain respects, religious life has gone the way of the wider society and has been unable to embody and to privilege radically alternative commitments to true community, genuine intimacy, and authentic living in right relationship. If, in terms of healthy relational living, society is hurtling down the track on a runaway train, does religious life have to follow suit? Can it develop enough self-awareness to witness to an alternative reality rooted in gospel values? When men and women dedicated to being ministers of a relational God and bearers of gospel truths are not sustained within their own communities and presbyteries, when they fall victim to the same symptoms of relational breakdown that are hobbling society, does the salt risk going flat? If it does, who will restore it? At this time, when the call to be salt and light is more urgent than ever, may leaders, formators, and brothers and sisters on the journey have the courage, generosity, and care necessary to begin addressing the serious issue of eating disorders and the toll it is taking, thereby contributing to creating a more nourishing and viable reality for religious life and priesthood.

We can definitely speak of a crisis of intimacy in our society and in religious life, with the epidemic of eating disorders being one of its most serious symptoms. The danger is that this crisis may continue to be left unnamed and unaddressed, with increasingly serious consequences for the physical, emotional, and spiritual health of countless individuals in religious life and, eventually, for the well-being of religious life itself.

As the wisdom of the Chinese language teaches us, every crisis contains both danger and opportunity. The opportunity is for individuals struggling with eating disorders, as well as for their leaders, to take up the challenge of looking long and hard at what needs to be renewed, redirected, and reconfigured so that priesthood and religious life can increasingly become realities that deeply nurture their members — that truly embody a relational lifestyle and ministry that prophetically (counterculturally) witnesses to a God who is relationship and who calls each person into fullness of life through healthy relational living.

RECOMMENDED READING

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