Eating Disorders
RESOURCE CATALOGUE

Treating ED in Adolescents
30 Years of Growth
The Brain
& Anorexia Nervosa
The Genetics
of Eating Disorders

• SELF-HELP BOOKS
• TREATMENT FACILITIES
• PROFESSIONAL RESOURCES
• CONFERENCES
• NATIONAL ORGANIZATIONS

GÜRZE/SALUCORE

ADVANCEMENTS IN THE FIELD // EMERGING RESEARCH // RECOVERY & SUPPORT
Welcome!

A warm welcome to all who come to the pages of our 2018 Gürze/Salucore Eating Disorders Resource Catalogue!

We are honored to have authors who devote much time, energy, passion, and expertise to this resource catalogue. Articles range from a discussion of “Developments in the Treatment of Eating Disorders in Adolescents over the Past 30 Years” to “Queer Body Image” to “Decision-Making, the Brain, and Anorexia Nervosa,” and more. Our excerpts illustrate the outstanding research, recovery tools, and diversity in the field. We are humbled to be able to share the robust information in this edition for you, whether you identify as an individual with a diagnosis, someone in recovery, a professional, a carer, or one of the many other categories that make up those who support eating disorder awareness, recovery, and hope.

I am repeatedly touched by the generosity of our contributors. I also want to thank the many of you who ask a great question: “How do we get the books in your catalogue?” You are most welcome to visit our website, EDcatalogue.com, and click on the heading “Books.” You’ll find what you are looking for alphabetically or by category. When you have chosen your reading material, just click.

If any of you have questions related to treatment, assessments, levels of care, etc., please email or call any of the recovery centers included in the second half of the catalogue. These facilities are here to provide support for you. They regard every individual, every question, and every concern worthy and deserving of respect and care.

Our team here at the catalogue also welcomes your thoughts. We would love to hear from you.

With my continued best wishes and gratitude,

Kathy Cortese
LCSW, ACSW, CEDS
Editor-in-Chief

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World Eating Disorder Healthcare Rights
An AED Global Blueprint for promoting Excellence in Care through Patient-Carer-Professional Partnerships

**ACCESS TO QUALITY CARE**
All patients have the right to immediate care for medical and/or psychiatric instability, followed by timely and non-discriminatory access to appropriate specialty care.

**RESPECT**
All patients, caregivers, and family members have the right to be treated with respect throughout the assessment, planning and treatment process. Patients and carers should never be judged or stigmatized based on symptoms, behaviors or past treatment history.

**INFORMED CONSENT**
When making healthcare decisions, patients and caregivers have the right to full disclosure by healthcare professionals about treatment best-practices, risks, costs, expected service outcomes, other treatment options, and the training and expertise of their clinicians.

**PARTICIPATION**
Families and other designated carers have a right to participate in treatment as advocates for the best interests of their loved-ones. Caregiving responsibilities and degrees of participation will necessarily vary depending on the age, mental state and diagnosis of the patient, as well as the caregiver’s skills, availability, personal health, resources and other circumstances.

**COMMUNICATION**
All patients and carers have the right to establish regular and ongoing communications through clearly defined channels. Caregivers and family members have the right to communicate their observations and concerns to professionals and to receive information when the patient’s medical stability and/or psychiatric safety is threatened or at risk.

**PRIVACY**
All patients and carers have a right to expect their health professionals to understand, communicate, and respect the applicable privacy or age-of-consent regulations that govern the communication of health and treatment information, as well as the circumstances and conditions that may override privacy concerns or transfer authority regarding treatment decisions.

**SUPPORT**
All caregivers have a right to receive information, resources and support services to help them understand and carry out the expectations and responsibilities of their roles as partners in treatment.

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**Guiding Principles**

1. Eating disorders are not lifestyle choices and do not discriminate by age, race, gender, sexual orientation, body size, weight, or ethnicity.
2. All care partners are obligated to act in the best interests of the patient.
3. Eating disorders are treatable and full recovery is possible.

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**Definitions**

**Caregiver or Carer:**
The individual(s) who directly care for the needs of a patient and hold the responsibility of advocating for the patient’s healthcare rights. This is often a parent or legal guardian, spouse, or other family member, but may also be a trusted friend, partner or family member “of choice” for an adult patient.

**Specialty Care:**
Specialty care for eating disorders is treatment administered by professionals with eating disorder specific training and experience, and should be comprehensive, empirically-informed, safe, and leading to recovery.

**Care Partners:**
A team of caregivers and health professionals working together to implement a patient’s treatment plan.
The Status of Treatment Studies for Eating Disorders

Although studies of the treatment of eating disorders in youth have spanned the past 30 years, there is still much to be learned. In adults, there is a relatively large body of literature to guide the treatment of bulimia nervosa (BN). To date, there have been more than 100 published randomized controlled trials (RCTs)—pharmacotherapy, psychotherapy, and combined—with substantial evidence that cognitive behavior therapy (CBT) is the most efficacious treatment for many individuals (Agras et al., 2000). Pharmacotherapy, and fluoxetine in particular, has also received considerable support as an adjunctive treatment for this patient population (Shapiro et al., 2007). While there is clear guidance for the treatment of BN in adults, less is known about the treatment of anorexia nervosa (AN) in adults, and although recovery is possible (Eddy et al., 2017), there is little evidence for the effectiveness of any particular approach for this age group (Bulik et al., 2007; Bulik, 2014).

Family-based approaches have the most evidence and should be the first-line treatment for medically stable youth with restricting eating disorders such as AN (Watson & Bulik, 2013). Despite the clear support for CBT as the leading treatment for adults with BN, there have been only four RCTs for the treatment of BN in youth. The limited evidence base suggests that there is benefit to including caregivers in treatment; however, further investigation is necessary to better inform treatment for this population.
Evidence-Based Treatments for Anorexia Nervosa in Youth

There have been 13 published RCTs for the treatment of AN in adolescents, four of which included a higher level of care such as inpatient medical or psychiatric treatment and/or day programs. The majority (11 of 13) have involved family-focused approaches, while only three studies have included an individual therapy approach. To date, there have been no published RCTs of psychopharmacological interventions.

The predominant models of evidence-based treatment of AN are inpatient treatment for weight restoration in either a psychiatric or pediatric (medical) setting or outpatient psychosocial treatments. Three studies have evaluated inpatient treatment in psychiatric settings. A study by Gowers and colleagues (2007) in Liverpool, England, found no advantage to first-line inpatient psychiatric treatment over outpatient treatment. Those who struggled in outpatient treatment also did poorly when transferred into an inpatient setting. In France, Godart and colleagues (2012) found that the addition of family therapy focused on intra-familiar dynamics, not eating disorder symptoms, improved effectiveness of treatment as usual following discharge from the hospital. A six-site study based in Germany by Herpertz-Dahlmann and colleagues (2014) found that patients in a day program after a short inpatient stay had comparable outcomes to those who completed a longer inpatient stay to achieve weight restoration. These findings suggest that a day program may be a safe and less costly alternative to an extended hospitalization. Madden, Miskovic-Wheatley, Wallis, Kohn, Lock, and colleagues (2015) in Westmead, Australia, found similar outcomes when comparing inpatient admissions in a pediatric medical setting for either a brief medical stabilization or extended admission for full weight restoration—both followed by a course of family-based treatment (FBT). In terms of higher levels of care, there is no advantage to first-line inpatient psychiatric treatment over a day program or outpatient management. The addition of family therapy to treatment as usual, after hospitalization, improves outcome, and weight restoration at home can be successful.

Outpatient psychosocial treatment is the second predominant model for the treatment of AN in youth. Three primary models of outpatient treatment have been evaluated. FBT aims to empower parents to manage symptoms early in treatment, and parent-focused treatment (PFT) utilizes a very similar approach without the patient participating in the treatment session. Whereas systemic family therapy places the focus on the family system to draw on their existing strengths, adolescent-focused therapy (AFT) is an individual therapy that aims to promote self-efficacy, self-esteem, and self-management of eating problems.

A United States–based study compared FBT with AFT and found that FBT brings about faster weight gain in early treatment, with fewer days of hospital admission (Le Grange et al., 2014; Lock et al., 2010). Therefore, FBT is more efficient than AFT in facilitating remission at short-term (6- and 12-month) follow-up (Lock et al., 2010). However, at four-year follow-up, AFT “catches up” with FBT and remission rates are stable (Le Grange et al., 2014). The Research in Anorexia Nervosa trial compared two family therapies (FBT and systemic family therapy) at six outpatient North American clinics. FBT was found to bring about faster weight gain earlier in treatment, with fewer hospital days; however, there were no differences at end of treatment (EOT) (Agras et al., 2014). In Melbourne, Australia, Le Grange and colleagues (2016) compared PFT with FBT and found that weight restoration was accomplished more efficiently in PFT where the adolescent was monitored by a nurse and did not participate in the treatment session. Eisler and colleagues (2016) compared multifamily and single-family therapy treatment formats across six specialist eating disorder services in the United Kingdom near London. At EOT, the multifamily group fared better, with significantly more participants in the good- or intermediate-outcome categories, but this statistical advantage was not maintained at follow-up. According to the authors, their study furthers the evidence for typical single-family approaches and confirmed the utility of an intensive multifamily format.

Based on the evidence thus far, FBT should be the first-line outpatient treatment for adolescents with AN who are medically stable, and it seems to be particularly effective at reducing the need for hospitalization. In addition, there is support for both intensive multifamily formats, as well as separated formats (PFT), of family therapy. AFT and systemic family therapy are both feasible alternatives when FBT is not an option (Agras et al., 2014; Le Grange et al., 2007).
Decision-Making, the Brain, and Anorexia Nervosa

BY / MARIYA BERSHAD, BA, DEBORAH R. GLASOFER, PHD, JOANNA STEINGLASS, MD & EVELYN ATTIA, MD

From skipping the mayo at the sandwich bar to counting macros on a fitness app, dieting occurs in up to three-quarters of healthy adults. In a society full of media outlets promoting the lean, fit ideal, it is no surprise that dieting—attempting to restrict caloric intake in order to change weight—is quite common among adolescent women. But what happens when a diet becomes a lifestyle—or an illness?

It is easy to imagine a scenario in which a teenage girl starts giving her nutrition a bit more attention. Whether it is a “clean eats” blog that provides recipes and photos, or a high school health class that brings attention to food groups, the initial motivation often comes with reasonable intentions and certainly does not intend physical or psychological harm. Efforts to eat “healthy” or lose a few pounds may not always be successful. However, an initial drop in the number on the scale is certainly possible—and can be very rewarding, especially if weight loss is accompanied by compliments from peers. In a social environment like high school, this initial weight loss can become associated with acceptance and improved social status. With such positive reinforcement, swapping cookies with fruit can begin to require less and less mental effort. Eventually, cookies—initially enjoyed in moderation—can become totally off-limits, and low-calorie “meal preps” can turn into rigid, daily rituals; what is risky is when “healthy” lifestyle changes turn into routines that feel impossible to get rid of.

These restrictive eating behaviors are initially goal-directed, meaning motivated by intent to achieve a particular outcome such as weight loss. Any behavior, when reinforced, gets repeated. With repetition, over time, the outcome (or reward) matters less and less, and then not at all—the behavior persists because of the cue, not because of the outcome. This is called stimulus-response.
Diagnosing Anorexia Nervosa

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in a way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

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learning, or habit formation. Goal-directed behaviors and habitual behaviors are associated with different brain mechanisms (Figure 1).

In many cases, habits are extremely useful in allowing our minds to perform efficiently. For example, making your bed and tidying up every morning can provide the initial reward of a clean room to come home to—soon enough, the behaviors can get linked together into a routine that requires little effort. However, when these behaviors include making certain foods off-limits and limiting oneself to rigid meal routines, the habits that are formed may not be so useful—in fact, they can be pathological. Could the same brain mechanisms that help create our morning routines also help create rituals that promote eating disorders like anorexia nervosa (AN)?

One way to test this hypothesis is by examining the brain mechanisms guiding food choice among healthy individuals compared with individuals with AN.

Why Study Food Choice?

With a disorder as complex as AN, there are plenty of important areas of research: biological, psychological, and sociocultural. Behaviorally, one feature that is central to the illness—and contributes most to the morbidity and mortality—is persistent caloric restriction.

Individuals with AN limit calorie intake—and specifically restrict fat in their diet. In addition, studies have shown that the more rigid a patient’s diet, the more likely he or she may be to relapse following treatment. This suggests that dietary patterns have an impact on the chronicity of the illness and its resistance to change—even among motivated individuals who desire treatment.

Furthermore, while it is important to study psychological components of AN (such as depression, anxiety, obsessionality, and compulsivity), not eating and the inability to maintain adequate weight are primarily what lead to hospitalization and the high rates of morbidity and mortality. Understanding the tendency to choose low-calorie, low-fat foods is therefore essential to understanding AN.

The Brain, Behavior, and Mental Illness

Neural mechanisms of AN are not yet clear—but why care about the brain mechanisms of behavior and mental illness in the first place? Historically, mental illnesses were distinguished from other medical illnesses because they were seen...
to be related to “higher cognitive processes referred to as the ‘mind.’” This view contributed to stigma around mental illness and drew medical resources away from mental health. While the relationship between mind and brain continues to be discussed in modern philosophy and psychology, contemporary psychiatry studies mental disorders as illnesses that “manifest as mind and arise from brain.” Brain-based models of disorders like depression have been developed and tested using animal models, neuroimaging, and other techniques that probe the brain. Research in brain mechanisms of mental illness can help identify diagnostic markers and lead to targeted treatment development. Identifying brain processes underlying AN can yield new directions for psychotherapeutic and pharmacological interventions.

The Eating Disorders research team at Columbia University Medical Center, including Joanna Steinglass and Daphna Shohamy, developed an approach to investigating brain mechanisms of restrictive eating. They administered a food-choice task during fMRI scanning. In this study, individuals with AN and healthy volunteers were asked to rate images of food based on healthiness, tastiness, and personal preference. As predicted, individuals with AN were less likely to prefer the high-fat foods. Importantly, the individual’s behavior in the task (i.e., how often the person selected the high-fat foods) was significantly correlated with actual food intake in a lunch meal, indicating that the computer task is capturing restrictive eating. The fMRI findings revealed an interesting difference in neural activation patterns between individuals with AN and healthy peers. Consistent with the investigators’ hypothesis, among individuals with AN—and not among healthy controls—the dorsal striatum was associated with food choice. The dorsal striatum is a brain region that may be associated with habit formation.

Treatment Implications

A habit-based model can help explain the persistence of the illness despite treatment and the elusiveness of lasting recovery for some patients. It can also guide new directions for treatment, including habit-busting interventions.

Understanding the tendency to choose low-calorie, low-fat foods is therefore essential to understanding AN.

Techniques that focus on changing habits are well-supported in the treatment of tic disorders and trichotillomania. This approach aims to help patients become more aware of the cues that set their routines in motion and, ultimately, develop alternate responses to the cues.

The Eating Disorders research team, including Steinglass and Deborah Glasofer, has attempted to do something similar with patients with AN. It is developing and studying an approach called REACH (Regulating Emotions and Changing Habits) to teach patients with AN to identify...
cues, develop new routines, and better manage uncomfortable feelings that can arise when trying to change behavior. In the REACH framework, a patient starts by tracking routines and their earliest cues. The therapist and patient then work together to develop alternate responses to the cues. This could involve a simple, competing response—a counteraction that is wholly incompatible with the target behavior—or a strategy to alter the environment to encourage a different behavior. When behavior change brings with it anxiety or sadness, patients are taught how to use relaxation exercises or to recall their “big picture” reasons for wanting to change. As patients try on new behaviors to break old habits, they are encouraged to notice the positive outcomes—the rewards—that result from behavior change. In the team’s first test of this approach, REACH was associated with a significant decrease in the strength of the habits that patients identified and was also associated with improvement in food intake.

By asking critical questions about the link between brain and behavior, researchers are learning more and more about eating disorders like AN—and putting these insights directly into practice.

REFERENCES
Diagnosing Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

by the American Psychiatric Association, excerpted from Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) © 2013 by American Psychiatric Publishing

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50 Strategies to Sustain Recovery from Bulimia
Jocelyn Golden
221 pages, paper, 2011

The Mindfulness & Acceptance Workbook for Bulimia
Emily K. Sandoz, Kelly G. Wilson & Troy DuFréne
137 pages, paper, 2011

The Dialectical Behavior Therapy Skills Workbook for Bulimia
Ellen Astrachan-Fletcher & Michael Maslar
192 pages, paper, 2009

Bulimia: A Guide to Recovery
Lindsey Hall & Leigh Cohn
280 pages, paper, 2010

My Name Is Caroline, Second Edition
A Candid, Hard-Hitting Account of a Seven-Year Descent into Bulimia, Leading Up to a Final Victorious Triumph over the Addiction
Caroline Adams Miller
285 pages, paper, 2014

Positively Caroline
How I Beat Bulimia for Good... and Found Real Happiness
Caroline Adams Miller
278 pages, paper, 2013

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2018 Eating Disorder Conferences

- **February 26–March 4, 2018**
  National Eating Disorders Awareness Week

- **March 22–25, 2018**
  Orlando, FL
  The International Association of Eating Disorders Professionals Foundation
  Focus on Neuroscience: Magic of the Mind and Language of the Body

- **April 19–21, 2018**
  Chicago, IL
  Academy for Eating Disorders Innovation;
  Expanding Our Community & Perspectives

- **May 12, 2018**
  Philadelphia, PA
  National Eating Disorders Association’s First Regional Conference
  Drexel University

- **November 9–11, 2018**
  Philadelphia, PA
  The Renfrew Center Foundation
  Feminist Perspectives and Beyond:
  Cultivating Hope in an Age of Discovery

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Request free copies of the 2018 Görze/Salucore Eating Disorders Resource Catalogue at EDcatalogue.com
Help is Only a Call, Text, or Click Away with the National Eating Disorders Association (NEDA)


If you are concerned about your food or exercise habits, there are a few different ways to reach out for help with NEDA:

- Call the National Helpline at **(800) 931-2237**
- Text ‘**NEDA**’ to **741741** for 24/7 crisis support
- Visit [www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org) to take an online eating disorder screening or chat with the National Helpline

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**Save the Date:** **NEDAwareness Week | Feb. 26 - Mar. 4, 2018**

Follow **#NEDAwareness** to get involved in National Eating Disorders Awareness Week!

**NEDA Walks: Recovery Starts Here**

Visit [www.nedawalks.org](http://www.nedawalks.org) to find a walk near you today!
As an outpatient internal medicine physician who specializes in eating disorders, I get to work on the front lines with therapists and dietitians, helping promote recovery work within the context of an individual’s everyday life. Some of my patients have never needed to step up to a higher level of care, and others arrive at my clinic having just completed their first, or 10th, full course of residential, partial hospitalization program, and intensive outpatient program care. I take care of adolescents and adults, of all shapes, sizes, and genders, with disordered eating and eating disorders.

The patient has responsibilities to continue to earn the privilege of remaining outpatient.
There are four key topics that this article will cover. One, I will review guidelines for appropriateness of outpatient care. Two, I will highlight the main considerations medically for those who purely restrict ... whether that occurs in the setting of low body weight, so-called normal body weight, or higher body weight. Three, I will discuss the major medical issues in those who purge. Finally, I will consider important weight-stigma-associated mistakes practitioners make and highlight the importance of a Health at Every Size® approach for those with binge eating disorder and patients in general. Of course, a comprehensive review of this set of topics would take a whole book, so I will review each topic briefly.

An outpatient with an eating disorder should have a multidisciplinary team, composed of at least a therapist and a dietician who have eating disorder expertise. Optimally, a physician with eating disorder knowledge—or a willingness to learn—should join this team so that the therapist and dietician are not required to step out of scope of practice and advocate for/interpret medical care. This team can certainly be joined by many other practitioners, from a psychiatrist to any number of specialists as needed. The team has the responsibility of communicating regularly with one another, allying always with the recovery process and one another to provide a united front against the pressure of the eating disorder, and should take a non-assumptive, patient-values-oriented approach. That is, when patients identify their top motivations to get better, and the team continually refocuses the recovery struggle around those motivations, patients feel they are being seen as a whole person. The physician can productively demonstrate objective evidence of body suffering from the eating disorder and use that to help patients understand that they are sick enough to progress with the recovery process. Many patients feel, in the throes of the mental illness, that they are “fine” and, therefore, have no reason to make changes in their eating-disordered behaviors.

Just as the team has responsibilities to the patient, the patient has responsibilities to continue to earn the privilege of remaining outpatient, rather than stepping up to a higher level of care. Outpatients should be seeing their multidisciplinary team regularly and need to grant open communicative access among those team members. Patients need to be able to follow, for starters, the fundamental medical rules that the team establishes: consuming (and not purging) a basic, sustaining number of calories each day; purging infrequently enough that blood laboratory values are minimally abnormal; moving physically at a level approved by their medical provider (and no more); and using substances in ways that appear safe in the outpatient setting. There may be other rules that the therapist establishes for safe outpatient care, related to self-harm, suicidality, and severity of comorbid psychiatric conditions. To remain in the outpatient setting over time, patients need to show at least slow progress toward recovery, or be able to maintain goals recently achieved. The rate of progress required will depend to a certain extent upon the patient’s individual presentation. A young teenager, for instance, with new onset anorexia nervosa, should make consistent weight gain progress of at least 1 to 2 pounds per week in the outpatient setting. On the other hand, a middle-aged patient with a lifelong eating disorder might be permitted to maintain a low body weight in the service of a harm reduction model, if that patient feels unable to progress with the recovery process. Many patients feel, in the throes of the mental illness, that they are “fine” and, therefore, have no reason to make changes in their eating-disordered behaviors.

Diagnosing Other Specified Feeding or Eating Disorder

This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The other feeding or eating disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder.

by the American Psychiatric Association, excerpted from Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) © 2013 by American Psychiatric Publishing
Binge Eating

Relapse Prevention
FOR BINGE EATING DISORDER

BY / JULIE FRIEDMAN, PHD & KARA RICHARDSON WHITELY

With the advent of DSM-5, binge eating disorder (BED) was elevated to the status of full-fledged eating disorder diagnosis and a separate entity distinguishable from other feeding and eating disorders versus a residual “eating disorder not otherwise specified.” DSM-5 also lowered the diagnostic threshold for BED by decreasing the frequency and duration of symptoms needed to meet diagnostic criteria. Research suggests that the impact of DSM-5 was to successfully reduce reliance on the residual “unspecified” category and provide further differentiation between types of eating disorder psychopathology (Nakai et al., 2017). In addition, the severity specifiers (mild-severe as determined by frequency of binge-eating episodes) seem to provide some clinical utility, with significant between-group differences observed in treatment outcome. As expected, patients with “mild” BED showed greater rates of abstinence from binge-eating episodes following treatment than patients with “severe” BED (Dakanalis et al., 2017).

With regard to treatment efficacy, cognitive behavioral therapy (CBT) (in both guided self-help and therapist-led forms) is the most well-established psychological treatment for BED (Wilson & Shafran, 2005), with studies showing the efficacy of CBT in generating both immediate reductions in behavior and long-term maintenance of treatment gains (Hilbert et al., 2012). The scope of adjunctive and combination therapies in concert with CBT is too large for this paper, but, interestingly, recent findings (Grilo, Reas, & Mitchell, 2016) show that pharmacotherapy plus CBT yields more effective treatment than pharmacotherapy alone, yet does not significantly change the impact of CBT alone. More research is needed to establish pharmacotherapy guidelines in the long term, owing to small sample sizes and other methodological concerns.

Through an interwoven recovered patient and provider perspective, the present writers would like to highlight the need for deepening the work of CBT for BED by highlighting cognitive and psychological variables that, if adequately addressed by CBT, could augment treatment outcomes and enhance CBT’s focus on relapse prevention—thus, creating more individualized, more effective, and more efficient treatment for patients. We suggest that the following variables (if present) be attended to, along with the traditional overconcern with weight and shape and dietary restraint focus of CBT:

1) Impulsivity and Negative Urgency. Negative urgency is defined as the tendency to behave impulsively or engage in rash, ill-considered decision-making in response to a negative or intense affective state. A recent study (Manasse et al., 2016) showed that working on emotion-regulation skills is inadequate in producing decreases in the tendency to manifest impulsive behaviors.
secondary to negative affect. The authors concluded that an explicit focus on developing skills for delaying or withholding impulsive responses in the context of strong negative emotion is necessary for those patients with high negative urgency and impulsive responses to food cues when stressed. Skills such as noticing the urge to binge and responding to it nonemotionally and nonjudgmentally (thought defusion): “urge surfing” and “urge postponement,” in which patients are taught to delay responding to urges to binge in a series of sequential steps; and formal problem-solving skills would all effectively address negative urgency and can be easily incorporated into a CBT protocol.

As someone who learned to use food at age 9 after my parents’ divorce and then took a deep dive into binge eating disorder at age 12 after being sexually assaulted, I’ve spent my adult life trying to undo an eating disorder that consumed me. I’ve even climbed Mount Kilimanjaro three times in search of answers.

The most daunting and difficult parts of the recovery journey have been when I’ve relapsed, especially after that first climb, after the birth of my oldest daughter. Veering off-path is so shrouded in shame and embarrassment, but each tumble off-trail has helped me get back up stronger and faster.

As my coauthor has taught me, binge eating disorder is squarely based in neurobiology; thus, my treatment had to “rewire” my brain. In this life, where one must have food to survive, I had to learn how to adapt differently to the brain I have. I still have the same urges and vulnerabilities and I’ve had relapses, but the key is responding to them differently.
The days of seeing a patient with a single diagnosis of an eating disorder are becoming a rarity. The comorbidities that accompany binge eating disorder (BED) include substance abuse, depression, anxiety, post-traumatic stress disorder, personality disorders, and thought disorders. Patients usually present with more common complaints of fatigue, sleeplessness, lack of energy during the day, lack of motivation, and feeling helpless to address their weight issues. Today, most patients can lose weight and have used various programs over the years to do so. The one common complaint is that they can’t keep the weight off. The frustration of yo-yo dieting and feeling like a failure keeps our patients from pursuing our help.

Today, the therapist, dietitian, psychiatrist, and internist have to deal with not only patients’ body image and their belief system around their weight, but also now the fact that the influx of information on the internet and television, in email and texts, in advertisements for “weight-loss products,” and about various workout options raises patients’ hopes and expectations. They can fall into the “what if” and “if only” position of being a victim of their BED. It is not unusual to see a patient who has been on several medications for hypertension, hypercholesterolemia, diabetes, depression, and numerous other medical issues. These patients may also present with a list of “natural supplements” they feel are necessary to “be healthy.” Their previous psychiatric history may show that they are addicted to alcohol or amphetamines. A medical condition might have progressed to the point that they need a risky surgery that is prohibited because of their weight. The patient may be in chronic pain and have limited mobility. The answer to how medications interact with substances and natural remedies is not available to providers. The picture becomes more complex and puzzling.

The unifying feature of BED for patients is the feeling of loss of control over their eating.
Diagnosing Binge Eating Disorder

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:
   1. Eating much more rapidly than normal.
   2. Eating until feeling uncomfortably full.
   3. Eating large amounts of food when not feeling physically hungry.
   4. Eating alone because of feeling embarrassed by how much one is eating.
   5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

by the American Psychiatric Association, excerpted from Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) © 2013 by American Psychiatric Publishing

food online with their phone, charging food, and having it delivered opens a pattern that allows a person to binge in private and is a challenge for providers. Many patients will binge and then their guilt and self-loathing become overwhelming. The idea that they may stop once they have started to binge is ludicrous to most patients.

The physiological changes that accompany taking in large amounts of food include such challenges as the loss of a feeling of satiety, the inability to regulate high blood sugar levels, and a loss of the ability to make good choices (sometimes referred to as a brain fog) after binging.² Their blood sugar levels may peak, then drop suddenly, leading to fatigue or dizziness.² The additional weight may lead to joint damage and poor mobility, making movement and exercise difficult. Those with BED often struggle with chronic problems such as diabetes, congestive heart failure, respiratory problems, body rashes, and many more physiological consequences of having excess body weight.⁴ The patient can start to feel trapped in a behavioral and psychological web.

The idea that people are just “weak” if they can’t control their weight is a message that society has perpetuated. There is a social stigma not only among the general population, but also among health care providers toward obese individuals.

How do people who have been on the receiving end of this discrimination feel good about their social interactions? Professionals know that binge eating numbs some of the feelings of isolation, sadness, and anger that trigger the behaviors. It has been a struggle for patients to get access to quality treatment to learn the appropriate tools for self-acceptance and change. Insurance companies still do not see BED as a disease that requires inpatient care. Why must patients get to the suicidal point with their depression and hopelessness in order to finally get treatment? It is a question that plagues providers—the idea that crisis intervention is the only means to treatment and that preventive or ongoing supportive treatment is “too expensive.”
Most eating disorders professionals recognize that negative body-image issues are the bookends of the struggle with an eating disorder. They are typically the first to show up and the last to leave. Quite often, individuals become embroiled in a full-blown eating disorder as a result of first wrestling with negative perceptions about their bodies, and then attempting to use food restriction, excessive exercise, or dieting as a solution. And the struggle with negative body image usually continues long after the eating disorder behaviors have ceased.

The prevalence of negative thoughts about the body is pervasive even for those who do not have diagnosable eating disorders or disordered eating patterns. As a result of our fat-phobic, diet-obsessed modern culture and a media that perpetuates an unrealistic ideal of beauty as excessively thin, flawless, and youthful, most of us have had to deal with negative thoughts about our appearance.

For those with eating disorders, however, and for some whose bodies do not fit the body-ideal of the culture, a negative body image can be crippling, often causing them to limit their lives extensively, leading to self-harm and life-endangering behaviors with food and exercise.

While it is important to challenge the constant fat-phobic messages from the culture, which emphasize an extremely narrow form of beauty, it is also necessary to address the messages that individuals who struggle with negative body image have already internalized—and believe to be absolutely true. Challenging those messages and shifting perceptions can be difficult, however, if an individual has spent a lifetime absorbing and believing them, either consciously or unconsciously.

One of the most powerful ways to transform perceptions is through the language of metaphor and the use of storytelling. Humans have always turned to story at those times when reason alone cannot help, those times when everything in the culture seems stacked against them. In times like those, it is a different story that is needed, personally and collectively, one that can go deeper into the psyche and ring "more true" than the old story that has been perpetuated, internalized, and used maladaptively in an attempt to cope with pain or fear, or in order to find a way out of a troubling situation.

Many ancient cultures made sense of the world they lived in through two ways of looking at and thinking about the world. The Greeks called them "logos" and "mythos." Logos seeks to find objective truths and definitive explanations that can be proved with observable facts, statistics, controlled experiments, and logical thought processes.

Unfortunately, when attempting to resolve negative body image, logos often fails us. Extreme fear of fat does not make sense and cannot be explained away, logically. Neither facts nor research support the current shame-based "war on obesity," which is doing more harm than good for those who struggle with negative body image. Body shaming of those who don’t meet the cultural ideal can create and perpetuate eating disorders, and exacerbate negative body image. Logos is of little assistance for those with negative body image who grew up being
told that fat is bad and who live in a culture that continues to misguided embrace that distorted and harmful belief.

The other way of viewing the world, mythos, uses a more imaginative and intuitive approach—and makes use of metaphor, stories, and imagery. While the power of logos lies in reason, the power of mythos lies in the imagination. While logos can be used to help us understand the realm of matter, mythos helps us get to the heart of the matter.

It is mythos that is more useful when logic fails us, when the facts don’t add up or are treated as irrelevant, as in the case of negative body image. Logically, we can understand that the beauty-ideal of the culture is unobtainable and that the messages of the media are manipulative. We can bemoan the pressures our culture places on our physical appearance, but logic alone often is not enough to keep those messages from penetrating our psyches. We need a different story so we can imagine a different, truer reality.

In our modern culture, one that prides itself on a rational, logical way of viewing the world, the term myth is often used synonymously for that which is not true. However, in traditional cultures, it was used to describe deeper truths that cannot be accessed by logic. Myths are those stories that are false on the outside but true on the inside. Myth can make the most sense when everything else seems to make less sense. The term mytho-logical suggests that myth has its own kind of logic and power. It can be a way of addressing situations that tend to defy logic and rationality, and can provide surprising solutions when logos fails.

Such is the case when dealing with the psychological processes involved in negative body image. Pointing out the “facts” to someone struggling with negative body image is often not useful for addressing belief systems that have been locked into place, remaining resistant to logical inquiry regardless of their irrational nature.

Stories, however, speak to us in the imaginative language of mythos and metaphor, and can bypass those deeply entrenched belief systems, allowing us to affect unconscious beliefs through the transformative power of the imagination, bringing about a greater awareness of a deeper, more profound truth.

This article continues and can be found in its entirety at edcatalogue.com.
Does This Feel Familiar? For Mothers of Children Struggling with an Eating Disorder

BY / LARA LYN BELL

HOW CAN I BE A BENEFIT TO MY CHILD’S HEALING RATHER THAN A HINDRANCE?

Have patience! Listen and then stand firm in your compassionate personal discipline and boundaries. The family unit is always complex. Good parenting should be based in love, and with experience, we do get better. Do not settle into believing your child will always have an eating disorder and/or that your family is unable to evolve into a more functional, loving unit. Everyone in the family has to do the work. The work begins with knowledge. The work should always be based in love, not in ego or control.

Try not to be defensive or resist new ideas. Relinquish the guilt and keep moving forward, understanding that it may be three steps forward and one step back, sometimes you level out, and sometimes you might even go backward. Always keep your eyes locked on the bigger picture—a healing, well-adjusted, and healthy child. Set it in your mind’s eye now that healing will happen. Your perception of how you see yourself in the role as a parent will affect the way your child will respond to you.

• Set boundaries intended to keep your child safe. Positive boundaries are not a parental “power play,” and we know the difference within our own selves. Safe, positive boundaries take more explanation and time. Your child eventually recognizes your intentions are on their behalf, and they do feel safe.

• Speak with firm, but loving, words. Mind your words in a mature and reflective way. Your voice is powerful—both positively and negatively.

• Establish a relationship of respect. Respect is a two-way street.

• Listen without judgment.

• Be an example. We hear this all the time, but how do we really implement being an example? Body language is the first impression; a frown, unhappy expression, lack of touch, and crossed arms says it all in a second. Being an example begins with how we manage our adult demeanor.
RECOMMENDED READING

Anorexia Nervosa, Second Edition
A Recovery Guide for Sufferers, Families, and Friends
Janet Treasure & June Alexander
192 pages, paper, 2013

Ed Says U Said
Eating Disorder Translator
June Alexander & Cate Sangster
288 pages, paper, 2013

Family Eating Disorders Manual
Guiding Families Through the Maze of Eating Disorders
Laura Hill, David Dagg, Michael Levine, Linda Smolak, et al.
227 pages, spiral-bound, 2012

My Kid Is Back
Empowering Parents to Beat Anorexia Nervosa
June Alexander with Daniel Le Grange
272 pages, paper, 2010

Surviving an Eating Disorder
Strategies for Family and Friends
Michelle Siegel, Judith Brisman, & Margot Weinshel
222 pages, paper, 2009

Give Food a Chance
A New View on Childhood Eating Disorders
Julie O’Toole
320 pages, paper, 2015

Helping Your Child with Extreme Picky Eating
A Step-by-Step Guide for Overcoming Selective Eating, Food Aversion, and Feeding Disorders
Katja Rowell & Jenny McGlothlin
240 pages, paper, 2015

Anorexia and Other Eating Disorders
How to Help Your Child Eat Well and Be Well
Eva Musby
450 pages, paper, 2014

Helping Your Teenager Beat an Eating Disorder, Second Edition
James Lock & Daniel Le Grange
310 pages, hardcover/paper, 2015

Throwing Starfish Across the Sea
A Pocket-Sized Care Package for the Parents of Someone with an Eating Disorder
Charlotte Bevan & Laura Collins Lyster-Mensh
96 pages, paper, 2013

Helping Your Dieting Daughter, Second Edition
Antidotes Parents Can Provide for Body Dissatisfaction, Excessive Dieting, and Disordered Eating
Carolyn Costin
256 pages, paper, 2013

Skills-Based Caring for a Loved One with an Eating Disorder, Second Edition
The New Maudsley Method
Janet Treasure, Gráinne Smith & Anna Crane
294 pages, hardcover/paper, 2016

A Short Introduction to Understanding and Supporting Children with Eating Disorders
Lucy Watson & Bryan Lask
112 pages, paper, 2016

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Eating disorders are frequently misunderstood—not only by family and friends, but also by health care professionals. It is essential, in order to be helpful and effective to a person diagnosed with an eating disorder, that people understand the nature of eating disorders.

One aspect of the nature of eating disorders is the “eating disorder voice,” which most people with an eating disorder will attest to knowing. This “voice” is the near-constant dialogue or self-talk that a person experiences as a result of the illness and makes it feel as though one has two brains. There is the healthy brain, which recalls what life was like before the eating disorder. The healthy brain voice remembers enjoying food, not thinking about food all the time, not overanalyzing every aspect about food, and not torturing the person with thoughts about having eaten too much, where and how to purge next, and getting fat. The eating disorder part of the brain, or the “eating disorder voice,” is the monkey on one’s back that feeds the stream of lies about both food and body. Researchers have identified this “voice” and state that it can be helpful for clinicians to address it with a person both in terms of content and how the person with an eating disorder responds to it. In addition, research has shown that a more powerful eating disorder voice is associated with a lower body mass index in those with restricting-type eating disorders.

It is advantageous to the individual with the eating disorder for that person’s treatment providers and family and loved ones to know and understand what that voice says and how to respond to it.

Some situations and examples:
A person has anorexia nervosa and compulsive-exercise or exercise-purging behaviors. The individual states that he cannot eat unless he exercises or “burns off” enough calories, or he states that he can’t be still, as movement helps him relax. Yes, movement does help most people relax, but excess movement (movement that continues despite pain, exhaustion, and too little fuel) is the work of an eating disorder.
Professionals, family, and friends do not need to give in to the individual’s pleas to continue to work out, stay in competitive sports, etc., as those pleas are the voice of the eating disorder.

The “eating disorder voice” will create intense negotiations over how much food to eat, or it will create food rules about what foods are “good” and what foods are “bad” or when and how to eat. This is seen in all eating disorders, including binge eating disorder. You might notice that it takes a person a very long time to make up her mind about what to eat. Or, if this person eats one thing, she can’t eat another thing. It is helpful for supportive others to call out reality here. Tell the person in a kind manner what you notice, and then separate the illness from the person. Say something like, “I notice that if you eat bacon, you will not put butter on your toast.” This occurs because the “eating disorder voice” might be saying something about “too much fat.” Especially if this is a person who restricts and needs to gain weight, call out the reality that her restriction is what is unhealthy, that she does need to gain weight, and that this one meal is not going to result in any type of drastic physical change. Tell her that you are sorry the “eating disorder voice” made that statement personally what the “eating disorder voice” can dish out. Don’t! If you understand the nature of eating disorders, you will know to not take that voice personally. It is the voice of delusion and fear. It is the eating disorder protecting itself. Stay calm, even when you are being yelled at. Later, you can state that you understand the person did not want to hurt or insult you and you are sorry the “eating disorder voice” made it so hard on that person. Many people with an eating disorder feel terrible if they have become enraged as a result of their illness. They feel bad enough about themselves, and do not need a lecture from us. Rather, they need compassionate understanding, and they need us to get on their side against the eating disorder voice.”

The “eating disorder voice” can be very nasty. Many health care professionals, family, and friends, at times, find it hard to not take personally what the “eating disorder voice” can dish out. Don’t! If you understand the nature of eating disorders, you will know to not take that voice personally. It is the voice of delusion and fear. It is the eating disorder protecting itself. Stay calm, even when you are being yelled at. Later, you can state that you understand that the person did not want to hurt or insult you and you are sorry the “eating disorder voice” made it so hard on that person. Many people with an eating disorder feel terrible if they have become enraged as a result of their illness. They feel bad enough about themselves, and do not need a lecture from us. Rather, they need compassionate understanding, and they need us to get on their side against the eating disorder and its “voice.”

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It was the morning of my first big photo shoot as a plus-size model and I was excited—and hungry! On the way to the location, I picked up a big box of chocolate and cinnamon rugelach from my favorite bakery for everyone to nosh on as we worked, then wondered if they would all say, “Of course the plus-size model would bring in something fattening to eat!” I wouldn’t care if they did. I was in such a great mood that nothing could bring me down.

My recent career after studying on a full rowing scholarship at Syracuse University was as a local reporter for NBC in Arizona. Then, at age 26, I transplanted to New York to embark on a new career as a plus-size fashion model with Ford Models. I loved my new vocation because I enjoyed exploring what we considered “beautiful” in our culture and other cultures, and why. As a plus-size model, I would be challenging and expanding society’s definition of “beauty.”

I arrived early at the West Side loft rented for the shoot to find a crew of 10 people already prepping—makeup artists, hair stylists, two wardrobe stylists, and various assistants. The only ones who hadn’t arrived yet were the photographer and his assistants.

The room was abuzz with activity. We were photographing an ad for blue jeans that day. It would be one of the first full-figured ads to be published in major magazines and on billboards. It was a big deal, and I was the model the client chose!

I was about to earn more money in one day than I usually made in a month. But it wasn’t about the money. I could feel something great was going to happen. We were on the verge of a new way of looking at women, we were nurturing a change in attitude about body shapes, and this shoot would symbolize it.

Enter the photographer, who has worked with the biggest publishers and fashion magazines in the world: Vogue, Elle, Harper’s Magazine, Marie Claire, and Cosmopolitan. I was beyond thrilled that I was going to be in front of his lens that day. Except, he wasn’t quite what any of us expected. He showed up to the loft looking dirty and disheveled, and seemingly drunk (or hungover?) from the night before.

 Barely giving others a nod, he strode to the back of the loft where I was being made up, my hair in Velcro rollers, and looked around.

Of course the plus-size model would bring in something fattening to eat!
“Where's the model?” he asked everyone, and no one in particular.

We all looked at each other, wondering if he had bad eyesight or something. I was sitting right there, three feet away from him. I raised my hand slowly.

“Hi, I'm Emme. Nice to meet you.”

The photographer looked at me blankly, and then his whole face pinched as he grew horrified.

“I am not shooting this fatty!” he yelled, and stormed across the room and out the door, slamming it.

We all froze and no one said a word. A minute later, I could feel someone expertly place tissues under my eyes—it was the makeup artist and her assistant, worried I'd start crying and ruin their hour and a half of careful makeup application.

They didn't have to worry; I wasn't upset, I was angry! How dare he speak to me or anyone, that way?  

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**RECOMMENDED READING**

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<th>Title</th>
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<td>Embody</td>
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<td>50 More Ways to Soothe Yourself Without Food</td>
<td>Susan Albers</td>
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**EXCERPTED FROM “SHAPE SHIFTING” BY SUPERMODEL EMME, CHICKEN SOUP FOR THE SOUL: CURVY & CONFIDENT © 2016 CHICKEN SOUP FOR THE SOUL, LLC. ALL RIGHTS RESERVED. 384 PAGES, PAPER.**
Eating disorders are heritable illnesses. Family and twin studies show that first-degree relatives of people with anorexia nervosa, bulimia nervosa, and binge eating disorder are more likely to develop these illnesses than relatives of controls with no history of eating disorders (Thornton, Mazzeo, & Bulik, 2010). Twin studies have found that when one twin has an eating disorder, if the other twin is identical, the twin has a greater chance of also having an eating disorder, compared with a fraternal twin who only shares 50 percent of the sibling’s genes. Family and twin studies have produced robust findings. Nevertheless, a criticism has been that environmental factors rather than genetics may explain the liability, since people raised together are also exposed to a common environment. Specialized analyses implemented in twin studies have shown that shared environment does not contribute to risk for these disorders. Adoption studies can shed light on this issue but are difficult to conduct. Only one adoption study in the eating disorders field has been carried out; the outcome variables were disordered eating such as overall eating pathology, body dissatisfaction, and binge eating, and not clinical eating disorders, because the large sample size necessary was not available (Klump, Suisman, Burt, McGuie, & Iacono, 2009). The adoption study found that genetic factors had a significant influence on all forms of disordered eating, and that shared environmental factors did not contribute to any outcome variable.

These studies turned the tide on knowledge of eating disorders, which, prior to this time, had been thought to be the result of only social, cultural, and family factors. Ascribing eating disorders with a part-genetic basis was a significant development in the field and suggested that there existed new, unexplored biological targets for treatment and prevention.

Twin and family studies cannot take one much further than establishing heritability. Other study designs, such as candidate gene studies and family linkage studies, followed, seeking to pinpoint the precise genetic loci responsible for the genetic effects. But the results from these studies were not consistent and showed a lack of replication (Yilmaz, Hardaway, & Bulik, 2015). As it turns out, this lack of replication is to be expected if, instead of a few specific genetic loci influencing risk, the picture is much more complicated with potentially many thousands of genetic loci, each contributing very small effects, as is now thought to be the case for eating disorders (O’Donovan, 2015; Sullivan, Daly, & O’Donovan, 2012).

Genome-wide association (GWA) studies have been used in biological research to elucidate complex genetic architecture. GWA studies scan the entire genome and identify the parts of the genome that differ between people with an eating disorder and controls who do not have an eating disorder. GWA studies have been applied to anorexia nervosa so far, but not bulimia nervosa or binge eating disorder (Duncan et al., 2017). A constraint of GWA studies is that they require a large number.
of participants to statistically detect risk loci across the genome. Large consortiums—interconnected, global, collaborating networks of scientists and centers—such as the Psychiatric Genomics Consortium, are organizing the amassing of all available data from around the world so that the objective of understanding the biological causes of eating disorders can be pursued. Eating disorders have been rather enigmatic illnesses and can be difficult to treat. They are underpinned by a complex etiology that involves heredity, as well as psychosocial factors. Psychosocial factors that increase risk include low self-esteem, depression, stress, a history of trauma and abuse, and body dissatisfaction (Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004). Existing treatments typically address the behavioral and psychological features of eating disorders. Falling costs of genetic sequencing, the organizing capabilities of consortiums, and public interest in participation in research are ushering in a new era that is promising to unravel secrets of the biological basis of eating disorders and, in doing so, may herald in new targets for treatment and prevention.

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**Apps for Recovery**

As with any opportunity for health and recovery, the process is the responsibility of the individual. Following are some of the apps available for iPhone and/or Android use. This list is not an endorsement, but rather a suggestion for your review. In alphabetical order:

- **Body Beautiful**
- **Cognitive Diary**
- **CBT Self-Help**
- **Gratitude Journal (New)**
- **Happify (New)**
- **Mindfulness Bell**
- **Optimism**
- **Recovery Record**
- **Rise Up + Recover**

More handpicked, non-triggering movies at [EDcatalogue.com](http://EDcatalogue.com)
A rapidly growing body of evidence suggests that exercise may be manageable in some, but not all, people with an eating disorder (ED). Accordingly, several recent narrative and meta-analytic reviews have concluded that when nutritional needs are satisfied, exercise appears to be a safe option in ED treatment (see Cook et al., 2016 for review). These preliminary results are encouraging and suggest that under close supervision and in the absence of medical or nutritional contraindications, exercise may be an efficacious adjunct to standard ED treatments. Moreover, these reviews suggest that one key to reversing exercise from being a compensatory behavior to that of a healthy behavior may be to change a person’s pathological attitudes and thoughts about exercise itself. This may change the fundamental function of exercise from that of a compensatory behavior to part of a comprehensive approach to managing health and ED recovery. Therefore, the goals of therapeutic exercise should include altering pathological exercise attitudes and beliefs, learning how one’s body feels when one engages in healthy amounts and types of exercise, and (most important) recognizing the need to properly support exercise with adequate nutrition. Exercise may then be introduced at low intensity and small amounts to support physiological and psychological healing and recovery. A recent study published in Medicine & Science in Sports & Exercise has consolidated

Clinicians and/or individuals with ED should not take a “go it alone” approach when introducing exercise.
various techniques and considerations that influence how exercise has been successfully used as part of ED treatment programs (Cook et al., 2016). From the extant literature, the following 11 guidelines for the therapeutic use of exercise in ED treatment were proposed.

1. Adopt a Team Approach

Including an exercise program in the treatment of ED requires specific knowledge related to exercise prescription, physiology, and nutrition, in addition to medical and psychological factors relevant to ED treatment. Simply stated, exercise is a complex behavior that requires specialized expertise to distinguish maladaptive use of exercise from the health-promoting potential for specific patterns of exercise. This includes a necessary nuanced understanding of specific motives, attitudes, physiology, nutrition, medical considerations, and the interaction of these and other factors as they relate to ED. Therefore, a multidisciplinary team of experts in exercise, nutrition, mental health, physical therapy, and medicine should work collaboratively to develop individually tailored exercise programs with participation contingent upon adherence to ED therapy and should closely monitor ED patients to ensure safety. Clinicians and/or individuals with ED should not take a “go it alone” approach when introducing exercise as part of ED treatment.

2. Continuously Monitor Medical Concerns/Contraindications

Safety is the primary concern when adding exercise to ED therapy, and all precautions must be taken to prevent harm. Beginning an exercise routine generally presents minimal health risks in nonclinical populations; however, ED patients present additional physiological and psychological concerns beyond that of an individual without an ED. Therefore, in addition to a standard physical activity readiness screening, such as the Physical Activity Readiness Questionnaire (Adams, 1999), a comprehensive medical screening for complications related to ED and nutritional deficiencies should be undertaken prior to engaging in any exercise. A non-comprehensive list of suggested factors to screen may include heart rate, electrolyte levels, glycogen stores, body mass index, bone density/osteoporosis risk, body temperature, blood pressure, orthostatic changes in pulse or blood pressure, hydration, and previous injury history.

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Group Clinical Guides

A Collaborative Approach to Eating Disorders
June Alexander & Janet Treasure
344 pages, paper, 2011

Beyond a Shadow of a Diet, Second Edition
The Comprehensive Guide to Treating Binge Eating Disorder, Compulsive Eating, and Emotional Overeating
Judith Matz & Ellen Frankel
338 pages, paper, 2014

A Clinician’s Guide to Binge Eating Disorder
June Alexander, Andrea Goldschmidt & Daniel Le Grange
304 pages, paper, 2013

New Edition

Group Nutrition

Quick Reference for Healthcare Providers
Jessica Setnick
139 pages, spiral-bound, 2013

Academy of Nutrition and Dietetics Pocket Guide to Eating Disorders, Second Edition
Jessica Setnick
222 pages, spiral-bound, 2017

Nutrition Counseling in the Treatment of Eating Disorders, Second Edition
Marcia Herrin & Maria Larkin
347 pages, paper, 2013

Recommended Reading

A Collaborative Approach to Eating Disorders
June Alexander & Janet Treasure
344 pages, paper, 2011

Beyond a Shadow of a Diet, Second Edition
The Comprehensive Guide to Treating Binge Eating Disorder, Compulsive Eating, and Emotional Overeating
Judith Matz & Ellen Frankel
338 pages, paper, 2014

A Clinician’s Guide to Binge Eating Disorder
June Alexander, Andrea Goldschmidt & Daniel Le Grange
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304 pages, paper, 2013

NEW
COMMON QUESTIONS

• What clues from a gastrointestinal (GI) history and physical examination are helpful during both early (occult) and later stages of eating disorders?
• What GI symptoms occur with early weight loss?
• What common abnormalities found on laboratory testing may signal the presence of an eating disorder?
• What symptoms and signs develop as weight loss becomes more severe and can frustrate weight restoration?
• What treatment strategies can be used for common GI symptoms (bloating, early satiety, fullness) that may interfere with nutritional rehabilitation?
• How do GI symptoms improve with time and weight gain? How can this be used to reassure patients?
• What can you tell patients about the long-term effects of anorexia nervosa on the GI tract?
• When are GI studies, such as upper or lower endoscopy, barium studies, or nuclear medicine testing, indicated?
• What role is there for medications to help treat various GI complications of anorexia nervosa and bulimia nervosa?

CASE 1

W.H., a 19-year-old female, presented with pure restricting anorexia nervosa, having had a 20-pound weight loss (height 5 feet 6 inches; original weight 115 pounds) and now 70 percent of ideal body weight. She had no prior history of intestinal disease. At the nadir of her weight loss, she complained of epigastric bloating and constipation. Physical examination revealed a normal abdomen, no evidence of distention, and hemoccult-negative stool.

Inpatient multidisciplinary treatment enabled W.H. to gain 25 pounds over a 10-week period. She was reassured that the bloating and constipation would improve with time and weight restoration. Fiber, which can often increase bloating, was avoided in her diet so as not to worsen her complaint of bloating. Her bloating and constipation spontaneously improved without the use of laxatives or need for any GI studies.

BACKGROUND

People who have eating disorders commonly complain of gastrointestinal symptoms (Salvioli et al., 2013). Such symptoms are often a consequence of the eating disorder rather than an etiologic factor in the disorder. However, early in the course of the illness, GI complaints may so preoccupy the patient and the physician that they interfere with and deflect attempts at psychological treatment. There may even be some question as to whether a primary GI disease exists in addition to the eating disorder. Moreover, an eating disorder may exacerbate a preexisting intestinal disease, especially irritable bowel syndrome, which is one of the most commonly encountered GI disorders in the general population and may overlap with eating disorders (Perkins et al., 2005).
PROFESSIONAL TREATMENT

Helping Patients Outsmart Overeating
Psychological Strategies for Doctors and Health Care Providers
Karen R. Koenig & Paige O’Mahoney
260 pages, hardcover, 2017

Measuring Health from the Inside
Nutrition, Metabolism & Body Composition
Carolyn Hodges Chaffee & Annika Kahm
168 pages, paper, 2015

The Comprehensive Learning Teaching Handout Series for Eating Disorders
Sondra Kronberg
50 handouts, CD (PDF format), 2009

Managing Severe and Enduring Anorexia Nervosa
A Clinician’s Guide
Stephen Touyz, Daniel Le Grange, J. Hubert Lacey & Phillipa Hay, editors
320 pages, hardcover/paper, 2016

Wellness, Not Weight
Health at Every Size and Motivational Interviewing
Ellen Glovsky, editor
288 pages, paper, 2014

Handbook of Assessment and Treatment of Eating Disorders
B. Timothy Walsh, Robyn Sysko & Deborah R. Glasofer, editors
358 pages, paper, 2015

Body-States
Interpersonal and Relational Perspectives on the Treatment of Eating Disorders
Jean Petrucelli, editor
354 pages, paper, 2014

Integrative Cognitive-Affective Therapy for Bulimia Nervosa
A Treatment Manual
Stephen A. Wonderlich, Carol B. Peterson & Tracey Leone Smith, with Marjorie H. Klein, James E. Mitchell & Scott J. Crow
242 pages, paper, 2015

RECOMMENDED READING

A Brain-Based Approach to Eating Disorder Treatment
Laura Hill
te-text, 2017
Go to EDcatalogue.com/hill for a special bonus!

Measuring Health from the Inside
Nutrition, Metabolism & Body Composition
Carolyn Hodges Chaffee & Annika Kahm
168 pages, paper, 2015

Casebook of Evidence-Based Therapy for Eating Disorders
Heather Thompson-Brenner, editor
372 pages, hardcover, 2015

Managing Severe and Enduring Anorexia Nervosa
A Clinician’s Guide
Stephen Touyz, Daniel Le Grange, J. Hubert Lacey & Phillipa Hay, editors
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242 pages, paper, 2015

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While this article is primarily about transgender body image, the LGBTQIA (lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual/agender) community needs our focus and care. Historically facing strong bias from traditional health care and insurance, members of this community can have varying levels of suspicion and mistrust, leading to avoidance of medical and mental-health practitioners. As with all underrepresented groups, they also face minority stress. Minority stress comes from external factors such as prejudice and rejection. Exacerbated by those are internal factors, including shame, escape tactics, social isolation, and internalized heteronormative and cisgender (non-trans) biases.

According to the National Institute on Media and the Family, \(^1\) 30 percent of high school girls and 16 percent of high school boys suffer from disordered eating. In addition, 78 percent of 17-year-old girls are dissatisfied with their appearance and body image. Treating negative body image and eating disorders really matters with the LGBTQ+ population. In a British study, \(^2\) 80.7 percent of men said they regularly discuss body shapes, and 58.6 percent said doing so made them feel worse about themselves. And 48 percent of gay men would trade a year of their lives for a perfect body; 10 percent would agree to die 11 years earlier if they could have their ideal body now.

Gettelman and Thompson \(^3\) reported that straight women and gay men were most negatively affected by body image; researchers thought that since both are trying to attract men, the media’s images of beauty were a common goal. The National Eating Disorders Association \(^4\) reports that the occurrence of eating disorders is three times higher in gay men than in straight men, and nearly 15 percent of gay men report dealing with anorexia or bulimia in their lifetimes. Both straight and gay men now feel more pressure to be muscular (“bigorexia”), and lesbian/bi women were the most accepting of heaviness, in their own and others’ bodies. These statistics feel accurate when I observe clients’ experiences, particularly those of college students. I counseled a gay grad student for several years who struggled with restricting and exercise bulimia, triggered by sexual abuse by a teacher. He had extensive dysmorphia, thinking an extra pound of weight rounded his face, and also questioned his gender; he wondered if he would have been abused if he were a girl.

Transgender and gender nonconforming people can have an even more complicated body image. Though not all transgender people suffer from body dysphoria and dissatisfaction, it is significantly more severe if one is actually haunted by being in a body that has no congruence with one’s identity. For the purpose of this article, sex is one’s biological anatomy, while gender is a social construct that includes social or cultural expectations about an individual’s role as the sex assigned.
Image

Treating negative body image and eating disorders really matters with the LGBTQ+ population.

at birth (vs. affirmed gender). Gender identity is one’s psychological sense of self, and gender expression is one’s external presentation. While not complicated concepts, they are particularly distressing when they are not in alignment with one’s sense of self or how one would like to be perceived. It should be noted that gender has no relation to sexual orientation, which describes one’s erotic/romantic response.

To acknowledge the difficulty of embodiment with this population, and to frame treatment in a supportive manner, we need to ask the person who they are as an individual, ask what name and pronouns they use (and use them!), and not make assumptions based on appearance or rumor. I’ve found it helpful to break the ice by modeling this: “I’m Martie, and I use she or they pronouns. How about you?” Increasingly, nonbinary gender identities are being affirmed, so even assuming maleness or femaleness might be off-putting. Clients may be androgynous, agender, bigender, gender-fluid, genderqueer, etc. These individuals often use gender-neutral pronouns, such as the singular they, or ze/zir/zirs. Ask what pronouns and name they use. As Kate Bornstein (trans writer and advocate) says, “We need to do away with gender enforcement.”

It is important to note that gender identity can be fluid. Also be aware that not all trans folks have dysphoria,
or feel a need to make any bodily adjustments. (Social transition can include name changing, desired gender identification with friends or family, and appearance changes, like dressing more masc or femme.) Transition is also a process, not an event, and many of my clients have grown to want more medical and surgical transition, even though initially they had no interest in this.

I recently worked with a lesbian client who had severe chest dysphoria. She was in outpatient treatment to deal with eating-disordered behaviors and was sent to me for a consultation on gender issues. She clearly identified as a woman with no gender questions, but simply did not like or want her breasts. She did note that monthly swelling or any significant weight gain brought her attention to her chest, creating significant distress and triggering her anorexia. She is very happy post-mastectomy. Another client, identifying as nonbinary, was horribly thin and in physical pain from various medical maladies, as well as anorexic restriction. While their case is too complex to go into in much detail, they were profoundly dysphoric and wanted to preserve their body in an adolescent, androgynous, and diminutive state.

Exploration might include questions such as, “How do you feel about your body, including parts you have and/or parts you want or don’t have? How was it growing up in your body? Any traumatic or negative experiences related to how others (or you) perceived you? What would your ideal body look like? How was body image helped or harmed by your family? Your cultural or racial community? How does your body give you pleasure? How do you take care of your body? What have you done to change, hide, enhance, or otherwise deal with your body/body image?” Clinicians need to ask the questions, as disorders related to eating or body image can be intentionally hidden or not apparent. Many of my clients say, laughing, “There’s thin, and there’s ‘gay-thin’”—i.e., being severely underweight.

Male-to-female responses can be different from female-to-male responses. Trans women may use breast enhancement, body padding, tucking (of the penis), or other image-enhancing methods. Trans men may bind (their chests) or pack (with a faux phallus). Weight may be a factor: Folks can strive for thinness to achieve androgyny, or to avoid developing or appearing to have sex characteristics, and gain weight to hide breasts or other parts, and these may or may not be conscious choices. When one is undergoing some physical (hormonal, medical, or surgical) transition, there can be great awkwardness in the in-between states, both for oneself and in others’ perceptions. And post-transition, a residual sense of the body as not real or authentic might need to be explored. This is not the same as regret about transitioning, which is actually extremely rare.

A therapeutic stance that all bodies and identities have inherent worth can help a client evaluate and pick apart the notion that their worth is based in heteronormative, cisgender, white ideals. Exposing and dismantling fat talk, body shaming, and racist, homophobic, or transphobic messaging helps clients develop a more personal values set. To actively support, educate, and advocate for the clients’ rights to determine what’s best for their body, even if that includes gender-confirming surgery or other procedures or services, is an important role for the LGBTQIA-affirmative clinician.

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256 pages, paper, 2016

Effective Clinical Practice in the Treatment of Eating Disorders The Heart of the Matter
Margo Maine, William N. Davis & Jane Shure
262 pages, hardcover/paper, 2009

Family Therapy for Adolescent Eating and Weight Disorders New Applications
Katharine L. Loeb, Daniel Le Grange & James Lock, editors
474 pages, hardcover/paper, 2015

Eating Disorders in Special Populations Medical, Nutritional, and Psychological Treatments
Jonna Fries & Veronica Sullivan, editors
372 pages, hardcover, 2017

Psychoanalytic Treatment of Eating Disorders When Words Fail and Bodies Speak
Tom Wooldridge, editor
288 pages, hardcover/paper, 2018

Treatment of Eating Disorders Bridging the Research-Practice Gap
Margo Maine, Beth Hartman McGilley & Douglas W. Bunnell
526 pages, hardcover, 2010

National Eating Disorders Organizations

- Academy for Eating Disorders (AED) aedweb.org
- The Alliance for Eating Disorders Awareness allianceforeatingdisorders.com
- Binge Eating Disorder Association (BEDA) bedaonline.com
- Eating Disorders Anonymous (EDA) eatingdisordersanonymous.org
- Eating Disorders Coalition for Research, Policy & Action (EDC) eatingdisorderscoalition.org
- Eating Disorders Information Network (EDIN) myedin.org
- The Elisa Project theelisaproject.org
- Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.) feast-ed.org
- The International Association of Eating Disorders Professionals Foundation (IAEDP) iaedp.com
- Maudsley Parents maudsleyparents.org
- Multi-Service Eating Disorders Association, Inc. (MEDA) medainc.org
- National Association for Males with Eating Disorders (N.A.M.E.D.) namedinc.org
- National Association of Anorexia Nervosa and Associated Disorders (ANAD) anad.org
- The National Eating Disorders Screening Program (NEDSP) mentalhealthscreening.org
- National Eating Disorders Association (NEDA) nationaleatingdisorders.org
- Parents to Parents parents-to-parents.org
- Project HEAL theprojectheal.org
- Trans Folx Fighting Eating Disorders (T-FFED) transfoxfightingeds.org

More information on these organizations can be found at EDeCatalogue.com.
EATING DISORDER PATIENTS OFTEN SPLIT THEMSELVES INTO A PSYCHOLOGICAL SELF AND A BODY SELF, responding to their bodily needs in a punitive manner, often with undisguised contempt. The body is experienced as something separate, with which a person is at war. Many report looking in the mirror or catching a glimpse of their reflection and feeling a sense of revulsion, along with the sense that the reflected image is not the “real” them. One woman poked at her stomach and declared, “This is not me. I don’t know who it is, but it’s not me.”

Conceptualizing a patient’s relationship to his or her own body is a crucial part of therapeutic exploration. Many people conceptualize their bodies as their only self-definition, without any regard for the emotional, relational, creative, intellectual, or spiritual aspects of themselves. I once treated a psychotherapy patient who had an extremely harsh internal critic and suffered a great deal because of her self-castigation. When I suggested cultivating a kinder attitude toward herself and practicing a higher degree of self-care, she protested that she took wonderful care of herself. She described herself as the “queen of self-care” and pointed out that she treated herself to weekly manicures and hair styling appointments, as well as monthly facials and massages. I acknowledged that she was taking extremely good care of her body, but framed this as grooming, not self-care.

“What do you mean?” she asked, baffled. “What other self is there?”

She had no other concept of her “self” other than her physical form. For her, and for many people with eating disorders and body image disturbances, the body functions as the primary self. Patients who define themselves by their appearance alone believe that they will be good enough only when their bodies are good enough. They think they can get other people to like them, hire them, accept them, and appreciate them by changing their appearance. They unconsciously imagine that by ridding themselves of excess weight, they are getting rid of aspects of themselves they despise. They believe they control their world by controlling their weight.

John Russon (2003) writes of the concept of embodiment, “To be a body is to be a specific identity that is open to involvement with others. Indeed, pleasure and pain are two faces of this involvement, the ways in which that with which we are involved either welcomes or hinders our determinacy. Our bodies are the living process by which we establish contact with reality” (p. 21). He goes on to describe how the culture has facilitated a way of thinking about bodies in terms of size and physical attributes, which has created a sense of a body as an object rather than a subject. He notes that this culture has led to a “fundamental separation between body and experience, as if ‘to experience’ were one thing and ‘to be a body’ something separate and unrelated” (pp. 22-23).
A revolutionary way to connect treatment providers and individuals looking for professional help.
The Competency of Compassion: A CORNERSTONE OF HEALING AND RECOVERY

BY / MICHAEL E. BERRETT, PHD, CEDS

Certainly in this age in which we live, there is an incredible need to nurture and increase, and notice and celebrate, compassion. The campaigns and acts of terror; the seemingly unprecedented natural disasters; the divisions, conflicts, and hatred freely expressed and enacted in public discourse; no shortage of illnesses—these all verify that this is a time of high need for compassion. In this article, I propose a model of compassion that takes from, and adds to, the works of wonderful thought leaders, researchers, writers, and clinicians. I offer a model that expands compassion into the broader context, with an environment in which compassion is nurtured, and offer consideration of seven specific competencies, which, if practiced, will increase compassion for ourselves and for those around us. This context and model can be used to benefit ourselves, our family and friends, our broader community, our clients, and our brothers and sisters wherever we may find them. This article presents as follows: 1) Meaning of compassion; 2) Personal brushes with compassion; 3) Creating a cradle that nurtures compassion; 4) The practice of seven core competencies of compassion; 5) The impact of compassion; 6) Final thoughts.

Meaning of Compassion

So what is compassion? It is in the eye and the definition of the beholder. According to the Dalai Lama, “Compassion can be roughly defined in terms of a state of mind that is nonviolent, nonharming, and nonaggressive. It is a mental attitude based on the wish for others to be free of their suffering.” Jinpa (2016) said compassion is “sensitivity to suffering with a commitment to alleviate and prevent it.” Berrett (2017) suggests that compassion is not just a feeling—but includes intention and action. Compassion is akin not to “feeling sorry for,” but rather, “feeling loving kindness toward,” according to Germer and Neff (2013). “Compassion ... involves 1) being touched by and open to suffering, 2) not avoiding or becoming disconnected from it, and 3) generating the desire to alleviate suffering and heal with kindness” (Germer & Neff, 2013).

Compassion is not just a choice and opportunity. It is necessary for effective treatment and solid recovery from eating disorders and related illnesses. Over many years of treating those suffering, I have learned that self-compassion is a necessary ingredient in recovery and healing. It is also helpful for clients to understand that they have great compassion for others, that it is a precious gift, and that they can notice their compassion, embrace it, and practice it. This recognition of compassion—seeing it as something they have to give that can affect others for the good—can increase understanding of one’s own spiritual identity. As clients progress in recovery, compassion is one of the “take-home gifts” of having suffered an eating disorder. It counterbalances the collateral damage of illness. Increased compassion is one of the blessings that often come to those who have traveled that difficult pathway.
Compassion is essential in the journey of both clinical provider and client. Compassion is one foundation stone of the spirituality of an individual, is essential for loving and close emotional relationships, and is a sign of health and hope in communities and in the world. It is a practice and a power that can transform, for good, the world that we live in, one individual at a time. When compassion is present, it so often comes across as the feeling “that which is right in our world.” When it is absent, it is at the center of “what is wrong in our world.” Compassion is necessary for a safe, uplifting, and improving society, and it is necessary for finding peace in an individual’s troubled heart.

As a veteran clinician, I have noticed that self-compassion is a cornerstone of recovery for those suffering mental, emotional, or addictive illness; that it is imperative for the improvement of couple and family relationships, and that it is at the core of the healing power of therapeutic group process—in which shame and pain meet healing. I have noticed that when clinicians practice it well in their work, miracles happen.

It has been suggested that compassion is not simply an emotion that we might feel toward another, but rather, it is a “practice” and “a way of living.” While we will have emotion at times when receiving or giving compassion, compassion is much more. It is a choice, a decision, something we give, and something we do. The implication of the word practice is that we need not be labeled as either “compassionate” or “non-compassionate” people, but that we can choose, and be, compassionate in a moment, and that we can “become” more compassionate as individuals over time and by the regular practicing of compassion.

THIS ARTICLE CONTINUES AND CAN BE FOUND IN ITS ENTIRETY AT EDCATALOGUE.COM.
OBJECTIVE
Whether you think in black and white, filter out positive information, or exaggerate the negative, by now you will be starting to see how important it is to challenge your negative thoughts as part of your recovery. The aim of this worksheet is to equip you with 20 questions you can ask yourself when you need help challenging your negative thinking.

TASK
Next time you catch yourself thinking negatively, work your way through the following list of questions, answering them honestly.

What is the evidence?
1. Am I confusing a thought with a fact?
2. Am I jumping to conclusions?

What alternatives are there?
3. Am I assuming that my view of things is the only one possible?
4. What do I want?
5. What are the advantages and disadvantages of thinking this way?
6. Am I asking questions that have no answers?

What thinking errors am I making?
7. Am I thinking in all-or-nothing terms?
8. Am I using ultimatum words in my thinking?
9. Am I condemning myself as a total person on the basis of one single event?
10. Am I concentrating on my weaknesses and forgetting my strengths?
11. Am I blaming myself for something that is not really my fault?
12. Am I taking something personally, which has little or nothing to do with me?
13. Am I expecting myself to be perfect?
14. Am I using a double standard?
15. Am I paying attention only to the black side of things?
16. Am I overestimating the chances of disaster?
17. Am I exaggerating the importance of events?
18. Am I fretting about the way things ought to be, instead of accepting them and dealing with them as they are?
19. Am I assuming that I can do nothing to change my situation?
20. Am I predicting the future instead of experimenting with it?

REFLECTION TIME!
Reflect on how you found this exercise—whether you were surprised by any of your answers or whether the questions helped you to think more positively. If you found them useful, you might even want to print them off and pin them somewhere as a reminder.

“At first, I was resistant to challenging my negative thinking, but then I realized that was because I was scared of being proven wrong. Surely, I would want to be proven wrong? No one wants to feel bad about themselves. This insight alone made me realize how unhealthy my thinking was and how important it was for me to tackle it.”

EXCERPTED FROM DR. NICOLA DAVIES AND EMMA BACON, EATING DISORDER RECOVERY HANDBOOK: A PRACTICAL GUIDE TO LONG-TERM RECOVERY (LONDON: JESSICA KINGSLEY PUBLISHERS, 2016). PAGES 75-76: 240 PAGES, PAPER.
Want to learn more about eating disorders but don’t know where to turn?

Don’t have time to weed through all the available information?

We know. It’s a lot.

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We curate the most up-to-date information from the web, newsletters, and magazines, to get you in the know.

LEARN MORE NOW.
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The word *disorder* in the dictionary is defined as “a breach of peace.” Eating disorders are just that: disorders that are a breach of peace in the soul. These are conditions of dis-order of life, body, food, and self. Not to mention, these disorders wreak havoc on relationships. It is no wonder that eating disorders are complicated and treatment is even more complicated. Every person is unique, and treatment varies with each person. A biological, psychological, and social approach has been standard in the treatment of eating disorders. However, treatment of the soul is needed for most everyone, and it is spirituality that brings the soul back to life and nourishes it.

**Defining Spirituality**
Ask 1,000 people and get 1,000 different answers on how to define *spirituality*. It’s different, fluid, and unique for everyone. It can be an experience, a feeling, an interaction, a dream, a phenomenon, an object, or anything else the person experiences as spiritual. The dictionary says that spirituality is a “search for the sacred.” My thoughts are that it could be a “search for,” or simply it could just “be.” It could be a connection or attunement with God or a higher power, feelings of enlightenment, harmony with truth, oneness with nature or the universe. It could also be love, compassion, and honesty. It can’t be bottled up or put into a package. It has to be experienced.

The Mental Health Foundation (2006) reports that spirituality is composed of the following:

- A sense of purpose
- A sense of “connectedness”—to self, others, nature, “God,” or other
- A quest for wholeness
- A search for hope or harmony
- A belief in a higher being or beings
- Some level of transcendence, or the sense that there is more to life than the material or practical
- Those activities that give meaning and value to people’s lives

On the other hand, *religion* can be a little more defined. It differs from spirituality in that religion may involve certain religious beliefs, practices, feelings about God or a higher power, or other things that may be expressed with a religious affiliation, institution, or denomination. The two can certainly intertwine and overlap, and some people can experience them as one and the same.

**A Place Setting for Spirituality with Eating Disorders**
Does spirituality belong in eating disorders treatment? In my training as a psychologist, spirituality and religion are openly recognized as types of diversity that we as professionals are ethically obligated to understand and respect. More than that, in the treatment of eating disorders, we are doing a disservice if we do not look at and explore an individual’s spirituality in an effort to connect with the soul.

Spiritual treatment approaches...
Spirituality

Encourage professionals treating eating disorders to address patients’ spiritual concerns when relevant and to use language, verbiage, and interventions that demonstrate honor and respect for the healing potential of their patients’ faith or spiritual connection.

Swinton (2001) argues that stress and anxiety have spiritual symptoms such as a loss of meaning in life, feelings of alienation and indifference, no sense of the future, and the inability to focus on God or to meditate. There is evidence that eating disorders and anxiety are significantly correlated. Thus, Swinton’s position may be applied to eating disorders.

Eating disorders affect identity, sense of self, and soul. I have observed a variety of spiritual and religious issues in my patients—lack of spiritual identity, negative images of God (punitive/shaming God), feelings of spiritual unworthiness, fear of abandonment from God, guilt over behaviors that are incongruent to their values and faith, difficulty with forgiveness, and a lack of grace for self and others. I have also seen a reduced capacity for compassion and forgiveness for themselves.

**Spiritual Nourishment**

Those who struggle with food, hardship, pain, and shame tend to be external seekers and want tangential representations to prove they are enough. They tend to look for love in all the wrong places, focus on the mirror or others for approval, and become hostage to their thoughts and feelings. They want some certainty in the control of food.

“I have a lot of faith,” writes Anne Lamott (2005). “But I am also afraid a lot, and have no real certainty about anything. I remembered something Father Tom had told me—that the opposite of faith is not doubt, but certainty. Certainty is missing the point entirely. Faith includes noticing the mess, the emptiness and discomfort, and letting it be there until some light returns.”

When you feed your soul through faith and spirituality, you feed your sense of self-worth. The more you realize your spiritual worth, the less dependent you are on your body to define you. And this sets you free to sharpen and attune to your values outside of shape, size, and weight. Spiritual nourishment is as important as physical nourishment.
as feeding your body. The soul is the lens in which we view life. It is art, song and dance, it is poetry, and it is love.

Part of spiritual connection and development is obtaining nourishment to regain or gain dignity and self-respect. Those with eating disorders experience significant loss not only in connection with the soul or self-worth, but in their dignity and self-respect. Michael Berrett has been inspirational in his work in spirituality and eating disorders. He shares in his coauthored book that “being true to the heart generates an inner strength in the patient that is expressed through dignity and self-respect. Dignity of self is expressed by increased confidence, faith, and determination to live life with real purpose” (Richards, Hardman, & Berrett, 2007). Spirituality is a powerful recovery tool, as it helps patients connect to the heart and find purpose and meaning in their lives.

Spiritual Menu

And how do we feed it? By allowing light, not darkness, into our body, heart, and soul. I read a quote that stated, “The soul always knows what to do to heal itself. The challenge is to silence the mind.” The difference in working with eating disorders is that sometimes we have to lasso the soul back from the eating disorder.

In Women Food and God (2010), Geneen Roth talks about “when even a moment of that ‘spiritual’ part of them is experienced with food, there is a natural inclination to want to keep exploring, keep discovering, keep touching the place that has never known suffering—which is, after all, the function of any spiritual practice.” When we feed our soul with spiritual food, then we begin to connect with life. Carolyn Costin writes in her book, “Think of your eating disorder self and your soul self; the one you ‘feed’ will be the strongest. Getting better is about feeding, or strengthening, your soul self” (Costin & Grabb, 2012).

Below is a spiritual menu including tools and interventions adapted from the “Food from Heaven” chapter in my book, Mom in the Mirror (Cabrera & Wierenga, 2013).

- When you feed your soul, you feed your sense of purpose, and spiritual tools can assist with that connection.

  **Truth:** Everyone’s truth is different. The bible says the truth will set you free. Working with those with eating disorders has taught me that the lies we tell ourselves are the most destructive. Finding truth can be a pathway to the heart.

  **Prayer:** It’s a great tool. There is no right or wrong way to pray. It helps you feel that you are not alone.

  **Humility:** Do nothing out of self-sufficiency—consider others.

  **Gratitude:** Create a journal in which you can jot down what you are thankful for. Reminding ourselves of the simple gifts such as a hug, smile, food, shelter, and family always puts things in perspective.

  **Generosity:** Give and then watch as, in turn, you receive.

  **Reflection:** It is important to process and engage yourself in thought, to sit still and become connected to life.

  **Community:** Creating a community of support and guidance is crucial. You must have support not only to survive, but to grow and develop as a spiritual person.

  **Compassion:** Berrett says, “Compassion is ‘something we do’ and ‘eventually who we become.’” Compassion helps us transform our perspective on life, especially with those with eating disorders where the internal voice can be demeaning and negative.

Spiritual Interventions

There are many wonderful suggestions regarding spiritual interventions in Spiritual Approaches in the Treatment of Women with Eating Disorders (Richards et. al., 2007). Here are a few that I have incorporated into my work:

- **Conduct a Spiritual Assessment:** What is the patient’s faith or spiritual life? Obtain an understanding of the distorted and dysfunctional religious and/or spiritual beliefs.
- **Integrate Spiritual Concepts:** God’s love and grace, forgiveness, love, higher power (all concepts learned from the client in the spiritual assessment).
- **Spiritual Journaling/Reading Scriptures:** Bible studies, inspirational readings.
- **Prayer:** It can be a powerful and meaningful resource to assist patients in their healing, coping, and growth.
- **Music:** Incorporate uplifting and sacred music.
- **Letter Writing:** To the self, God, body.
- **Teach Compassion Training:** A great resource is A Fearless Heart: How the Courage to Be Compassionate Can Transform Our Lives by Thupten Jinpa.
- **Mindfulness and Meditation:** There are many books and resources on the subjects.
- **The Big Book:** The Twelve Steps can very useful and helpful.

Overall, working with individuals with eating disorders is about being willing to enter a dark place with them and pull them from the depths of the abyss. It’s about meeting people where they are at and learning what they yearn for in their life. We must follow their lead, respect their boundaries, and, through our own compassion, assist them in spiritual health.

**REFERENCES**


**Kids**

- **Full Mouse Empty Mouse**  
  *A Tale of Food and Feelings*  
  Dina Zeckhausen  
  Illustrated by Brian Boyd  
  Ages 7-12  
  40 pages, paper, 2008

- **No “Body” Is Perfect But They Are All Beautiful**  
  Denise Folcik  
  Illustrated by Lily Weber  
  Ages 3-6  
  32 pages, paper, 2012

- **Beautiful Girl**  
  *Celebrating the Wonders of Your Body*  
  Christiane Northrup with Kristina Tracy  
  Illustrated by Aurélie Blanz  
  Ages 4-10  
  28 pages, hardcover, 2013

- **Your Body Is Awesome**  
  *Body Respect for Children*  
  Sigrún Danielsdóttir  
  Illustrated by Björk Bjarkadóttir  
  Ages 4+  
  36 pages, hardcover, 2014

- **Positive Body Image for Kids**  
  *A Strengths-Based Curriculum for Children Aged 7-11*  
  Ruth MacConville  
  Kids 7-11  
  256 pages, paper, 2017

- **Minnie and Max Are OK!**  
  *A Story to Help Children Develop a Positive Body Image*  
  Chris Calland & Nicky Hutchinson  
  Illustrated by Emmi Smid  
  Ages 3-7  
  40 pages, hardcover, 2017

- **Shapesville**  
  *A Tale of Food and Feelings*  
  Dina Zeckhausen  
  Illustrated by Brian Boyd  
  Ages 7-12  
  40 pages, paper, 2008

- **Can I Tell You About Eating Disorders?**  
  *A Guide for Friends, Family and Professionals*  
  Bryan Lask & Lucy Watson  
  Illustrated by Fiona Field  
  Kids 7-15  
  56 pages, paper, 2014

- **Amanda’s Big Dream**  
  Judith Matz  
  Illustrated by Elizabeth Patch  
  Ages 4+  
  32 pages, paper, 2015

- **Mirror, Mirror on the Wall**  
  *Breaking the “I Feel Fat” Spell*  
  Andrea Wachter & Marsea Marcus  
  Tweens/Teens/Young Adults  
  106 pages, paper, 2016

- **Your Body Is Awesome**  
  *Body Respect for Children*  
  Sigrún Danielsdóttir  
  Illustrated by Björk Bjarkadóttir  
  Ages 4+  
  36 pages, hardcover, 2014

- **shapesville**  
  *A Tale of Food and Feelings*  
  Dina Zeckhausen  
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  40 pages, paper, 2008

- **The Bulimia Workbook for Teens**  
  *Activities to Help You Stop Bingeing and Purging*  
  Lisa Bluth  
  Teens  
  200 pages, paper, 2017

- **Getting Over Overeating for Teens**  
  *A Workbook to Transform Your Relationship with Food Using CBT, Mindfulness, and Intuitive Eating* (Teen Instant Help)  
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  Teens  
  156 pages, paper, 2010

- **Amanda’s Big Dream**  
  Judith Matz  
  Illustrated by Elizabeth Patch  
  Ages 4+  
  32 pages, paper, 2015

- **Mirror, Mirror on the Wall**  
  *Breaking the “I Feel Fat” Spell*  
  Andrea Wachter & Marsea Marcus  
  Tweens/Teens/Young Adults  
  106 pages, paper, 2016
THE HONEST BODY PROJECT WAS CREATED FOR MANY, MANY REASONS.
I hope that after reading this book, your eyes have been opened a little more, your heart has been touched, and you feel less alone. One thing I have learned from this experience is there is always someone else struggling through similar things and no one is truly alone. We need to open our hearts more and share our experiences with one another.

One of my main inspirations for this project is my daughter, Anna. She is currently entering the “tween” years, when our bodies often change rapidly, bullying runs rampant, and kids are very susceptible to the messages from society. This is such a formative time for young girls. We live in a society where over 80 percent of 10-year-old girls are afraid of being fat (Mellin et al., 1991). This should shock you, but it more than likely doesn’t, because you probably remember how you felt when you were 10. I remember being picked on, hating my body, and wishing I were thinner. I wasn’t truly overweight, but just being slightly bigger than your peers is grounds for bullying at that age. I can recall one bus ride home where a boy I had a crush on called me “pot belly” the whole ride home. That comment always stuck with me.

I want us all to be good examples for the daughters we are raising. Speak positively about your body in front of them, show them how to love themselves, and end the negative talk. These girls are already receiving messages from the media telling them they aren’t good enough—we need to counteract these messages and show them how to ignore the negativity. I want my daughter to know that she should love herself, always, without question. No one can tell you when you should feel beautiful. You are always beautiful.

When I first began my journey to self-love, I had no idea where to start. After some time, I found out that all you have to do is decide to start. There’s no magical pill to swallow, no step-by-step tutorial; you just have to jump in and decide to love yourself. If it sounds too simple, that is because it truly is. Stand in front of the mirror right now and tell your body that you love it, you accept it, and you appreciate it. Tell yourself that you are beautiful. It may feel strange, you may cry, and that is OK. You might not believe it, and that is OK, too. I didn’t believe it or truly mean it at first, either. The trick is that

BY / NATALIE MCCAIN

you have to keep doing it. When you feel a negative thought enter your mind, replace it with a positive. Lift yourself up daily; spend some time getting to know and loving your body. Find beauty in your imperfections; after all, they are uniquely yours and they really are beautiful and make you, you. There is no right way to be beautiful, despite what society may suggest. There is no size where you will suddenly wake up and realize you are now allowed to be beautiful. You are beautiful right now. Not 20 pounds from now, not 10 pounds from now, not tomorrow. Now.

If you’ve been avoiding certain activities due to how you feel about your body, I urge you to stop. A few years ago, my grandfather passed away after a long battle with cancer. I missed one of the last family get-togethers he held at his house, not because I was sick, not because I was busy, but because I was embarrassed that I had gained back weight that I had recently lost. I missed my last chance to see my grandfather with our family because I was so embarrassed by my body. Saying it back to myself, I realize how truly sad that is. I’ll never get that moment back. The truth is that nobody cares what your body looks like. Your family and friends want you to be present, they want you in their lives, no matter what the number on the scale is. Don’t let your body hold you back from living, because one day you’ll regret it.◆
Eating Disorders and Borderline Personality Disorder

BY / LESLIE K. ANDERSON, STUART B. MURRAY & WALTER H. KAYE, EDITORS

EXAMPLES OF THERAPY-INTERFERING BEHAVIORS

<table>
<thead>
<tr>
<th>Behaviors that Interfere with Receiving Therapy</th>
<th>Noncompliant Behaviors</th>
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<tbody>
<tr>
<td><strong>Nonattentive Behaviors</strong></td>
<td>• Refusing to be weighed</td>
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<tr>
<td>• Cancel appointment/drop out</td>
<td>• Refusal to allow family members to be involved in treatment when doing so would aid in recovery</td>
</tr>
<tr>
<td>• Getting admitted to the hospital</td>
<td>• Not filling out diary cards; partially or incorrectly completing diary cards</td>
</tr>
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<td>• Using mind-altering substances prior to a session</td>
<td>• Not bringing in diary cards</td>
</tr>
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<td>• Walking out of sessions/groups before they end</td>
<td>• Not completing or partially completing homework</td>
</tr>
<tr>
<td>• Having seizures during session</td>
<td>• Refusing to comply with treatment recommendations</td>
</tr>
<tr>
<td>• Dissociating during session</td>
<td>• Exercising against medical advice</td>
</tr>
<tr>
<td>• Inadequate intake resulting in inattention during session</td>
<td>• Refusal to agree to higher level of care when necessary</td>
</tr>
<tr>
<td>• Pacing or standing during session</td>
<td>• Not bringing in food for therapeutic meal</td>
</tr>
<tr>
<td>• Involuntary vomiting in group</td>
<td>• Hiding food</td>
</tr>
</tbody>
</table>

| Noncollaborative Behaviors                     |                               |
| • Inability/refusal to work in therapy         |                               |
| • Lying                                       |                               |
| • Not talking at all                          |                               |
| • “I don’t know”                              |                               |
| • Withdrawing emotionally during session      |                               |
| • Using water or other weights to make it appear weight has increased |                               |
| • Refusal to work on eating “in vivo”         |                               |
| • Lying about intake                          |                               |

| Behaviors that Interfere with Other Patients  |                               |
| • Openly critical, hostile, and judgmental remarks directed at other patients |                               |
| • Critical remarks directed toward treatment program |                               |
| • Wearing revealing clothing to ED treatment |                               |
Behaviors that Burn Out Therapists

Behaviors that Burn Out Therapists by Pushing the Therapists’ Personal Limits
(everyone has their own limits that may vary over time and over patients)
• Phoning too much
• Going to the therapist’s house (social media contact?)
• Interacting with the therapist’s family members
• Refusing to engage/accept strategies that the therapist believes are essential to progress
• Continuing to lose weight and refusing to collaborate on weight maintenance or gain

Behaviors that Burn Out Therapists by Pushing Organizational Limits
• Not waiting for therapist in waiting room
• Not paying therapy bill
• Openly critical, hostile, judgmental, oppositional remarks toward other staff and therapists
• Vomiting in lobby restroom

Statements that Burn Out Therapists by Decreasing Therapists’ Motivation
• Statements that the therapist is “not a good therapist”
• A hostile attitude
• Criticism of the therapist’s person or personality
• Criticism of the therapist’s place of work
• Demanding refund for therapy
• Slow progress
• Chronic medical instability due to ED behaviors

Therapy-Interfering Behaviors Specific to ED Therapists
• Not staying current in EDs
• Not addressing eating issues as a part of treatment (e.g., weighing patient and food log)
• Therapist ED issues interfere with objectivity
• Not pushing for family involvement when it would be effective
• Failing to recognize or confront persistent lack of progress

Behaviors Showing a Lack of Respect for the Patient
• Misses or forgets appointment
• Frequently cancels or reschedules appointments
• Does not return phone calls/messages
• Loses papers/files/notes
• Is late for appointments
• Allows interruptions such as phone calls or messages
• Dozes off when with patient
• Talks about other patients
• Ends sessions prematurely

Therapy-Interfering Behaviors of Therapists

Behaviors Creating a Therapeutic Power Imbalance
• Imbalance of change versus acceptance
• Imbalance of flexibility versus stability: switching strategies in an effort to progress
• Rigidly maintaining strategies that produce no progress or extreme distress for patient
• Imbalance of nurturing versus change
• Doing for the patient versus withholding help
• Imbalance of reciprocal versus irreverent communication

EXCERPTED WITH PERMISSION FROM CLINICAL HANDBOOK OF COMPLEX AND ATYPICAL EATING DISORDERS, EDITED BY ANDERSON, MURRAY & KAYE (2017), BOX 6.1 PP. 99-101, BY PERMISSION OF OXFORD UNIVERSITY PRESS, U.S.: 440 PAGES, PAPER.
COMMON PITFALLS
Staying motivated in recovery requires a significant amount of self-awareness and honesty. Staying 100 percent motivated all the time is an unreasonable and unrealistic expectation. Recovery is not always pleasant. It is hard work and is often more of an “Ugh … recovery” experience—not “Yay, recovery!” There are plenty of times when apathy takes over, and you struggle to make even the tiniest step toward your values and goals. It is important to expect those moments and allow yourself to experience your emotions that are related to your low level of motivation. It is equally as important to pick yourself back up to get back on track before a pattern of slipups spirals into a relapse. Thus, acknowledging times when you will be prone to making choices that move you away from your values and goals and identifying the signs that you are slipping is important. If you do not notice you are slipping, you cannot change your behaviors or know that it is time to reach out for help. These pitfalls—times that make you vulnerable to decreased motivation—are common in the recovery process. Below are some typical pitfalls in maintaining motivation through recovery. Take some time to identify which of these are relevant to you, and add your own potential pitfalls in the space at the end.

EMOTIONAL AROUSAL
When experiencing too much anxiety and stress, you may develop a sense of hopelessness and feel overwhelmed, which will inevitably decrease your ability to think rationally, concentrate, and focus. Without such cognitive processes in place, your anxiety and stress essentially paralyze you, and you create a self-fulfilling prophecy. For example, you may end up creating situations in which you are unable to succeed because of the intense level of anticipatory anxiety about not being able to succeed. 

Suggested Solution—Take time for self-care or to engage in relaxation and mindfulness exercises (see chapters 11 and 12). Taking time to participate in activities that
you enjoy helps your ability to feel productive, clear-minded, levelheaded, efficacious, and satisfied with yourself. Relaxation and mindfulness exercises help you to be aware of your emotions, remain present, let go of fears and worries, and decrease anxiety. You may add to this list once you complete chapters 11 and 12, but take a moment right now to list three ways you can help yourself relax when you are feeling intense emotions.

AVOIDANCE OF DISCOMFORT

A common pitfall you may find yourself falling into is only creating goals or taking steps that are comfortable. You are likely highly motivated most of the time to take comfortable steps toward your values-based goals and recovery, but your motivation to truly challenge yourself could be lacking. Of course, comfortable steps are necessary and useful, but by avoiding any sense of discomfort, you are avoiding a significant portion of your recovery. For example, if you are meeting your meal plan but sticking rigidly to specific foods because you are fearful of increasing the variety of foods you eat, you are doing enough to maintain your weight, but you are still living by a set of eating-disordered rules. Recovery is not typically a comfortable process, so if you find yourself complacent and consistently comfortable, you may want to take a step back and evaluate what steps in your recovery you are avoiding.

Suggested Solution — Take hold of your committed action and do what is uncomfortable. ….
PERSONAL STORIES

A Girl Called Tim
Escape from an Eating Disorder Hell
June Alexander
267 pages, paper, 2011

Eating with Your Anorexic
A Mother’s Memoir
Laura Collins
192 pages, paper, 2014

Man Up to Eating Disorders
Andrew Walen
202 pages, paper, 2014

In the Labyrinth of Binge Eating
Hilda Dulin Lee
270 pages, paper, 2016

Life Hurts
A Doctor’s Personal Journey Through Anorexia
Elizabeth McNaught
144 pages, paper, 2017

Almost Anorexic
Is My (or My Loved One’s) Relationship with Food a Problem?
Jennifer J. Thomas & Jenni Schaefer
287 pages, paper, 2013

Life Without Ed, 10th Anniversary Edition
How One Woman Declared Independence from Her Eating Disorder and How You Can Too
Jenni Schaefer with Thom Rutledge
188 pages, paper/audiobook, 2014

Hunger
A Memoir of (My) Body
Roxane Gay
320 pages, hardcover, 2017

Shattered Image
My Triumph over Body Dysmorphic Disorder
Brian Cuban
224 pages, paper, 2013

Goodbye Ed, Hello Me
Recover from Your Eating Disorder and Fall in Love with Life
Jenni Schaefer
249 pages, paper, 2009

Phoenix, Tennessee
(music CD)
Jenni Schaefer
7 songs, 2010

Washed Away
From Darkness to Light
Nikki DuBose with James Johanson
303 pages, paper, 2016

Request free copies of the 2018 Gürze/Salucore Eating Disorders Resource Catalogue at EDcatalogue.com
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<thead>
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<th>Treatment Center</th>
<th>State</th>
<th>PG</th>
<th>Children</th>
<th>Teens</th>
<th>Adults</th>
<th>Females</th>
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<td>Robert Wood Johnson University Hospital Somerset Eating Disorders Program</td>
<td>NJ</td>
<td>61</td>
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<td>Rogers Behavioral Health</td>
<td>FL, IL, MN, TN, WI</td>
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<td>Torrance Memorial Medical Center’s Medical Stabilization Program for Adolescents and Young Adults</td>
<td>CA</td>
<td>58</td>
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<td>Upstate New York Eating Disorder Service</td>
<td>NY</td>
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<td>Veritas Collaborative</td>
<td>GA, NC, VA</td>
<td>56</td>
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<td>Walden Behavioral Care</td>
<td>GA, CT, MA</td>
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Working Together
Towards Recovery

For over three decades, more than 75,000 adolescent girls and women from all walks of life have chosen The Renfrew Center to help them overcome their eating disorder.

Through Renfrew’s community, women learn to embrace hope, perseverance, strength, and gratitude to live the life they deserve.

The combined elements of Renfrew’s treatment model, the in-depth experience of our clinical staff and the collaborative partnership we have with the referring team, underscore our patients’ progress in achieving full recovery.

Contact us – we can work together to get your patient the care she needs.

1-800-RENFREW (736-3739)
www.renfrewcenter.com

The road to resilience begins at Rogers.

Getting on the path toward recovery from an eating disorder and staying there takes courage and commitment. Your team at Rogers Behavioral Health is with you every step of the way. We offer treatment that works for males and females at any age – children, teens and adults.

Visit rogersbh.org or call 800-767-4411 for a free screening.

Accredited by the Joint Commission
Your Strength Is Within

What We Treat:
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Avoidant/Restrictive
- Food Intake Disorder
- Compulsive Exercise
- Comorbid Medical and Psychiatric Issues
- Disordered Eating in High Weight Patients

Who We Treat:
- Males/Females
- Adults
- Adolescents
- Children
- Athletes

Free and Confidential Pre-Admission Assessment
800-828-8158 | McCallumPlace.com

Veritas Collaborative is a specialty hospital system for the treatment of eating disorders.

Durham, NC · Charlotte, NC · Richmond, VA · Atlanta, GA

TOLL FREE: (855) 875-5812 · veritascollaborative.com

 onClick="location.href='https://www.mccallumplace.com'"

LASTING SUPPORT THROUGHOUT THE JOURNEY TO RECOVERY

Walden provides individualized care for:

- ALL TYPES OF EATING DISORDERS
  Anorexia, Bulimia, Binge Eating Disorder, ARFID, OSFED
- ALL LEVELS OF CARE
  Inpatient, Residential, Partial Hospitalization, Intensive Outpatient, Outpatient
- ALL AGES
  Adults, Adolescents, Children
- ALL GENDERS

Locations:
New England (781) 647-6727
Georgia (770) 458-8711
waldeneatingdisorders.com
info@waldeneatingdisorders.com

Request free copies of the 2018 Gürze/Salucore Eating Disorders Resource Catalogue at EDcatalogue.com
Quality Care in a Community Environment

The Cambridge Eating Disorder Center provides individuals suffering with eating disorders a comprehensive continuum of support services focused on their recovery. Led by an experienced, multi-disciplinary team, clients receive individualized treatment across the complete spectrum including:

Residential • Partial Hospital • Intensive Outpatient
Outpatient • Transitional Living

Located in Harvard Square and New Hampshire, CEDC fosters recovery in a comfortable, nurturing environment.

CEDC 888.900.CEDC (2332) • info@cedcmail.org
www.eatingdisordercenter.org
Cambridge, MA • Concord, NH

Trauma-Focused Treatment for Eating Disorders

Our comprehensive individualized treatment programs for eating disorders help women address the underlying issues which are often barriers to wellness and recovery: trauma, depression, anxiety, relationship, intimacy and/or substance use disorders — all can effectively be cared for by our experienced professional team.

• Trauma Treatment
• Co-Occurring Disorders
• Relapse Prevention Planning

Get evidence-based treatment in an inspiring setting.

Why Remuda Ranch at The Meadows?

An industry leader in treating eating disorders and co-occurring conditions in women and girls from our critical care unit to our inpatient and residential programming.

Hospital-level care...

• Critical Care Unit focused on medical and psychological stabilization, nutritional rehabilitation and chemical dependency (detox) services
• 24-hour nursing
• More than 25 years of experience
• Highly-qualified, multifaceted treatment team that includes doctors, psychiatrists, nurses, dietitians, and therapists
• Comprehensive Trauma Program

...inpatient and residential program settings.

• Inpatient and residential programming and dedicated older child and adolescent units
• Art and Expressive Therapies
• Resident therapy dog to comfort patients
• Organic garden maintained by the patients as a source for meal preparation
• Equine Program
• Faculty-lead academics for school-age patients
• Week-long family program

Multifaceted Approach to Recovery

Nutrition
We help our patients develop a healthy relationship with food through an integrated culinary program that includes...

• exposure and response prevention,
• supervised daily meal preparation,
• weekly nutrition challenges,
• restaurant and grocery shopping excursions, and
• tending a communal garden.

Dual-diagnosis
Our treatment team is uniquely qualified to treat eating disorder patients with additional complications from...

• drug and alcohol addiction,
• depression,
• self-harm,
• anxiety, and
• unresolved emotional trauma.

Remuda Ranch
AT THE MEADOWS

866-390-5100
www.remudaranch.com
Wickenburg, Arizona
Request free copies of the 2018 Gürze/Salucore Eating Disorders Resource Catalogue at EDcatalogue.com
ADOLESCENT EATING DISORDER TREATMENT IN THE SF BAY AREA

Our PHP and IOP Programs

1. Are designed for adolescents between the ages of 12 and 20 and include teen-friendly treatment, foods and environment
2. Support the whole family and include expertise in Family Based Treatment
3. Include a multidisciplinary treatment team of experienced clinicians
4. Include medical and psychiatric staff on site for all program days
5. Have specialized registered dietitians that attend all meals and snacks

www.HealthyTeenProject.com

919 Fremont Ave., Suite 100
Los Altos, CA 94024
650.941.2300

Saving a life begins here.

Effective treatment for adults with eating disorders

• Inpatient
• Partial Hospitalization
• Specialty track for males
• Trauma or substance use issues

Call 800-366-1740, 24 hours a day.

For more information call
1-877-ACUTE-4-U
ACUTECenterforEatingDisorders.org

Jennifer L. Gaudiani, MD, CEDS, FAED
Founder & Medical Director

• Expert outpatient medical care for patients with eating disorders and disordered eating
• Collaborative multi-disciplinary approach
• Telemedicine and in-person treatment plans
• Adolescents and adults of all genders
• Professional consultation and education

720.515.2140 | www.gaudianiclinic.com

ACUTE CENTER FOR EATING DISORDERS
BY DENVER HEALTH.

With limited exceptions, physicians are not employees or agents of this hospital. For language assistance, disability accommodations and the non-discrimination notice, visit our website. 173089 9/17
WHAT DOES AN EATING DISORDER LOOK LIKE?

Eating disorders do not discriminate based on age, gender, ethnicity, or socioeconomic status.

At The Center for Eating Disorders at Sheppard Pratt, we offer highly specialized treatment for people of all ages affected by eating disorders, including anorexia nervosa, bulimia nervosa, binge eating disorder, and other forms of disordered eating. Most insurance plans accepted.

Learn more or refer a client by calling 410.938.5252 or visiting eatingdisorder.org

• Males and Females with Eating Disorders
• Adolescents and Adults 15+
• Co-Occurring
• All Eating Disorders
• Specialize in Diabulimia
• Vegan and Vegetarian patients

Admissions: 866-948-2036

www.centerforhopeofthesierras.com
People travel from all over the country to receive treatment at Princeton Center for Eating Disorders. We have earned a national reputation for our expert care with access to on-site medical treatment and our healing approach that provides the tools for long-term recovery. No matter how far you travel to get here, you’ll definitely go far while you are here.

Inpatient treatment for people of all genders, ages 8 and older.

TAKE THE FIRST STEP TODAY.
877.932.8935
princetonhcs.org/eatingdisorders

Robert Wood Johnson University Hospital Somerset’s nationally recognized Eating Disorders Program offers comprehensive care for male and female adolescents and adults, featuring:

- Evaluation of all patients regardless of their weight
- Inpatient treatment (one of only two in New Jersey)
- Partial hospitalization program
- Intensive outpatient services
- Weekly support group
- Multidisciplinary team approach
- Access to medical specialists

For more information, call 1-800-914-9444 or visit RWJUH.edu/eatingdisorders.
Somerville, NJ 08876-2598
HEALING ENVIRONMENT. PERSONAL CARE.

The nationally recognized Laureate Eating Disorders Program in Tulsa, Oklahoma is designed to meet the needs of individuals with anorexia nervosa, bulimia and other eating-related difficulties.

- Exclusively for women and girls, our personalized program meets the unique needs of each patient
- Separate treatment programs for adults and adolescents
- Dedicated clinical team that follows patients through acute, residential and partial hospital care
- Monthly family week provides support and education to family members
- Affiliated with the Laureate Institute for Brain Research
- Nonprofit, behavioral health facility accredited by The Joint Commission

800-322-5173
laureate.com/eatingdisorders

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GÜRZE/SALUCORE

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At Children’s Health®, we know that eating disorders are complex diseases that impact the entire family. The Children’s Medical Center Eating Disorders program in the Dallas, TX area is the only pediatric program in the country to receive The Joint Commission’s Disease-Specific Certification for comprehensive eating disorders treatment and care. With more than 30 years of expertise, we treat both boys and girls ages 5-17, with a range of care that includes inpatient, partial hospitalization and intensive outpatient to provide families with the care needed most.

Visit childrens.com/eatingdisorders or call 214-456-8899 to learn more.

children'shealth®
Plano
Specialized Treatment for Adolescent Girls & Adult Women with Eating Disorders

“There is No Substitute for Experience”

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- Residential Treatment
- Day & Evening Programs
- Independent Living Program
- Diabetes (ED-DMT1) Program
- Outpatient Therapy
- Aftercare Follow-up
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888-224-8250 info@centerforchange.com

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Eating Recovery Center
Leading the way to recovery

what makes us unique?

- **National Vertically Integrated Healthcare System**
  Comprehensive care at all levels of care from inpatient medical stabilization to intensive outpatient

- **Strong Commitment to Family Involvement**
  Dedicated therapies for families impacted by eating disorders and related conditions

- **High Care Team Member to Patient Ratio**
  We ensure patients get the individualized attention they deserve to achieve lasting recovery

- **Collaboration with Referring Providers**
  We work jointly with providers to achieve best possible treatment outcomes

resources for patients, family members, and providers

- **MyERC Professional Portal**
  One convenient location to earn continuing education online, become a member of the National Referral Network and refer a patient via Quick Admit

- **eLearning Webinars**
  Ongoing educational trainings from the comfort of your home or office

- **Mental Note Podcast**
  Hope-filled episodes provide education and inspiration through relatable, personal stories of recovery

- **Family Support Center**
  Online resources for family members and caregivers including meal planning, education, and a recovery-focused forum

- **National Recovery Advocates**
  Our advocates inspire hope through sharing their own stories of recovery from an eating disorder

- **Become a Recovery Ambassador**
  Receive a monthly email with ways to raise awareness and educate others about eating disorders

- **Educational Events**
  Local, regional and national events for providers, alumni, family and community members

- **Alumni Support**
  We support you in sustaining recovery after treatment

- **Virtual Program Tour**
  Experience a 3D tour of our programs via YouTube videos and virtual reality glasses

Visit eatingrecovery.com/2018 to get connected today.