Contents

PAGE  
4 9 Truths About Eating Disorder Recovery By Beth-Ann McGeary, PhD, FAED, CEDS
6 Body Image, Eating Disorders, and Women at and Beyond Midlife: The Nine Truths By Margot Marks, PhD, FAED, CEDS
8 Sick Enough: A Guide to the Medical Complications of Eating Disorders By Jennifer L. Gastamin, MD, CEDS, FAED
12 Assessment and Treatment of Anorexia/Restrictive Food Intake Disorder By Jessie Messer, PhD
14 Structuring Mealtime By Lauren Muhlheim, PsyD
15 The Complex Relationship Between Eating Disorders and Substance Use Disorders By Amy Baker Dennis, PhD, FAED & Tamara Pryor, PhD, FAED
15 Understanding Teen Eating Disorders: Warning Signs, Treatment Options, and Stories of Courage By Ciri L. Hutton, MA, PhD, CEDS, Caitlin Simpson, PhD, LMHC & Mary Tantin, PhD, PMHCNS-BC, FAED, CDP
22 When Autism Spectrum Traits Complicate Eating Disorders Treatment By Kim McCullum, MD, FAAPA, CEDS
24 Understanding PTSD and Eating Disorders By Jennifer Wang-Hall, PhD
26 Implications to Health Promotion & Prevention By Niva Piran, PhD
28 I’m Hiding, Please See Me: Unmasking Shame By Nikki Rollo, PhD, LMFT
30 Emily’s Guide to Eating Disorders: A Workbook for Children Ages 5-11 By Sherri Hicks, LMWW
32 The Principles of Yoga and How They Apply to Eating Disorder Recovery By Lisa Diers, RDN, LD, E-RYT & Dianne Neumark-Sztainer, PhD, MPH, RD, RYT-500
34 Eating Disorders and Palliative Care By Patricia Westmoreland, MD & Philip S. Mehler, MD, FAAP, FAED, CEDS
36 Hunger for Connection: Finding Meaning in Eating Disorders By Alitta Kullman, PhD
40 Food and Body Image for Special Events By Signe Darvin, Women, Starting, and Shelley Aggarwal
44 National Organizations
44 Treatment Facilities Index
44 Our New Store!

DEAR READERS,

We are grateful and so appreciative of your loyalty and support of our mission to serve and benefit individual sufferers, their families, their loved ones, and eating disorder treatment professionals.

I am excited to share this 2019 edition with you. The depth of wisdom, intensity of research, and generosity of time shared by each of our writers humbles me. When it comes to the field of eating disorders—and all aspects of their lives—our contributors don’t know any other way but to rely on their passion and integrity. My heartfelt thanks is extended to each of them.

In this all-new issue, you are presented with timely topics such as “The Complex Relationship Between Eating Disorders and Substance Use Disorders,” “Eating Disorders and Palliative Care,” additional “Nine Truths,” and other compelling articles.

Please take time to review the quality treatment options listed in our Treatment Facilities Index starting on page 42. These organizations offer their support to help make this publication possible, and they welcome your questions.

We are all here for you.

WITH WARM REGARDS,
Kathy Cortese
LCSW, ACCSW, CEDS
Editor-in-Chief

P.S. Don’t forget to check out our weekly ED Matters podcast.

We know. It’s a lot.

Visit EdCatalogue.com/CE for Online Courses to Complete Your Hours!

Copyright © 2019 Salucore, LLC unless otherwise stated. All rights reserved. Contents may not be reproduced without permission. Cover and inside images: Getty Images. Models used for illustrative purposes only. Catalogue designed by Wendy Robison, wendyrobison.com. This catalogue is printed on recycled paper with at least 10% postconsumer waste.

Sponsorships

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

Welcome!
The expression “flapping one’s wings” generally conjures images of a fruitless pursuit to shift positions, an ineffective effort to elicit change, The “butterfly effect,” on the other wing, so to speak, offers an alternative perspective of metamorphic potential (Lorenz, 1963). Lorenz, a meteorologist and pioneer of chaos theory, introduced the concept that nature is highly sensitive to small changes, thus small causes can have large, unpredictable effects—the flapping of a butterfly’s wings in Brazil could be a catalyst for effects—the flapping of a butterfly’s wings in Brazil could be a catalyst for what might be a later tornado in Texas. What might wings in Brazil could be a catalyst for these nine truths about ED recovery that I also presented at IAEDP (McGilley, 2018), I offer these nine truths with humble hopes that the fluttering of my concepts will similarly expand, sensitize, and destigmatize perceptions of ED recovery as considered through a holistic, inclusive, and social justice lens.

TRUTH #1. GETTING REAL IS REAL AND ROUGH AND FULLY POSSIBLE.

My nine truths begin where the AED nine truths leave off: “Full recovery from an eating disorder is possible. Early detection and intervention are important.” (AED, 2015). While fully possible, the recovery process is generally lengthy, typically messy, and invariably requires—yes, what a radical notion—love! Self-love and that of our caregivers—of whom much is asked if we’re lucky enough to have their support. The wisdom of the Skin Horse in The Velveteen Rabbit (1922) poignantly captures my sentiments on recovery, what I liken to “getting real.”

“The real isn’t how you are made,” said the Skin Horse. “It’s a thing that happens to you. When a child loves you for a long, long time, not just to play with, but REALLY loves you, then you become Real.”

“Does it hurt?” asked the Rabbit.

“Sometimes,” said the Skin Horse, for he was always truthful. “When you are Real you don’t mind being hurt.”

“Does it happen all at once, like being wound up,” he asked, “or bit by bit?”

“It doesn’t happen all at once,” said the Skin Horse. “You become. It takes a long time. That’s why it doesn’t happen all at once. It only happens when a child loves you. Then you become Real.”

It takes a long time. That’s why it doesn’t happen all at once, like being wound up, “or bit by bit?” It only happens when a child loves you. Then you become Real. “You become. It was Margo Maine briefly presented her version of nine truths about midlife EDs at Maine (1922). That doesn’t happen often to people who break easily, or have sharp edges, or who have to be carefully loved and worthy for our brains and bodies to be restored to wholeness, but braving the interruption of symptoms and sustaining recovery efforts is arguably much more likely to happen in those who feel lovingly and honestly felt—those who come to trust that they belong and have a place at the table of humanity. And when this happens, down to our loose joints and very shabby. But these things don’t matter at all, because once you are Real you can’t be ugly, except to people who don’t understand” (Williams, 1922).

“The real isn’t how you are made,” said the Skin Horse. “It’s a thing that happens to you. When a child loves you for a long, long time, not just to play with, but REALLY loves you, then you become Real.”

“Does it hurt?” asked the Rabbit.

“Sometimes,” said the Skin Horse, for he was always truthful. “When you are Real you don’t mind being hurt.”

“Does it happen all at once, like being wound up,” he asked, “or bit by bit?”

“It doesn’t happen all at once,” said the Skin Horse. “You become. It takes a long time. That’s why it doesn’t happen all at once, like being wound up, “or bit by bit?” It only happens when a child loves you. Then you become Real. “You become. It was Margo Maine briefly presented her version of nine truths about midlife EDs at Maine (1922). That doesn’t happen often to people who break easily, or have sharp edges, or who have to be carefully loved and worthy for our brains and bodies to be restored to wholeness, but braving the interruption of symptoms and sustaining recovery efforts is arguably much more likely to happen in those who feel lovingly and honestly felt—those who come to trust that they belong and have a place at the table of humanity. And when this happens, down to our loose joints and very shabby. But these things don’t matter at all, because once you are Real you can’t be ugly, except to people who don’t understand” (Williams, 1922).

The recovery process is generally lengthy, typically messy, and invariably requires—yes, what a radical notion—love!
“Eating disorders,” instantly, most of us just visualized a teenage or college-age girl. And let’s be honest—she was probably white.

True—not so long ago, age seemed unprecedented opportunities and unprecedentدس stress for women. Now we have so much today—to growing economic strength, political influence, and educational and career opportunities. Yet according to a Gallup Well-Being Index, women ages 45 to 64 have the lowest well-being in the U.S. The cultural pressures to be perfect—including having a flawless, slim body—have no expiration dates and no boundaries. Our fast-moving consumer culture has created unprecedented opportunities and unrelated between scrutinizing every morsel they ingest and shamefully bingeing or purging. Often, the eating disorder changes over time, starting with one category of symptoms and moving to another. The issue is less about the specific diagnosis and more about the frequency, intensity, and duration of the symptoms and other contributing factors—like comorbid substance abuse, severe mood and anxiety disorders, and trauma. In all life stages, anorexia is the least common of the eating disorders. Bulimia is more frequent, but binge eating disorder and the atypical eating disorders, now called other specified feeding and eating disorders (OSFED), are the most frequent, especially among adult patients.

Eating disorders are serious, life-threatening illnesses—not character flaws. It’s time to bring marginalized groups—like middle- and older-aged women—who are often ignored in treatment and research out of the closet.

Inspired by the Academy for Eating Disorders Nine Truths About Eating Disorders, I propose The Nine Truths About Eating Disorders and Beyond Midlife.

**Truth #1**

Eating disorders in women at and beyond midlife have rapidly emerged as a major public health problem. In the U.S., 13.3 percent of women 50 and older report eating disorder symptoms, surpassing the 12.4 percent incidence of breast cancer. A recent lifetime prevalence in the U.K. indicates that as many as 15.3 percent of middle-aged women suffer from eating disorders. OSFED was the most prevalent diagnosis, mirroring my clinical experience. Only 27.4 percent of women who sought help or received any treatment for the eating disorder. I suspect that even fewer access services in the U.S. as a result of inadequate mental health insurance and stereotypical beliefs that eating disorders are a young woman’s problem.

**Truth #2**

Eating Disorders are multIdetermined biopsychosocial disorders. DNA contributes risk but does not code for a specific condition or disease. In other words, genes create vulnerabilities to be tempered or intensified by other factors, including the environment, early development, physical conditions, and social experiences or expectations. The shared heritable environment is a key force contributing to disordered eating, including toxic intergenerational attitudes toward weight, food, and body image.

As eating disorders still occur disproportionately in women, it is safe to say that gender is the greatest risk factor. Adult women experience countless repeated exposures to this toxic culture, but media literacy and prevention efforts focus much more on adolescents and young adults, rarely trying to raise consciousness about the risks of disordered eating and body image preoccupation in middle and older women.

**Truth #3**

In contrast to the past, eating disorders are truly a global phenomenon. Eating disorders are found on all continents, including Asia and in Arab countries, and in a broad range of cultural, racial, and ethnic populations. The world is in transition, so women are in transition. In the words of holistic physician Christiane Northrup: “The state of a woman’s health is indeed completely tied up with the culture in which she lives and her position within it.”

This new cultural environment includes: exposure to the “war on obesity,” weight bias, and the misinformation promulgated by the diet industry; an overpowering consumer culture with constant exposure to strict and unrealistic media images of beauty; shifting gender roles because of industrialization, urbanization, and modernization; and the trend toward highly palatable prepared and fast foods and the adoption of a more sedentary lifestyle, contributing to increased BMIs and eating issues. All of these factors create a global risk for body image issues and eating disorders.
The act of bingeing and purging can fulfill certain psychological needs. For instance, purging can play the role of diffusing anger, sadness, loneliness, or frustration. It can help someone feel numb. It can even bring on a sense of euphoria. Purging may not be at all about the calories. It may be about needing to feel empty, which speaks to many patients’ fears of fullness, of being in and aware of their physical bodies as well as of their emotional needs and responses. Purging can also be a mode of self-harm, punishing a body that the mental illness insists is unworthy and unacceptable. Recovery cannot be successful unless patients find a way to get these needs met in other ways.

Unless medical practitioners recognize these aspects of the disease, they can make incorrect assumptions about what purging does for the patient, and in so doing cause invalidation, alienation, and harm. These interactions don’t just have psychological ramifications. They have medical ones, too, because they teach patients to avoid medical care. This is one of the many reasons I always work closely with therapists and dietitians as part of a patient’s treatment team. Recovery is far more complex than “just stop purging.”

**VOMITING**

Studies show a wide range of the prevalence of specific purging behaviors, with vomiting the most commonly used modality, followed by laxative abuse and diuretic abuse. Many people engage in multiple modalities. Vomiting can be triggered manually, where the person’s finger or an object like a spoon triggers the gag reflex. In the former case, patients can end up with calluses and abrasions on the back of their hand from grazing the teeth, a physical finding called Russell’s sign. Over time, vomiting can become almost effortless.

**LAXATIVE ABUSE**

Laxative abuse can start insidiously with patients who have become constipated from metabolic slowing. There are two main types of laxatives, osmotic (those which draw water into the intestine in order to help stools pass more easily) and stimulant (which force the intestinal muscles to contract and propel stool). The former class are safe and rarely abused. The latter class includes senna and bisacodyl, and these are the dangerous ones if abused. Don’t be fooled by pretty labels on boxes bought from organic grocery stores: Herbal teas, for instance, can also contain senna and can contribute to laxative abuse.

No calories are lost with laxative abuse. Rather, individuals develop a compulsive need to have nothing inside them, to be “empty.” Patients may use laxatives until they have nausea, cramps, and diarrhea. A progressive obsession can develop with the appearance of the stomach, along with fears of constipation. Patients can lose touch with normal bowel function; they panic, thinking they are constipated if they have nausea, cramps, and diarrhea. They can begin to plan their days not only around food consumption but around proximity to bathrooms. They may engage in fewer social interactions, since laxative abuse can contribute to laxative abuse.

**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.
Request free copies of the 2019 Gürze/Salucore Eating Disorders Resource Catalogue at EDcatalogue.com

A revolutionary way to connect treatment providers and individuals looking for professional help.

THE GÜRZE/SALUCORE Treatment Provider Directory

CONNECT AT EDcatalogue.com/treatment-provider-directory
Avoidant/restrictive food intake disorder (ARFID) is a distinct feeding disorder of infancy and childhood, and captures a broad spectrum of restrictive eating behaviors, not motivated by weight or shape, that are present across the life span. These restrictive eating behaviors may be characterized as “picky eating” or “selective eating,” or as food phobias (e.g., fear of vomiting, choking, or illness), or as avoidance of particular food groups or texture or sensory sensitivities. Restriction owing to sensory sensitivities, restriction owing to a lack of appetite or interest in food, or by an associated culturally sanctioned practice. These descriptions have led some clinicians and researchers to adopt the stance that these functions represent distinct and meaningful “subtypes” of ARFID. However, while a recent study found that the occurrence of these subtypes could be detected with good reliability, a significant portion of patients endorsed symptoms of more than one subtype (Norris et al., 2018). Thus, others in the field have speculated that these different patterns of restrictive eating may rather represent behavioral phenotypes with distinct underlying etiologies that are not mutually exclusive (Thomas et al., 2017). As such, it is important to recognize that a patient with ARFID may not fit cleanly into one “subtype” of ARFID, but rather may endorse multiple reasons for restrictive eating. It is important to recognize the presence of these distinct, yet often correlated behavioral phenotypes, as they likely indicate that different treatment approaches may be needed for different restrictive functions.

Food Refusal and Avoidant Eating in Children, Including Those with Autism Spectrum Conditions: A Practical Guide for Parents and Professionals
Gillian Harris & Elizabeth Shaw, 232 pages, paper, 2018

Compass Picky Eating for Teams and Adults: Activities and Strategies for Selective Eaters
Jerry McGrath & Kalja Roest, 162 pages, paper, 2018

Spectrum Conditions: Those with Autism, Children, Including Selective Eaters and Strategies for Adults: Activities
Jenny McGlothlin, 162 pages, paper, 2018

Selective Eaters and Strategies for Adults: Activities
Jenny McGlothlin, 162 pages, paper, 2018

A Practical Guide
BY / JESSIE MENZEL, PHD

© 2013 by American Psychiatric Publishing

the condition or disorder and that routinely associated with an eating disturbance occurs in the context of another condition or medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another mental disorder or medical condition or not better explained by another mental disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

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

Significant weight loss or gain (or failure to achieve expected weight gain or faltering growth in children).

Significant nutritional deficiency.

Dependence on enteral or parenteral nutritional supplements.

Significant weight loss (or failure to grow) within 6 months (children) or 1 year (adults).

Significant weight loss (or growth impairment) in the absence of a concurrent medical condition or not better explained by another mental disorder.
Structuring Mealtime

BY / LAUREN MULHHEIM, PSYD

To deliver your teen’s primary medication—an effective meal plan—you need to establish a structure and expectation that she will eat. Remember that your home is now effectively a residential treatment center for one patient. Most patients in residential treatment centers are neither tube fed nor fed against their will. However, they are required to eat. Centers establish a tightly controlled structure. Meals and snacks are prioritized and occur at regular times in a regular place. Patients are expected to eat within a specified time frame. Until they complete the meal, they are not allowed to proceed to the next activity. If they do not complete the meal, there is a consequence.

REQUIRE YOUR TEEN TO EAT

Remember that your teen may have a voice in his head that berates him for eating anything “fattening” or unhealthy. It is hard for your child to defy that voice. Your insistence that he eat more than he intends is a rational thing “fattening” or unhealthy. It is hard for your teen may have a voice that your child eat more than he intends.

Felicia, a mother from Georgia, recounts:

“In the beginning, when we started giving our daughter a daily shake, it was really hard. We tried to offer different flavors, but she would only have strawberry. The eating disorder in her head told her that at least it is a ‘fruit.’ Every day she would say, ‘Just do not give me chocolate, Mom.’ Well, after a few months we gave her a chocolate shake and it was not fun. There was lots of screaming and crying, but eventually she drank it. Months later she said to me, ‘I was so glad when you gave me that chocolate shake and made me eat it. My eating disorder did not want me to have chocolate but I wanted chocolate so bad’.

Do not lose heart and never underestimate the power of what you are doing. ♦
THE COMPLEX RELATIONSHIP BETWEEN EATING DISORDERS AND Substance Use Disorders

BY / AMY BAKER DENNIS, PHD, FAED & TAMARA Pryor, PHD, FAED

Eating disorders (ED) and substance use disorders (SUD) frequently co-occur but are rarely treated in a comprehensive integrated manner. Substance abuse programs often do not admit patients with active ED. Likewise, ED programs frequently admit patients with over-the-counter (OTC) diet pills, laxative, or diuretic abuse but exclude patients abusing alcohol, benzodiazepines, cannabis, stimulants, or opiates. The latter effects reported that treatment programs, at all levels of care, has left individuals with both ED and SUD vacillating between disorders and treatment providers. Unfortunately, this leads to consumer confusion, extends time in treatment, increases treatment costs, and can compromise continuity of care as patients travel through different levels of care (Den- nis, Pryor & Brewerton, 2014). In ad- dition, study indicates that patients who receive nonintegrated services have poorer treatment outcomes (Brewerton & Dennis, 2016).

According to the National Center on Addiction and Substance Abuse, approximately 50 percent of individu- als with ED abuse alcohol or other illicit substances, compared with 9 percent of the general public, and approximately 35 percent of drug abusers have ED (CASA, 2003). This study may be an underestimate of the actual substance abuse in individuals with ED. This research does not take into account OTC laxatives, diet pills, and diuretics; internet supplements: caffeine, nicotine, artificial sweeteners; or the misuse of insulin, thyroid medications, or other prescribed medications frequently abused by individuals with ED.

Individuals with SUD rarely enter treatment without other psychiatric comorbidities. Researchers have found that 28 percent of those seeking treatment for SUD will have five or more comorbid disorders, including mood disorders, anxiety disorders, post-traumatic stress disorder, and borderline personality disorder (Compton, Thomas, Stinson, & Grant, 2007). When an ED is also present, this can further complicate assessment and treatment planning for these complex patients.

Alcohol and other substance abuse is more prevalent in ED subgroups that engage in binge eating/purging, with lower rates of SUD in individuals with anorexia nervosa restricting type. However, there is a significant body of research that elucidates the relationship between food restriction/starvation and the use of psychoactive sub- stances. This research has found that food deprivation leads to increased self-administration of virtually any psychoactive drug, including alcohol, nicotine, amphetamines, barbiturates, phencyclidine, and opioids (Carroll, France, & Meisch, 1979; Specker, Lac, & Carroll, 1994). The presence of either disorder is to moderate risk of suicide, and when left untreated, they have high mortality rates (Bulik et al., 2008). ED and SUD run in families and are heritable conditions. Studies report that 50 percent to 80 percent of phenotypic variance found in alcohol use disorder and SUD is due to genetic factors (Hicks, Krueger, Iacono, & Patrick, 2004).

Likewise, twin studies, de- signed to distinguish environmental from genetic effects, reported that 50 percent to 80 percent of the contribu- tion to liability is genetic in anorexia nervosa and bulimia nervosa (Bulik et al., 2006). ED and SUD share several behavioral similarities. As alcohol/drug use continues and tolerance builds, pa- tients describe intense cravings and uncontrollable consumption, despite negative consequences. Similarly, ED patients, particularly individuals with bulimia nervosa and binge eating dis- order, report powerful food cravings and a sensation of “loss of control” that leads to overconsuming. Food, drugs, and alcohol are often used for their mood-altering effects; to escape, avoid, or numb; or to manage nega- tive emotional states (Brewerton & Dennis, 2016).

While there are similarities between ED and SUD, there are also differenc- es. From a psychological and pharma- cological perspective, ED and SUD are unique disorders that are concep- tualized and treated quite differently. Although both ED and SUD are classi- fied as psychiatric illnesses, as listed in the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), during the past several decades there has been a strong movement in the medical community to view SUD as a chronic medical illness that can be arrested but not cured. Treatment of SUD is designed to help patients increase restraint, and abstinence is considered the path to sustain remis- sion. Individuals with SUD are strongly encouraged to continue participation in self-help programs (Alcoholics Anonymous and Narcotics Anony- mous) during remission because this has been found to improve outcomes and decrease relapse (Donovan et al., 2008).

ED are conceptualized as complex, curable psychiatric illnesses that re- quire aggressive psychological inter- vention, medical management, and, in some instances, psychopharmacolog- ical intervention to treat target symp- toms and/or other comorbid con- ditions. One of the primary goals of treatment of ED is to help patients improve outcomes and decrease relapse (i.e., eliminate dieting, food restric- tion, and compensatory behaviors) which can result in ED treatment recovery, and lifelong participation is not required to prevent relapse.
Understanding Teen Eating Disorders

Warning Signs, Treatment Options, and Stories of Courage

BY CRIS E. HALTOM, MA, PHD, CEDES, CATHEE SIMPSON, PHD, LMHC & MARY TANTILLO, PHD, PMHCNS-BC, FAED, COTP

Emma’s mother [Carolyn] correctly tapped into Emma’s risk to suffer from low body esteem and related weight teasing because of her gender. What Carolyn didn’t realize was that what is known as adiposity, or degree of body fat, is not necessarily a predictor of low body esteem. While high BMI has been shown to be a risk factor for body dissatisfaction and eating disorders in the past, recent research suggests that it may not be increased body size that puts teen girls at risk for eating disorders. Rather, it is the degree of body dissatisfaction at any size that is the biggest risk factor for later eating pathology. Carolyn’s best effort at prevention was misplaced. The focus on changing Emma’s body size might be better directed toward body satisfaction, regardless of her size. Emma cringed when her mother tried to limit her food or question her about it. Carolyn hoped Emma’s family doctor would be more sensitive with Emma, it was out of the ordinary, but accepted that Emma might be oddly normal from a medical perspective. Nonetheless, Carolyn and James [Emma’s father] were so fearful about Emma’s future, they both took on the responsibility of preventing any chance of her becoming obese.

Emma’s parents, along with so many others in their environment, were guilty of weight bias. Weight bias is “the inclination to form unreasonable judgments based on a person’s weight.” These judgments are founded on the mistaken belief that people need to lose weight if they do not meet society’s thin standard. Furthermore, weight bias rests on the assumption that if weight is not lost, there has been a failure of willpower and self-discipline. Emma’s pediatrician, Dr. Chen, observed Emma’s weight and growth history over time and determined that she was in a higher-than-average weight percentile. She was consistently in the same height and weight range given her growth history. Combined with other health data, he determined Emma was in a healthy weight percentiles, throughout her childhood and teen years. Combined with other health data, he determined Emma was in a healthy weight range given her growth history. However, because our culture values thinness, and because our culture supports, or at least overlooks, weight bias, Emma’s parents were unsatisfied with his failure to suggest Emma lose weight. They wanted Dr. Chen to support their fears for their daughter’s future by supporting weight bias.

COPYRIGHT © 2018 FROM UNDERSTANDING TEEN EATING DISORDERS: WARNING SIGNS, TREATMENT OPTIONS, AND STORIES OF COURAGE. REPRODUCED WITH PERMISSION OF TAYLOR AND FRANCIS GROUP, LLC. A DIVISION OF INFORMA PLC. 122 PAGES. PAPER.
**Do You Have an Eating Disorder?**

Respond honestly to these questions. Do you:

- Constantly think about your food, weight, or body image?
- Have difficulty concentrating because of those thoughts?
- Worry about what your last meal is doing to your body?
- Exercise guilt or shame around eating?
- Count calories or fat grams whenever you eat or drink?
- Feel “out of control” when it comes to food?
- Have difficulty concentrating because of those thoughts?
- Constantly think about your food, weight, or body image?

**Warning Signs**

- An obvious increase or decrease in weight not related to a medical condition
- Abnormal eating habits, such as severe dieting, starvation, or laxative or diuretic use
- Compulsive or restrictive exercising, especially without adequate nutritional intake or when injured or ill
- Mood swings, depression, and/or irritability
- An intense preoccupation with weight and body image
- Feelings of being fat, secretive bingeing, or lying about food

If you answered “yes” to any of these questions, your attitudes and behaviors around food and weight may need to be seriously addressed. An eating disorders professional can give you a thorough assessment, honest feedback, and advice about what you may want to do next.

**Personal Stories**

- Dancing with a Demon: A Mother’s Inspiring Journey Through the Labyrinth of Her Daughter’s Eating Disorder. Valarie Foster with Janna Warncke, 273 pages, paper, 2017

**Recovery Workbooks**

- The Intuitive Eating Workbook: 10 Principles for Nourishing a Healthy Relationship with Food. Evelyn Tribole & Elyse Resch, 244 pages, paper, 2017
- Eating Disorders: Understanding Causes, Controversies, and Treatment [2 volumes]. Justin J. Reel, 716 pages, hardcover, 2018
- In the Labyrinth of Binge Eating. Mildred D. Lee, 270 pages, paper, 2016
- Dancing with a Demon: A Mother’s Inspiring Journey Through the Labyrinth of Her Daughter’s Eating Disorder. Valarie Foster with Janna Warncke, 273 pages, paper, 2017

**Recommended Reading**

- Encyclopedia of Feeding and Eating Disorders. Tracey Wade, editor, 901 pages, hardcover, 2017
- Eating Disorders: Your Questions Answered (Q&A Health Guides). Justin J. Reel, 143 pages, hardcover, 2018
- The Intuitive Eating Workbook: 10 Principles for Nourishing a Healthy Relationship with Food. Evelyn Tribole & Elyse Resch, 244 pages, paper, 2017
A young man with anorexia and osteopenia has trouble maintaining friendships; he displays odd mannerisms, monotonous speech, and aggressive outbursts, with periods of rapid weight loss associated with restrictive eating and periods of purging.

A brilliant teenage girl with anorexia and periods of purging. She has difficulty with relationships and avoids expectations, including participation in psychotherapy and meal exposures, work, or school.

What do these patients with eating disorders also have in common? They all manifest traits of autism spectrum disorder, which may complicate their clinical course. Our understanding of autism has changed considerably over the past 30 years. DSM-5 (2013) replaced subcategories of nonverbal autism, pervasive developmental disorder, and Asperger’s syndrome with the unifying diagnosis of autism spectrum disorder (ASD). Current diagnosis requires:

- presence of persistent deficits in social communication (i.e., abnormal prosody of and tone of speech, speech delays) and social interaction across multiple contexts: deficits in social-emotional reciprocity (i.e., reduced sharing of emotions, awkward conversations), deficits in nonverbal communication (i.e., abnormal gaze, facial expression, or use of gestures), deficits in relationships (i.e., difficulties adjusting behavior to new contexts, maintaining closeness) and
- restricted, repetitive behavior or activities, as manifested by at least two of the following: repetitive motor movements, insistence on sameness (i.e., eating the same food every day, inflexible adherence to routines), highly restricted interests, and hyper- or hypo-reactivity to sensory input.

Although the new ASD criteria are less confusing and more reliable, inclusion criteria are narrower, resulting in some patients with significant spectrum symptoms not meeting full criteria for ASD.

Cognition in those with ASD spans the cognitive spectrum from average to superior. Autism spectrum traits measured by standardized assessments occur in higher rates in those struggling with eating disorders including anorexia, ARFID, bulimia, and binge eating disorder (Dell’Osso et al., 2018; Gesi et al., 2017; Huke, Turk, Saedt, Kent, & Morgan, 2013). Depression, bipolar disorder, ADHD, phobias, anxiety disorders, and OCD are all common in both ASD and eating disorders, suggesting common brain circuitry underlying some, if not all, of the symptoms. For instance, cerebellar pathways are now thought to be involved in social communication, cognition, eating, and emotion regulation. The cerebellum is thought to play an important role in ASD. Anorexia nervosa, bulimia nervosa, and ASD patients showed different patterns of intrinsic connectivity involving cerebellar pathways than controls (Fatem, 2013; Amianto et al., 2013). There is growing evidence of similarities between anorexia and ASD in terms of impaired cognitive, social, and emotional processing (Westwood, Stahl, Mandy, & Tchanturia, 2016; Westwood, Lawrence, Fleming, & Tchanturia, 2016). Adolescents and young adults with ASD are at a high risk for suicide attempts and are significantly more likely to show gender dysphoria. Screening for traits of ASD may help us identify a subgroup of patients who are at increased risk.
Understanding PTSD and Eating Disorders

BY / JENNIFER WANG - HALL, PHD

INTRODUCTION
The etiology of eating disorders is multifaceted and complex. Many factors have been suggested to contribute to the development of eating disorders, including temperament, dispositional, family history, and difficulties in regulating emotions. One factor that contributes to emotion regulation difficulties is experiences of trauma, which often create strong negative emotions and intrusive thoughts that can be difficult to tolerate, frequently resulting in maladaptive attempts to regulate these emotions. One such method may be engaging in eating-disordered behaviors, including restricting, binging, and purging. These behaviors may serve to give an individual a sense of control when traumatic experiences have left them feeling helpless and vulnerable. Living with the aftereffects of trauma and an eating disorder can be exceptionally difficult, and these symptoms are often debilitating, preventing individuals from living full and meaningful lives. Fortunately, a few evidence-based treatments have been shown to target the cognitive, behavioral, and emotional patterns frequently seen in individuals with post-traumatic stress disorder (PTSD). The purpose of this review is to provide information regarding the prevalence of traumatic experiences and PTSD in eating disorder populations, discuss available treatment options, and explore the experiences of treating clinicians.

TRAUMA AND ITS CONSEQUENCES
General population studies have shown that a large proportion of people have been exposed to at least one traumatic event in their lifetime (Bjerke et al., 2016). Trauma comes in many forms and can be experienced by individuals of all ages, backgrounds, and circumstances. Traumatic events include, but are not limited to, childhood abuse, sexual assault, accidents, natural disasters, and intimate partner violence. In addition, trauma may include being directly involved in the event, witnessing the event, or repeated or extreme exposure to details of the event. Traumatic events may lead to a series of psychological consequences including nightmares, flashbacks, avoidance, negative mood, distorted beliefs, and hypervigilance. Many individuals experience these symptoms for a brief period of time and then the symptoms naturally resolve themselves. However, for others these symptoms persist and can lead to significant distress and impairment. When these criteria are collectively met, an individual is diagnosed with PTSD. There are many psychological conditions that frequently co-occur with PTSD, including depression, anxiety, substance abuse, and eating disorders.

EATING DISORDERS AND PTSD
Research has indicated that rates of eating disorders are higher in people who have experienced trauma and PTSD. One study indicated that up to 23 percent of patients with anorexia nervosa and up to 25 percent of patients with bulimia nervosa met criteria for PTSD (Tagay, Schlottbohrm, Reyes-Rodriguez, Repic, & Senf, 2014). Among patients attending eating disorder residential treatment, up to 52 percent met criteria for PTSD (Gleaves, Eberenz, & May, 1998). With treatment research is mixed regarding PTSD prevalence in specific subtypes of eating disorders, some of it has suggested that binging and purging behaviors are more prevalent in individuals with PTSD than is restriction (Brewerton, 2004). It has been suggested that overeating may be a form of self-soothing and may numb out unpleasant feelings and intrusive thoughts related to the traumatic event. Purging behaviors are thought to have a similar function, acting as a way to expel unwanted experiences and improve mood. Although the research provides more support for the link between bulimia and PTSD, there has also been speculation that anorexic patients may be using restricting to regulate emotions, particularly those related to trauma. Restriction may result in emotional numbing and a feeling of power that may be desirable to a traumatized individual (Trim, Galovski, Wagner, & Brewerton, 2017). Given the considerable role that these behaviors may take on in regulating emotions, giving up the behaviors in order to recover from the eating disorder is exceedingly difficult.

TREATMENT FOR PTSD AND EATING DISORDERS
There are many important considerations that therapists (and their patients) must deliberate prior to beginning PTSD treatment. Brewerton (2007) describes the need for clinicians to ensure nutritional rehabilitation (most often guided by a dietitian) before proceeding with trauma treatment. Research has demonstrated that anorexia-induced starvation leads to deficits in set-shifting, attention, and decision-making (Treasure & Russell, 2011). These cognitive impairments appear to resolve with adequate weight restoration (Hatch et al., 2010). Another frequent error is failing to ensure appropriate skill acquisition prior to beginning PTSD treatment. Without adequate distress tolerance, a patient may resort to problematic coping mechanisms (bingeing, purging, restricting, substance use, self-harm, etc.) (Brewerton, 2007).

RECOMMENDED READING
Man Up to Eating Disorders Andrew Wain, 202 pages, paper, 2014
Personal Stories
Shattered Image: My Triumph over Body Dysmorphic Disorder Brian Cuban, 224 pages, paper, 2013

25 800-756-7533 - ED catalogue.com
24 Request free copies of the 2019 Gürze/Salucore Eating Disorders Resource Catalogue at ED catalogue.com

24 800-756-7533 - ED catalogue.com
25 Request free copies of the 2019 Gürze/Salucore Eating Disorders Resource Catalogue at ED catalogue.com

24 800-756-7533 - ED catalogue.com
25 Request free copies of the 2019 Gürze/Salucore Eating Disorders Resource Catalogue at ED catalogue.com
Implications to Health Promotion & Prevention

BY NIVA PIRAN, PHD

The DTE (Developmental Theory of Embodiment) delineates a positive way of inhabiting the body with respect to the quality of embodied lives. Toward that goal, health promotion and prevention activities can take place in the three domains of social experiences: physical, mental, and social power and relational connections. In particular, DTE emphasizes systemic interventions that concurrently address all these domains.

PHYSICAL FREEDOM DOMAIN

Toward health promotion, the DTE emphasizes focusing on several protective factors in the physical domain: joyful engagement in physical activities, safety from violations and from forced compliance with harsh appearance standards, experiences of attuned self-care, and a pleasurable connection to desires.

Regarding joyful engagement in physical activities, health promotion interventions need to increase access to physical activities that involve immersion and pleasure, enhance the experience of physical agency and functioning, and support a positive connection to the body. Azzarito and Solomon recommend seeing students’ own choices regarding physical activities and related clothing. Physical activities could include: team sports that are non-competitive and that involve no weight criteria or disruptive clothing, wilderness trips, hiking, freestyle dance, or yoga. The importance of experiencing comfort in one’s body during physical activities cannot be overstated. In our prospective study, girls often described skipping physical activities, such as swimming, if they were not comfortable in their bodies or with the associated dress code. Chapter 1 described how following the introduction of Lycra bodysuits, instead of using shorts and T-shirts as the uniforms for netball, 35,000 fewer girls and women across Australia participated in the sport. Both girls and women complained about experiencing bodily discomfort while playing in the Lycra bodysuits. In a prevention program I implemented in a dance school, students—both girls and boys—asked to have at least one class a week where they could choose what to wear, enhancing their body comfort and immersion in movement and dance.

Inherently, systemic changes need to take place in sports organizations, schools, community centers, families, and multiple other social organizations to successfully enhance girls’ and women’s participation in pleasurable physical activities. The most important systemic intervention to date that has contributed to girls’ and young women’s participation in sports in the United States has been Title IX, the Education Amendment Act, which ensures there is no gender discrimination in educational institutions receiving federal funding; in turn, Title IX was used toward the cause of equalizing opportunities for girls and women in sports. Additionally, girls are socialized to pursue feminine activities rather than sports, which are still commonly constructed as “masculine”; female athletes also face sexualization as well as prejudicial treatment and negative labeling.
I’m Hiding, Please See Me: Unmasking Shame

By / Nikki Rollo, PhD, LMFT

At the core of our humanity is an inexorable search for connection. It is what brings meaning to our lives. In this pursuit, we are asking questions about our identity and looking for answers that will help us define who we are in the world. We are searching for a place of belonging and a community we can call home. We are looking for a sense of belonging and a community we can lean into for emotional spaces where the whole of who we are can be expressed, witnessed, and validated.

As we search for connection, we inevitably will encounter our shame. Psychologist and author Gershen Kaufman wrote in 1974, “The experience of shame is inseparable from man’s search for himself.” While shame is skilled at hiding, it is also woven into the fabric of the human experience.

I write not as an objective observer of the shame of others, but as one who has also experienced shame. As a depth-oriented psychotherapist, I lean into the Jungian tradition that says we all have a shadow and in it are the darker and rejected parts of ourselves that we struggle to accept and integrate. These may be things that are incompatible with our outward presentation, such as anger, rage, hatred, or jealousy. Yet there is also gold in our shadow—for example, there could be a gift or talent that we have rejected because we think we aren’t good enough. These are the parts of ourselves about which, somewhere along the way in our development, we received messages stating they were unacceptable, not good enough, or defective. As you can see, shame and self-criticism live and thrive in the shadow.

Shame is hard to reach, and when we do touch it, our instinct is to quickly move to cover ourselves up. We want to hide, get far away, or pretend it isn’t there. In writing about it, in talking about it, we draw it out and begin to get some clarity about how we can heal.

In this article, we will embark on an exploration of four areas: defining shame, entering into the lived experience of shame, shame and eating disorders, and, of great significance, healing from shame.

DEFINING SHAME

In order to discuss what is healing to shame, we need to understand it deeply. Kaufman (1996) says, “The inner experience of shame is like a sickness within the self, a sickness of the soul. If we are to understand and eventually heal what ails the self, then we must begin with shame.” So, together, let us start by moving toward a deeper understanding of shame.

Shame is a conviction at the very core that one is defective and wrong. It is a deeply rooted emotion that is one is bad, is wrong, and can’t do anything right. Shame is accompanied by self-loathing and feelings of deep inadequacy. It must be distinguished from guilt, which is the feeling that one has transgressed a boundary, hurt someone, or done something wrong. Guilt is typically followed by remorse and an attempt to make amends. It can actually be a beneficial feeling to motivate us when we have not lived up to our values and commitments or if we have wronged or hurt someone. Shame is not about doing anything wrong or bad, but more about a deep embarrassment and humiliation connected to feeling inadequate at the core of oneself. It is an overwhelming sensation that one is small, insignificant, and fundamentally flawed or defective.

Shame-inducing experiences can happen to us as children and as adults. If one experiences frequent shaming or something happens that breaks our spirit, we may come to believe it is our fault, that we deserved it, and that we are not worth taking up space and existing in this world. It is something that becomes woven into our identity.

Diagnostic 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 associated with the recurrent use of inappropriate compensatory behavior as in self-induced vomiting, fasting, or excessive exercise that does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

When your loved one stopped feeding their body correctly, their brain and stomach stopped talking to each other in the right way. Their stomach started telling their brain that they were no longer hungry—or, they cannot get enough food.

Next, their brain started saying that the food didn’t taste good anymore. Then, their brain started telling them that they are overweight and they really are not, or their brain told them they need more food even when they are full.

Poor brain and stomach... they just didn’t know what to do!

When your loved one’s eating disorder became stronger, they might have done some strange new things. Put a check by the one that you saw them do.

☐ Be tired/sleep too much
☐ Take a long time to eat
☐ Cut food into small pieces
☐ Cried because they had to eat
☐ Not want to go out to eat
☐ Tell other people what to eat
☐ Chew food and spit it out
☐ Throw up in weird places
☐ Argue about eating
☐ Be cranky
☐ Exercise too much
☐ Stay alone in their room
☐ Throw food away
☐ Eat too much

Can you draw a picture of your family at dinner time when your loved one’s eating disorder was strong?
The Principles of Yoga
AND HOW THEY APPLY TO EATING DISORDER RECOVERY
BY / LISA DIERS, RDN, LD, E-RYT & DIANNE NEUMARK-SZTAINER, PHD, MPH, RD, RYT-500

INTRODUCTION
Having an eating disorder can serve as a distraction from unwanted feelings, experiences, and stressors. Eating disorders create a disconnect between body and mind. When one is struggling with an eating disorder, the needs of the body are often ignored to an extreme degree, and the disconnect from uncomfortable sensations can occur through a variety of maladaptive coping mechanisms. These coping mechanisms can be dangerous to body and mind. In order to live life in a recovery-minded way, one needs to learn how to cope with the patterns of the mind, stressors in life, and unwanted feelings, experiences, and memories in a healthful manner. Paramount to recovery is a greater understanding of the patterns of one’s mind, the language of one’s body, the mechanisms developed to cope, and an increased awareness of eating disorder thoughts, urges, or dysregulation in one’s system. This internal awareness can be very useful in using more positive coping skills when faced with life challenges and delaying, reducing, or even preventing eating disorder symptoms or behaviors.

There is no “one way” to recover from an eating disorder. Eating disorders are multifaceted, nonlinear, and complicated, and can evolve over time from one condition to another. Many approaches may be tried to build momentum and sustain recovery. A multidisciplinary approach (psychotherapy, nutrition therapy, medical monitoring) is highly recommended, but even all of these components in combination may not always be enough. Getting into one’s body and truly feeling what is going on in the body may also be helpful, even necessary. Enter: therapeutic yoga and yoga therapy.

THE AUTHORS’ EXPERIENCE WITH YOGA AND EATING DISORDERS
It is perhaps useful to understand a bit about the authors’ relevant perspectives and experiences, particularly with yoga. Prior to delving into a discussion of yoga and related research, there is a description of each author’s role in recovery and conducting research in the area of eating disorders.

Lisa Diers is a registered dietitian who has specialized in eating disorder treatment for 15 years. More than 10 of those years have been as both a registered yoga teacher and dietitian in an eating disorder treatment setting, instructing clients at multiple stages in the recovery process (residential through outpatient). She was also instrumental in successfully incorporating yoga into an eating disorder treatment program, which, as of 2017, held 125 weekly yoga classes across four states. To date, Lisa has completed more than two of four years training as a Viniyoga therapist in the lineage of Sri Krishnamacharya and T.K.V. Desikachar. She has developed yoga interventions for research study designs seeking to learn yoga’s potential benefit for treating eating disorders, and has instructed thousands of therapeutic yoga classes, hundreds of individual sessions, and multiple trainings for those struggling with an eating disorder or wanting to learn how to help others. Her current role is continuing this work, integrating yoga and nutrition therapy into recovery, conducting trainings, writing, and research in private practice (Diers, 2016a, 2016b; Klein & Diers, 2018; Pacanowski, Diers, Crosby, & Neumark-Sztainer, 2017).

Dianne Neumark-Sztainer is also trained as a dietitian and a yoga teacher. Her current primary role is as a researcher in the area of eating and weight-related problems in young people, with a focus on understanding and addressing risk and protective factors across the life course to prevent these problems. Through her own practice, she recognized yoga’s potential for coming inward into one’s body in a positive manner, establishing a greater connection to oneself, and emotion regulation. These observations, in addition to various comments made by her yoga teachers, made her curious about the potential for yoga to help in the area of eating disorders, particularly prevention. She began to read more about yoga, practiced more regularly, and trained as a yoga teacher (500-hour certification), taught yoga within an eating disorder treatment facility (with Lisa), and embarked on a program of research exploring connections between yoga and body image, eating disorders, eating behaviors, physical activity, and weight status (Neumark-Sztainer, 2014; Neumark-Sztainer, Eisenberg, Wall, & Loth, 2011; Neumark-Sztainer et al., 2017; Neumark-Sztainer, MacLeahose, Watts, Pacanowski, & Eisenberg, 2018; Pacanowski et al., 2017, Watts, Rydell, Eisenberg, Laska, & Neumark-Sztainer, 2018).

Through her own practice, she recognized yoga’s potential for coming inward into one’s body in a positive manner, establishing a greater connection to oneself.
Eating Disorders and Palliative Care

BY / PATRICIA WESTMORELAND, MD & PHILIP S. MEHLER, MD, FACP, FAED, CEDS

INTRODUCTION
Although it only recently has been noted that patients with anorexia nervosa may recover after 20 years of illness, there is a subgroup of individuals with SEEDs (severe and enduring eating disorders) whose illness appears intractable. These individuals are no longer looking for a “cure” in the traditional sense, but for enough improvement in their condition that allows them a reasonable quality of life. Individuals with SEEDs are often profoundly underweight—body mass index (BMI) < 13—physically disabled, and dependent on relatives or other caregivers. These individuals have exhausted many prior treatments and have not been able to maintain their weight between treatments. They may not be able to work or attend school or engage in anything but the most basic activities. However, they can usually articulate what is most important in their lives—such as spending time with family, friends, and pets; tending to a garden; or engaging in hobbies in which they find a sense of accomplishment and peace. Quality of life is paramount, even if they cannot be fully independent.

HARM REDUCTION, PALLIATIVE CARE, AND END-STAGE EATING DISORDERS
Depending on their willingness to enter treatment and engage in at least some degree of weight restoration, individuals with SEEDs may choose to participate in a harm-reduction model. The goal of a harm-reduction model is to reach and then maintain a lower-than-optimal weight, rather than being subjected to prolonged hospitalization and a weight-restoration diet with the goal of achieving ideal body weight. Individuals who have endured multiple prior eating disorder treatments with minimal success, and for whom full weight restoration has not been sustainable, may be candidates for a harm-reduction strategy. Individuals who engage in a harm-reduction model are managed as outpatients once they have attained an agreed-upon body weight and are out of immediate medical danger. Individuals with a BMI lower than 13 are at the highest risk of morbidity and mortality, whereas those with a BMI higher than 16 are at the lower end of the risk spectrum. However, aside from BMI, an individual’s risk of illness and death increases with rapid weight loss and comorbid medical problems (electrolyte abnormalities, infection, fractures, renal or hepatic failure). Individuals who receive treatment according to the harm-reduction model must schedule regular visits with their outpatient team (psychiatrist, or primary care physician, dietitian, and therapist). They should be monitored for depression, hopelessness, and suicidal ideation. Patients with chronic, severe eating disorders often feel hopeless and attempt suicide using highly lethal means because they are well accustomed to physical pain. For individuals with SEEDs who are not willing to accede to the requirements of a harm-reduction model, and whose goals are more in line with comfort than prolonging life, palliative care may instead be suggested. The goal of palliative care is to reduce suffering through comfort care, including, but not limited to, the management of physical and psychological pain. Palliative care does not necessarily mean "giving up," but realizing that eating disorder treatment (or even a harm-reduction model) is unlikely to prove beneficial. Individuals who decide to move forward with palliative care often have severe and intractable medical and psychiatric comorbidities. Symptomatic relief may include anaglogics for pain associated with osteoporosis and stress fractures; wound care for decubitus ulcers; medications to reduce anxiety, depression, and obsessive thinking; and treatment of insomnia. Palliative care may take place in an individual’s home, in a hospital, in a skilled nursing unit, or possibly (although not necessarily) in a hospice care unit if said eating disorder reaches end stage.

When exactly an eating disorder becomes “end stage” has been a matter of considerable debate. There is a lack of clarity as to what is meant by the term “end stage” as it applies to an eating disorder, even if it is severe and enduring, as medical complications of eating disorders are usually treatable, even in their most severe form. What makes an eating disorder end stage is most often dependent on whether an individual (and his or her family) decides not to engage in further treatment. But are individuals with SEEDs capable of refusing treatment in favor of harm-reduction or palliative care or deciding that these choices is end stage?

For individuals with SEEDs who have not been able to maintain their weight between treatments, they may recover after 20 years of illness, even if they cannot be fully independent. Quality of life is paramount, even if they cannot be fully independent.
Hunger for Connection
Finding Meaning in Eating Disorders

BY / ALITTA KULLMAN, PHD

BOOK EXCERPT

Hunger for Connection
Finding Meaning in Eating Disorders

BY / ALITTA KULLMAN, PHD

What had we been talking about that could have triggered her sudden dyssynthymia shift from thinking with her mind to “thinking” with her body, happening right before our eyes! Megan’s sudden shift, from thinking with her mind to “thinking” with her body, is what I call “dyssynthymia.” Dyssynthymia, as I have conceived and developed it, is “an impairment in the ability to distinguish between felt-states or senses of the body and mind.” A reflection of what I believe to be the failure of the mind and body to separate and differentiate from each other beginning with the earliest feedings, dyssynthymia may account for such phenomena as:

• The replacement of normally intact thinking with “food thoughts” in the face of distressing or overwhelming emotional experiences
• The confusion of internal or “gut” feelings of longing, anxiety, sadness (and so forth), with sensations of hunger
• The inability to differentiate between the ingestion of toxic, explosive elements and the ingestion of food or “fat”
• The attempt at garnering emotional fortitude by eating (or not eating)
• The literal use of food for thought.

As I listened to Megan, my mind went on instant replay, scanning our conversation.

What had we been talking about that could have triggered her sudden dyssynthymia shift from thinking with her mind to “thinking” with her body?

“I wonder if something just happened,” I asked her, “a sudden ‘something’ that made you uncomfortable in some way?”

Megan thought for a moment. “I think I just got anxious telling you all that,” she said sheepishly.

“What about it made you anxious?” I asked her gently.

“It just makes me feel embarrassed and ashamed,” she replied, her face reddening.

“All like the things I was just like I am on the outside are just really a fraud.”

“You know,” she continued, after a few minutes of silence, “I was just thinking about last night. The managing partner gave me an assignment related to this really important case involving one of our biggest clients. Jon was out of town, so I decided to stay late at the office and have dinner with my dad to talk about the case. I was so excited about the assignment! I had a healthy meal and felt really good about the conversation…I had a pretty good idea of what I needed to write, but I kept getting more and more anxious. Before I knew it, I just had to eat. First I ate the leftover lasagna. That didn’t work. Then I made macaroni and cheese. Then I ate ice cream, then some M&Ms. It was like I was crazed. What! What will work! Nothing did!”


Jessica Tripp, 119 pages, spiral-bound, 2021

Eating Disorders in Children and Adolescents

Daniel Le Grange & James Lock, 332 pages, hardcover, 2011
Food and Body Image for Special Events

BY / SIGNE DARPINIAN, WENDY STERLING & SHELLEY AGGARWAL

UNLESS you’re from the planet Mars, your pursuit for thinness will increase when you have an event coming up for which you want to look good. Let’s take as an example the “Spring Fling.” As if seeing your teachers at night wasn’t unexpectedly awkward enough, we start hamster-wheeling about how we’re going to lose weight for the big day. It’s not uncommon for people to not even go below their events because of their weight. It’s time to swap your strategy and understand the real story about attractiveness.

It is well documented that we are all attracted to happy people, those that are not internally sucked into their own misery. So, yeah, physicality might come into play in that first 5 to 10 minutes of seeing someone, but, beyond that, we are like bees to honey for happy people. Keep in mind it’s ultimately the negative thoughts about your body that are throwing you off your game, not your actual body.

Worry-thoughts, whether they are about not being thin enough, chiseled enough… emit insecurity, and insecurity is unappealing in any color. Body dissatisfaction takes not being thin enough, chiseled enough… not your actual body.

Note to self: Your body doesn’t care about whatever fancy-pants event you have coming up. It doesn’t know you are trying to look cool; it is only concerned with keeping you alive. (I know; big deal, right?) So, while some measure of quick weight loss may take place (probably water weight), it can cost you your presence and promote a sluggish metabolism, not to mention that it also makes you no fun to be with.

Many of you have heard the term “hangry”—hungry + angry = hangry. When your hunger comes on with a vengeance, and believe us, it will, you will no longer be running your food, it will start running you.

Your obsession with food can overtake you to the point where you end up missing the event in real time. So, while everyone is lining up to dance with the happy hot person, you’ll be the wallflower obsessing about ice cream.

TWO EXTREME BEHAVIORS WHEN TRYING TO LOOK GOOD FOR AN UPCOMING EVENT

First, there is the infamous and wildly self-defeating Weight Loss Effort Before the Event. This plan, executed on sheer willpower alone, is like holding your breath; and we all know what happens after you hold your breath too long. Remember, when restricting your food, you are ultimately eating below your metabolic rate, basically hanging out in the semi-starvation state.

Note to self: Your body doesn’t care about whatever fancy-pants event you have coming up. It doesn’t know you are trying to look cool; it is only concerned with keeping you alive. (I know; big deal, right?) So, while some measure of quick weight loss may take place (probably water weight), it can cost you your presence and promote a sluggish metabolism, not to mention that it also makes you no fun to be with. Of many of you who have heard the term “hangry”—hungry + angry = hangry. When your hunger comes on with a vengeance, and believe us, it will, you will no longer be running your food, it will start running you.

Your obsession with food can overtake you to the point where you end up missing the event in real time. So, while everyone is lining up to dance with the happy hot person, you’ll be the wallflower obsessing about ice cream.

TWO EXTREME BEHAVIORS WHEN TRYING TO LOOK GOOD FOR AN UPCOMING EVENT

First, there is the infamous and wildly self-defeating Weight Loss Effort Before the Event. This plan, executed on sheer willpower alone, is like holding your breath; and we all know what happens after you hold your breath too long. Remember, when restricting your food, you are ultimately eating below your metabolic rate, basically hanging out in the semi-starvation state.

Note to self: Your body doesn’t care about whatever fancy-pants event you have coming up. It doesn’t know you are trying to look cool; it is only concerned with keeping you alive. (I know; big deal, right?) So, while some measure of quick weight loss may take place (probably water weight), it can cost you your presence and promote a sluggish metabolism, not to mention that it also makes you no fun to be with. Many of you who have heard the term “hangry”—hungry + angry = hangry. When your hunger comes on with a vengeance, and believe us, it will, you will no longer be running your food, it will start running you.

Your obsession with food can overtake you to the point where you end up missing the event in real time. So, while everyone is lining up to dance with the happy hot person, you’ll be the wallflower obsessing about ice cream. 

Eating Disorders Anonymous (EDA)
ediningdisordersanonymous.org
* The Alliance for Eating Disorders Awareness
alliancedeatingdisorders.com

* Eating Disorders Anonymous (EDA)
ediningdisordersanonymous.org

* Academy for Eating Disorders (AED)
aedweb.org

* The International Association of Eating Disorders Professionals Foundation (IAEDPF)
aiedp.com

* Maudsley Parents maudsleyparents.org

* Multi-Service Eating Disorders Association, Inc. (MEDA)medanic.org

* National Association for Males with Anorexia Nervosa and Associated Disorders (NANAD)nanad.org

* The National Eating Disorders Screening Program (NEDSP) mentalhealthscreening.org

* National Eating Disorders Association (NEDA) nationaledic.org

* Parents to Parents parents-to-parents.org

* Project HEAL theprojectheal.org

* Trans Folx Fighting Eating Disorders (T-FFED) transfolxfightingeds.org

More information on these organizations can be found at EDcatalogue.com
The Renfrew Center

- First residential treatment facility in the nation for eating disorders, opened in 1985.
- Established as a family-run business, currently operating with multi-generational leadership.
- Accepts 450+ insurance plans across the country and is a preferred provider for many insurance companies.
- Incorporates The Renfrew Center Unified Treatment Model for Eating Disorders®, integrating our relational approach with the latest scientific research.
- Offers residential, day treatment, intensive outpatient, and outpatient services.

Specialized Treatment for Adolescent Girls & Adult Women with Eating Disorders

Stop by our new online shop for inspirational gifts, journals, and keepsakes.

EDCATALOGUE.COM/SHOP

There is No Substitute for Experience

CREATING A PARADIGM SHIFT
A NEW WAY OF THINKING ABOUT EATING DISORDERS

800.330.0490 • 435.938.6060
Logan, UT • www.avalonhills.org

WE HAVE OVER 30 YEARS IN EATING DISORDER TREATMENT
TREATED MORE THAN 75,000 ADOLESCENT GIRLS & WOMEN
19 LOCATIONS IN THE US

“There is No Substitute for Experience”

- Inpatient Treatment
- Residential Treatment
- PHP & IOP Programs
- Independent Living Program
- Diabetes (ED-DMT1) Program
- Outpatient Therapy
- Aftercare Follow-up
- Accredited High School
- TRICARE® Certified
- Joint Commission Accredited

www.CenterForChange.com
888-224-8250 info@centerforchange.com

Scan to take our eating disorder quiz

EDCATALOGUE.COM/SHOP

* All genders is a designation for individuals who do not identify as a binary gender.
Breaking free from an eating disorder takes courage and commitment. At Rogers Behavioral Health, we’ll support you every step of the way.

With inpatient, residential and specialized outpatient programs, we offer evidence-based treatment for men, women, children and teens who are struggling with anorexia, bulimia, ARFID and other eating disorders.

To learn more about the results of our treatment, visit rogersbh.org/outcomes.

If you or someone you know needs help with an eating disorder or other mental health issue, contact Rogers for a free screening. Visit rogersbh.org or call 800-767-4411 today.
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.

LEADING TREATMENT CENTER
FOR EATING DISORDERS IN NEVADA

We treat men, women, and gender non-conforming.

• Ages 14 and up
• Locations in Reno and Las Vegas
• Residential facility with 10 bed Female setting
• Co-Occurring Disorders (including OCD, PTSD, etc.)
• All eating disorders
• Partial Hospitalization Program – 8 hrs a day 5 days a week
• Intensive Outpatient Program – 4 hrs a day 5 days a week
• Trauma
• Diabulimia
• Vegan and Vegetarian lifestyles

Let Center for Hope be part of your journey towards recovery!

Call us today for a FREE assessment and Insurance Verification: 866-948-2036
www.centerforhopeofthesierras.com

HOWEVER FAR YOU TRAVEL, YOU WILL COME A LONG WAY AT PRINCETON CENTER FOR EATING DISORDERS

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

PRINCETON CENTER FOR EATING DISORDERS IS NOW PART OF PENN MEDICINE

A BOWL OF BROCCOLI IS NOT DINNER.

It’s a medical condition.

Give her a hug then give us a call to set up an evaluation and learn more.
800-300-0628 or visit rwjbh.org/eatingdisorders

THE EATING DISORDERS PROGRAM AT
Robert Wood Johnson University Hospital Somerset

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

• Dedicated clinical team that follows each patient through acute, residential and partial-hospital care
• Separate, specialized treatment programs for adult women and adolescent girls
• Long-tenured staff experienced in helping acute patients who need advanced medical and psychiatric treatment
• Monthly family week program to support and educate family members
• Affiliated with the Laureate Institute for Brain Research

1-800-322-5173 | laureate.com/eatingdisorders

HEALING ENVIRONMENT. PERSONALIZED CARE.

The Center for Eating Disorders at Sheppard Pratt

Learn more or refer a client by calling 866-948-2036 or emailing ced@ced.org

CALL US TODAY FOR A FREE ASSESSMENT AND INSURANCE VERIFICATION: 866-948-2036
www.centerforhopeofthesierras.com

NEW JERSEY / NEW YORK / OKLAHOMA

UPSTATE NEW YORK EATING DISORDER SERVICE

• Sol Stone Center Partial Hospitalization
  - males and females 18 & older
  - Supervised Overnight Lodging
• Outpatient & Intensive Outpatient in Multiple Upstate Locations

ELMIRA, ITHACA, BINGHAMTON, SYRACUSE - NEW YORK
(877) 785-7886 - www.unyed.com

MARYLAND / NEVADA / NEW JERSEY
Leading the way to recovery

**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/2019](http://eatingrecovery.com/2019) to get connected today.