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Eating Disorders

› RESOURCE CATALOGUE

THE MOST WIDELY-USED RESOURCE IN THE EATING DISORDERS FIELD SINCE 1980

What Does "I Feel Fat!" Really Mean?

The Value of DEVELOPMENTAL CONVERSATIONS

2022

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

Welcome!

Dear Readers,

Thank you for another year of support for our eating disorders resource community!

Perhaps you or someone you care about has been affected by the current mental health crisis augmented by the pandemic. Those with eating disorders know the challenges—stigma, lack of access to quality specialized treatment, financial constraints, food insecurity, etc. We have no quick fixes, but please remember there are people and providers to whom your well-being matters.

We are especially grateful to the professionals who developed the articles for this catalogue, as we know they have been overwhelmed with increased demands. Thank you! Your day-to-day resilience exemplifies a remarkable dedication.

We also thank our esteemed advertisers who allow us to share these wonderful articles and book excerpts in an effort to encourage validation and further recovery.

We wish you well and hope we can continue to grow together in the pursuit of more research, prevention, advocacy, and overall health and stability.

Warm regards,

Kathy Cortese

LCSW, ACSW, CEDS
Editor-in-Chief

Contents

Scott Moseman, M.D., CEDS and Katherine Godwin, M.D.

MEDICAL DIRECTORS OF THE LAUREATE EATING DISORDERS PROGRAM

HEALING ENVIRONMENT. PERSONALIZED CARE.

The internationally 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. As a not-for-profit organization, Laureate provides values- and mission-driven care for girls and women from all over the world.

At Laureate, you can expect evidence-based care and an experience tailored to the unique needs of the patient. This includes:

- an intentionally small milieu that provides opportunity for meaningful connection;
- a therapist-to-patient ratio of 1:3;
- a dedicated clinical team that follows each patient through acute, residential and partial-hospital care;
- Magnolia House, a group home focusing on independent living for adult women in recovery from eating disorders;
- separate, specialized treatment programs for adult women and adolescent girls;
- a monthly Family Week program to support and educate family members; and
- an affiliation with the Laureate Institute for Brain Research, which focuses on identifying new, effective treatments for eating disorders.

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Eating Disorders Program
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Medical Concerns in Eating Disorders

By Suzanne Dooley-Hash, MD, FAED

All eating disorders (EDs) are serious mental illnesses that may result in a multitude of medical complications ranging from minor to potentially life-threatening. Every organ system in the body is affected in some way, leading to medical complications directly related to the effects of starvation and malnutrition, binge eating, and the frequency and type of purging behaviors used. The majority of individuals with EDs recover fully; however, prognosis is much improved by early diagnosis and effective early treatment. Early identification of medical conditions related to EDs is equally important because while almost all complications are completely reversible with treatment of the ED, restoration of adequate nutrition, and stopping any inappropriate ED-related behaviors, the risk of permanent damage increases over time.

Although generally not acutely life-threatening, some of the classic signs and symptoms of EDs may be helpful in identifying an undiagnosed ED. Often, the first noticeable sign of an ED is marked weight loss or gain, fluctuations in weight, or failure of a child or adolescent to gain weight or grow as expected. Other common symptoms include feeling cold all the time, low body temperature, and bluish discoloration of the hands and feet, along with generalized weakness, fatigue, dizziness, or fainting.

Other commonly described findings include the development of lanugo hair (fine hair growth on the body and limbs), hair loss, carotenoderma (yellowish skin discoloration), brittle nails, dry/itchy skin, and poor wound healing. The development of a callus or scar may be seen on the back of a hand that has been used repeatedly to induce vomiting. Oral trauma, dental erosion, perimyolysis (increased erosion on the back surface of the front teeth), cheilosis (cracking and redness at the corners of the mouth), and salivary gland enlargement can also be seen. Mild blood abnormalities such as iron deficiency anemia are relatively common in low-weight patients as a result of inadequate dietary iron intake. Rarely, bone marrow failure related to severe malnutrition may result in reduced red and white blood cells, as well as platelets.

Cardiovascular complications are seen in up to 80 percent of individuals with EDs and may appear early in the illness. Individuals may complain of chest pain, shortness of breath, swelling, palpitations, lightheadedness, or fainting. Abnormal heart rhythms, or arrhythmias, are among the most frequent cardiac abnormalities seen. Sinus bradycardia, a heart rate of less than 60 beats per minute, is the most common arrhythmia. Hypotension, or low blood pressure, is also frequently seen in individuals with EDs. Structural changes of the heart, such as loss of cardiac muscle, are less common, but can lead to potentially fatal heart failure in the most severe EDs.

Pulmonary complications are not common, but can also be very serious. Self-induced vomiting can lead to aspiration, which may result in inflammation of the lungs or a punctured lung. In addition, weakened respiratory muscles can lead to the development of respiratory insufficiency, with low oxygen and high carbon dioxide levels and the need for supplemental oxygen.

Gastrointestinal (GI) complaints such as abdominal pain, bloating, and constipation are among the most common symptoms of EDs. These symptoms may reflect relatively mild disease or may indicate a life-threatening condition. Indigestion or heartburn can be caused by repeated exposure of the esophagus to stomach acid from repeated self-induced vomiting. Sequelae may include gastroesophageal reflux disease (GERD) and inflammation or spasm of the esophagus. Small tears of the esophageal wall from forceful vomiting can lead to hematemesis (blood in vomit). Prolonged starvation, chronic vomiting, and chronic laxative abuse can all contribute to significant slowing of the entire GI tract. Gastroparesis, or delayed gastric emptying, may occur after prolonged starvation and/or recurrent vomiting. It results in nausea and vomiting, as well as abdominal bloating and discomfort, which are increased with

food intake. Constipation is almost universal in very malnourished patients. It is also related to slowed GI (colonic) motility and/or a consequence of chronic laxative abuse, electrolyte abnormalities, and dehydration.

Long-term complications of EDs, including infertility, pregnancy complications and fetal abnormalities, amenorrhea (lack of periods), osteoporosis (low bone density), increased risk of fractures and overuse injuries, and arrested growth, can also occur. Osteoporosis is one of the few complications that may not be completely reversible with ED recovery. Severe hypoglycemia, or low blood sugar, is uncommon in individuals with EDs; however, when seen, it can result in confusion, seizures, or a coma and can be life-threatening.

Neurologic complications are generally reversible with restoration of adequate nutrition, but some individuals may experience permanent cognitive deficits. Brain imaging has shown significant atrophy in very malnourished individuals with EDs that's similar to that seen in Alzheimer's disease. This atrophy may manifest as cognitive impairment such as decreased concentration and memory loss. Peripheral neuropathies (numbness and tingling in the hands or feet) are also seen in malnourished individuals and may be related to vitamin B and/or other micronutrient deficiencies. Seizures have also been reported in individuals with EDs and may be related to electrolyte abnormalities, medications (e.g., bupropion), and/or hypoglycemia.

Psychiatric complications are also frequently seen in individuals with EDs. These include depression, anxiety, substance abuse, obsessive-compulsive behaviors, self-harm behaviors, and suicidal thoughts and/or attempts. In fact, suicide is among the most common causes of death in people with EDs.

Finally, it is important to remember that eating disorders can affect individuals of any age, race, size, gender, level of education, and socioeconomic status. The vast majority of individuals with EDs do not appear to be underweight, and yet they can still experience very serious, even life-threatening, medical complications. Individuals of any weight can be malnourished or engage in inappropriate, dangerous ED behaviors. Recognizing the common signs and symptoms of EDs and encouraging the individual to seek medical care is one way that loved ones, friends, teachers, coaches, and others can help. Anyone with an ED, and especially anyone with physical symptoms commonly associated with EDs, should be promptly evaluated by a medical provider. A thorough medical evaluation is an important part of a comprehensive, multidisciplinary approach to the diagnosis and treatment of all EDs. Psychological and nutritional evaluations are also crucial. Recovery is possible and is much more likely with timely recognition and treatment.

Among other sources, more information on identification, evaluation, and treatment of the medical complications of eating disorders can be found at:

aedweb.org/publications/medical-care-standards

Identification and Management of Eating Disorders in Children and Adolescents | American Academy of Pediatrics (aappublications.org) ◆

IMAGE: iSTOCK

The Value of Developmental Conversations

By Leah L. Graves, RDN, LDN, hon CEDRD-S, FAED

One challenging and nuanced element of eating disorders nutrition practice is the determination and discussion of treatment targets for individuals whose eating disorder behavior has resulted in a need for nutritional rehabilitation including weight recovery. Clients and their families are affected by the weight-focused culture and may have established patterns of weight concern and bias. Many arrive at the treatment threshold with significant lived experiences to potentially color discussion of nutrition-related treatment targets, especially those involving weight. Developmental conversations offer a productive way to engage clients and families in discussing weight-related goals in a manner that places emphasis on overall development and well-being.

What Is a Developmental Conversation?

Developmental conversations present treatment recommendations and targets that consider a client's current developmental stage, health status, and potential for growth, offering perspective that focusing on weight alone does not. In developmental conversations, weight and stature are considered vital signs to be viewed within the context of growth and development, much like heart rate and blood pressure. Other information, such as pubertal stage, genetic predisposition for height and shape, historic growth patterns, historic weight patterns, nutrition history, family eating culture, and patient-specific health needs, is addressed together to create a broad, inclusive recommendation that encompasses multiple facets of well-being. Families often respond well to the desire for a child to grow and develop completely. While developmental conversations incorporate many elements, they do address any recommendation regarding nutritional rehabilitation, including weight restoration.

What Do the Experts Say About Setting Weight Targets?

Weight targets are routinely set for clients who need nutritional rehabilitation. For children and adolescents, determining a target weight recommendation is particularly challenging because the onset of eating disorder behavior and treatment occurs during a time of significant growth and development. During puberty, adolescents experience changes in height, weight, and brain and bone development. Malnutrition during this phase can have lifelong consequences. To date, no empirically supported methods exist for determining weight-specific treatment targets in eating-disordered youth. A study of dietitians considered to be experts in eating disorders noted little consensus around setting target weights for adults with eating disorders; however, there was consensus regarding the need to set individualized weight targets considering historic trends and utilizing growth charts in eating-disordered youth.[1] Supporting the monitoring of growth charts for early detection of eating disorders in children and adolescents, Marion et al. demonstrated that nearly half of the participants in their retrospective review showed

deviation on their growth curve a median of 9.7 months prior to eating disorder symptoms being reported by parents.[2] In other words, the shift in nutritional state was evidenced in growth records much earlier than symptoms were identified. Dietitians also agree that the focus of nutrition intervention should be on reaching a healthy nutrition state rather than on weight alone.[1]

How Would One Focus on Healthy State?

One way to focus on healthy state is to look at functioning and frame weight as only one of many factors that inform nutritional well-being. Children and adolescents who are in a healthy state have an ability to nourish themselves adequately with parental support. In addition, youth with a healthy state have normalized vital signs and labs, reinitiation of growth, psychological function that is on track for their age and developmental stage, shaving or return of menses in those who are at the appropriate pubertal stage, and interest in the ability to resume activity without nutrition compromise. During the developmental conversation, parents/carers—and clients when appropriate—learn of the need for any weight recovery as a part of the overall health picture, with a focus on functioning.

How Should One Prepare for a Developmental Conversation?

Preparing for the developmental conversation begins with a thorough assessment of the client's current nutritional state within the context

FOR CHILDREN AND ADOLESCENTS, DETERMINING A TARGET WEIGHT RECOMMENDATION IS PARTICULARLY CHALLENGING BECAUSE THE ONSET OF EATING DISORDER BEHAVIOR AND TREATMENT OCCURS DURING A TIME OF SIGNIFICANT GROWTH AND DEVELOPMENT.

IMAGE: iSTOCK

MIDPARENTAL HEIGHT CALCULATIONS

BOY — In: Father's Height + (Mother's Height + 5) / 2
Cm: Father's Height + (Mother's Height + 13) / 2

GIRL — In: (Father's Height - 5) + Mother's Height / 2
Cm: (Father's Height - 13) + Mother's Height / 2

of historic growth and weight patterns. When looking at historic growth, the dietitian should factor in the pubertal stage with any additional information that may influence the pace and course of development, such as the developmental experiences of the biological parents. The dietitian can gather very basic information using the following questions:

- How tall are you now?
- How old were you when you had your adolescent growth spurt?
- How long did your growth spurt last?
- What do you remember about how your body changed during this time?
- How old were you when you began shaving/menstruating?
- What are your family patterns/tendencies regarding body shape/size?

One way to use the information gathered from biological parents in preparation for the developmental conversation is to complete a midparental height calculation on the client. The midparental height calculation utilizes the current height of both biological parents to predict how tall a child/adolescent will likely become. The result of the midparental height calculation can be plotted on the Centers for Disease Control and Prevention growth chart for stature at age 20 to estimate how tall the client should be at the completion of adolescent growth. The percentile line for the midparental height can then be traced backward to the current age and compared with the client's current stature percentile to assess for growth disruption. The client's current stature percentile would be expected to be near the midparental height percentile. If height is at a percentile significantly lower than expected, the client may have growth disruption.

Clients with growth disruption who have not completed puberty need weight targets that reflect a return to a weight beyond that indicated by the pre-eating-disorder weight percentile to allow for catch-up growth. Those who have completed puberty should return to the pre-eating-disorder weight percentile and may not have significant growth with nutritional rehabilitation. Recommendations should be discussed within the developmental conversation, with a focus on overall return to health and well-being.

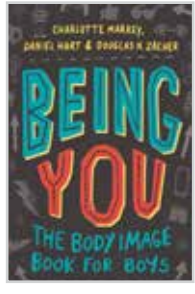
Who Should Be in the Developmental Conversation, and When Should It Occur?

The timing of the developmental conversation is vitally important.

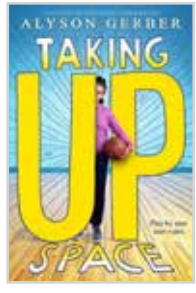
RECOMMENDED READING

Love Your Body: Your Body Can Do Amazing Things...
Jessica Sanders, illustrated by Carol Rossetti, 2020

Starfish
Lisa Fipps, 2021



Being You: The Body Image Book for Boys
Charlotte Markey, Daniel Hart & Douglas N. Zacher, 2022



Taking Up Space
Alyson Gerber, 2021

Developmental conversations need to be planned as early as possible after thorough assessment, case conceptualization, and recommendations have been established by the treatment team. The aim is to have enough time to establish highly individualized recommendations while bearing in mind that letting too much time pass may challenge client and parent/carer tolerance of the treatment process.

Initially, developmental conversations include parents/carers and the treatment team—often the dietitian, therapist, and medical and psychiatric providers. This offers the parents/carers an opportunity to hear information, ask questions, and have a discussion with the treatment team without the patient present. Treatment recommendations affect parents/carers and other family members. Giving space to allow organic responses and challenging questions provides the whole team, including the parents/carers, the opportunity to align prior to bringing in the client. Once there is alignment, then a client who is therapeutically ready to hear recommendations can be brought into the meeting for their part of the developmental conversation. The client part of the discussion should be curated for their developmental stage. The time with the client is used to communicate treatment recommendations through an overall health and well-being paradigm, to allow for questions and discussion, and, most important, to demonstrate alignment of the parents/carers and the treatment team.

THE MIDPARENTAL HEIGHT CALCULATION UTILIZES THE CURRENT HEIGHT OF BOTH BIOLOGICAL PARENTS TO PREDICT HOW TALL A CHILD/ADOLESCENT WILL LIKELY BECOME.

Developmental conversations offer eating disorder professionals a vehicle for discussing individual treatment recommendations with a client and their parents/carers while focusing on establishing a healthy nutritional state, considering growth and development and overall functioning. The developmental paradigm provides a well-accepted alternative to treatment recommendations that may be experienced as weight-based, which may unwittingly reinforce cultural weight bias and challenge alignment with the eating disorder treatment process. ◆

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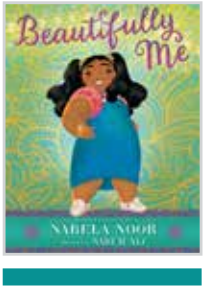
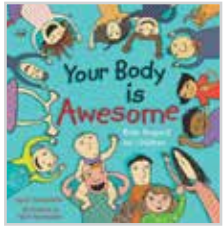
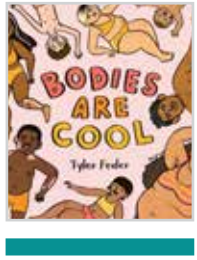


Beautifully Me
Nabela Noor, 2021

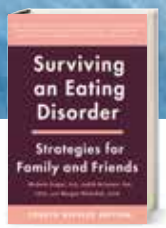


Your Body Is Awesome: Body Respect for Children
Sigrún Danielsdóttir, illustrations by Björk Bjarkadóttir, 2014

Free to Be Me: Self Love for All Sizes
Lesley Williams-Blackwell, 2019



Bodies Are Cool
Tyler Feder, 2021



[Book Excerpt]

Surviving an Eating Disorder

In this excerpt from *Surviving an Eating Disorder: Strategies for Family and Friends*, **Michele Siegel, PhD, Judith Brisman, PhD, CEDS, and Margot Weinshel, LCSW,** offer tips on how to approach a loved one who is dealing with an eating disorder.

NO MORE SECRETS: BRINGING IT OUT IN THE OPEN

IF YOU SUSPECT OR KNOW THAT SOMEONE IS EATING DISORDERED, ONE of the first questions you will probably ask yourself is whether you should say anything to the person you're worried about. And if you do speak to them, what should you say?

If you think someone is in trouble, this is no time for secrets. If the person does not know you are worried about them, the first thing you must do is tell them. Silence at these times will at best continue the discomfort and at worst lead to a dangerous and serious problem being ignored. No change can occur without first breaking the silence.

PLANNING TO TALK

Bringing up the subject of an eating disorder is never an easy task, but if done with some planning and forethought, difficulties and embarrassments can be minimized. What you say can potentially influence the course of the person's recovery. You will need to anticipate how you should approach the subject, what will be said, who will say it.

This chapter will help you anticipate what will happen in the discussion and will offer effective guidelines. By planning the discussion in advance, you can ease the discomfort and anxiety you are inevitably feeling, and by being prepared, you will have the best chance of being understood.

HOW TO APPROACH THE PROBLEM

Use the following guidelines before speaking with the person you're concerned about.

1. Think through who the best person is to do the talking.

If you are a parent with a partner, both of you should be present to signal that you are both concerned. You can decide who would have an easier time talking without any party getting upset, but it's important to give the message that you both are involved. Don't involve the rest of the family until after speaking with your son or daughter privately. If parents don't live together, make sure both parents still give the message that they each are concerned.

If you are a sibling and concerned about your sister or brother, you may want to speak with them privately or you may want your parents to do so. If your sibling is a minor or you are a minor, your parents really need to know what's going on.

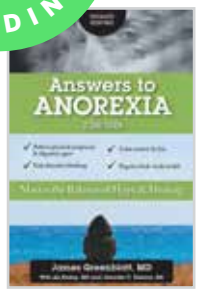
If you are a spouse or in a relationship, it is your responsibility to speak with your partner. You can discuss together if anyone else needs to be told. Respect privacy, and do not speak with friends, in-laws, or others until you speak with your partner.

If you are a friend or roommate, ……..

If you are the son or daughter, ……. ◆

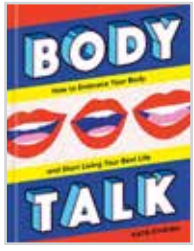
IMAGE: UNSPLASH

RECOMMENDED READING

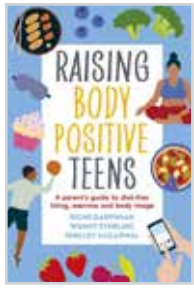


Answers to Anorexia, Second Edition: Master the Balance of Hope and Healing
James Greenblatt with Ali Nakip & Jennifer C. Dimino, 2021

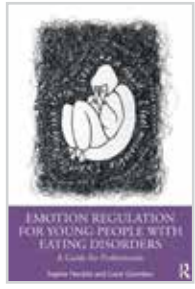
Unworthy Weight: Reclaiming Your Worth from a Number on a Scale and Finding True Identity in Christ
Kristin Williams, 2020



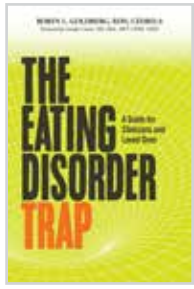
Body Talk: How to Embrace Your Body and Start Living Your Best Life
Katie Sturino, 2021



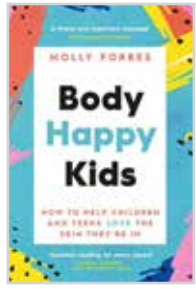
Raising Body Positive Teens: A Parent's Guide to Diet-Free Living, Exercise, and Body Image
Signe Darpinian, Wendy Sterling & Shelley Aggarwal, 2022



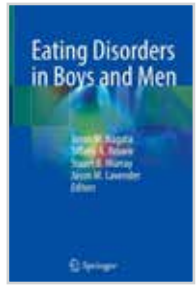
Emotion Regulation for Young People with Eating Disorders: A Guide for Professionals
Sophie Nesbitt & Lucia Giombini, 2021



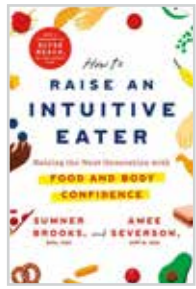
The Eating Disorder Trap: A Guide for Clinicians and Loved Ones
Robyn L. Goldberg, 2020



Body Happy Kids: How to Help Children and Teens Love the Skin They're In
Molly Forbes, 2021



Eating Disorders in Boys and Men
Jason M. Nagata, Tiffany A. Brown, Stuart B. Murray & Jason M. Lavender, editors, 2021



How to Raise an Intuitive Eater: Raising the Next Generation with Food and Body Confidence
Sumner Brooks & Amee Severson, 2022

Brief Cognitive Behavioural Therapy for Non-Underweight Patients: CBT-T for Eating Disorders
Glenn Waller, Hannah M. Turner, Madeleine Tatham, Victoria A. Mountford & Tracey D. Wade, 2019

What Does "I Feel Fat!" Really Mean?

By Carolyn Coker Ross, MD, MPH, CEDS

In our fat-phobic, diet-obsessed culture, we have come to confuse being thin with being happy. We have been conditioned to believe we have to look a certain way in order to deserve the life we want. We have been taught by the media, our families, and society that if we are in a bigger body—or if we are different in any way from what society deems acceptable (young, thin, not gay, of a certain race or religion or political affiliation)—we cannot have what others have and, most important, what we desperately want.

It is not uncommon for individuals with binge eating disorder, emotional eating, or food addiction to report that they "feel fat." But fat is not a feeling. So how can a person understand what it means to "feel fat"? Feeling fat describes a negative relationship with the body. How a person thinks, feels, and sees their body, and what behaviors result from this, is the definition of body image (National Eating Disorders Collaboration, 2021), and individuals with eating disorders often view their self-evaluation from the lens of how they think or feel about their bodies, which can lead to higher levels of emotional distress, a poorer quality of life, and depression (Ferreiro et al., 2014).

The formation of body image is complex and includes influences from parents, family, peers, and media images. Media images that promote the thin ideal play a direct role in body dissatisfaction (Hogan & Strasburger, 2008), starting very early in childhood and continuing through adulthood. Girls and young women are more likely to be praised for their appearance than for their sports achievements or good grades.

WE HAVE BEEN CONDITIONED TO BELIEVE WE HAVE TO LOOK A CERTAIN WAY IN ORDER TO DESERVE THE LIFE WE WANT.

Body Image and the Media

Images in the media of influencers, models, and other public figures are often computer enhanced, meaning that what a young girl sees is not the real version of the person, but an enhanced, perfected one. In other words, the media portrays images that are not attainable in the real world (Grabe et al., 2008).

The involvement of the media in promoting a specific body type dates back to the 1800s, when women were forced into painful corsets that accentuated their breasts and buttocks. A century later, a thin, boyish body type was in favor and women who had curvy figures were seen as indulgent and lacking in self-control.

The modern-day emphasis on

the thin ideal has trained women to aspire to have Barbie-doll figures that are impossible to achieve, and that has led to 80 percent of U.S. women being dissatisfied with their bodies and children as young as 6 years old wanting to lose weight. The influence of images in the media has continued to grow and has become more "real" than real life.

Black Women and Body Image

Since slavery, Black women's bodies have been vilified and devalued and, when compared with white bodies, were considered to be hypersexualized, unattractive, and undesirable. In the past, studies on Black women's body image showed more acceptance of larger body size and less internalization of the dominant culture's body image ideals. A deeper examination of these studies shows that Black women are not immune to the dominant culture and are affected by European standards of beauty. Hip-hop videos and other media aimed at Black women used to promote being "thick," or having a curvy body and big butt, as the ideal. However, newer trends promoting the thin ideal are showing up in hip-hop music. A recent analysis of body types in hip-hop music videos showed an overrepresentation of thin women. The smallest body sizes were associated with music themes of sex or materialism (Zhang et al., 2010).

Body image for Black women may also be tied to their hair. For many Black people, their conformance with dominant cultural norms and identity is wrapped up in the style and texture of their hair. Straighter hair or relaxed curls that mimic the dominant cultural ideal of straight hair have been prized in many Black women. Black women spend an inordinate amount of time and money to conform to European standards for

IMAGE: iSTOCK

hair, and if they choose to wear their hair natural, they not infrequently face discrimination at work and microaggressions in social settings.

Finally, colorism has long been a part of BIPOC cultures, in which lighter skin color is seen as more favorable to darker skin. This is an in- and out-group measure of value and attractiveness and status that is not easy to manipulate and may have a direct effect on Black women's body image. More research is needed on the impact of hair and skin color, which are not usually included in studies on body image in Black women (Awad et al., 2015).

What Are the Causes of Negative Body Image?

Girls are more likely than boys to develop body dissatisfaction. Children of parents who diet frequently or have a negative body image are at higher risk for body dissatisfaction. Experiences of being bullied, being called names because of your size, being told that you fit in an "unhealthy weight category," or seeing images on social media that make you feel bad about how you look can all cause negative body image. Research has repeatedly shown that exposure to social media images that depict and glorify the thin ideal affects body image concerns, particularly in women (Grabe et al., 2008).

Early childhood trauma is an often-overlooked cause of body dissatisfaction. Childhood sexual or physical abuse, which is interpersonal trauma, involves violations of physical boundaries and can have a far-reaching effect on an individual's body image. The fact that these types of traumas often occur during the period of development when a child is in the process of distinguishing between their body and those of others (body ownership) makes them more likely to result in body image disturbances. Memories of childhood trauma involving the body may lead to an individual's rejection or withdrawal/disconnection from the body. This is seen in many eating disorder patients with a history of trauma who feel cut off or alienated from their bodies. Lacking body awareness, they are unable to identify and, therefore, regulate emotional sensations felt in the body and often turn to food or food-related behaviors to regulate uncomfortable emotions.

A FOCUS ON BODY IMAGE, BODY DISSATISFACTION, OR BODY HATRED IS THE SOLUTION THAT CAN SERVE AS A DISTRACTION FROM OTHER ISSUES.

Many trauma survivors with eating disorders also experience body shame and body hatred. They may report a lack of physical vitality and reduced physical well-being. Survivors of repeated physical or sexual trauma are also more likely to experience dissociation from their bodies as a survival or coping strategy from the time of their trauma, persisting into adulthood. Studies have shown that early childhood trauma affects multiple domains, including body satisfaction, body attitude, body awareness, and body acceptance (Scheffers et al., 2017).

Why Body Image Issues Are Not the Problem

Abuse or neglect or any other negative experiences in childhood can lead to what is called toxic stress. Toxic stress causes an overproduction of stress hormones: cortisol, adrenaline, and noradrenaline. This leads to physical changes in the brain. The brain of a traumatized child resets itself to be in fight-or-flight—regardless of whether there is a current threat to the individual's safety or security.

Childhood trauma or adversity makes it seem as if everything in the world is dangerous and unsafe. Childhood adversity is associated with difficulties in school, depression, feelings of despair, and trouble developing healthy relationships with peers and teachers because of difficulty with trust. People who have had toxic stress in their lives often find solace in food, drugs, or alcohol; inappropriate sex; high-risk sports; or work, in an effort to cope with their feelings of depression, fear, and shame. That is why food and body image issues are not about food or about the body. Rather, a focus on body image, body dissatisfaction, or body hatred is the solution that can serve as a distraction from other issues, such as childhood trauma, that may not have been addressed.

Body image issues can also serve as a cover-up for underlying shame, low self-esteem, or feelings of unworthiness that stem from adversity in childhood. It is important to identify the root cause of body image issues. *What is the true cause of body hatred or dissatisfaction?* Body hatred may serve a specific purpose that is unconscious:

1. Many people feel they can "hate themselves thin." This

is the belief that if you keep beating yourself up mentally about your body size or shape, it will motivate you to engage in behaviors that will help you attain the "thin ideal."

2. Another purpose that body dissatisfaction can serve is as a distraction that keeps you from thinking about other issues in your life or trauma from your past. If all your problems are related to hating your body, that's where your focus goes when you have problems in your relationship or when you're anxious about your job insecurity. You may think, "If I could just lose weight, this wouldn't be happening." Then you can focus on finding the perfect diet or joining a gym, which takes your mind off your divorce or other problems.

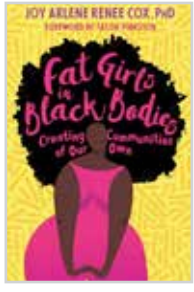
Identifying the root cause of body image issues requires taking the focus off the number on the scale, because the problem is not the size or shape of your body. The underlying driver of the thought "feeling fat" is emotions that have been pushed down and the behaviors you've used to keep yourself from actually dealing with those emotions and past traumas or current life problems.

Fixing your body won't fix your life. Losing weight or fixing your body won't fix the problems you have at work. It won't help you change the core beliefs, such as "I'm worthless" or "I'm not lovable," that came with you from previous experiences of childhood adversity. Having the "perfect body" won't actually make an abusive spouse change their behavior, nor will it guarantee that no one will ever leave you.

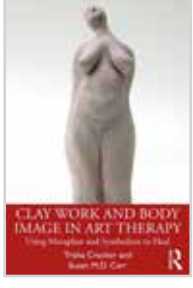
THIS ARTICLE CONTINUES AND CAN BE FOUND IN ITS ENTIRETY AT EDCATALOGUE.COM.

RECOMMENDED READING

The Body Is Not an Apology, Second Edition: The Power of Radical Self-Love
Sonya Renee Taylor, 2021

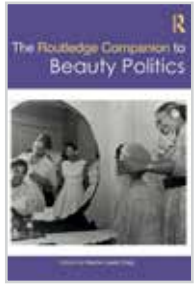


Fat Girls in Black Bodies: Creating Communities of Our Own
Joy Arlene Renee Cox, 2020



Clay Work and Body Image in Art Therapy: Using Metaphor and Symbolism to Heal
Trisha Crocker & Susan M.D. Carr, 2021

Fattily Ever After: A Black Fat Girl's Guide to Living Life Unapologetically
Stephanie Yeboah, 2020

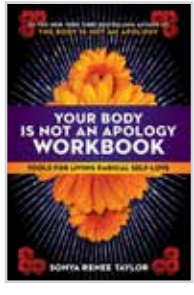


The Routledge Companion to Beauty Politics
Maxine Leeds Craig, editor, 2021

Fitness for Every Body: Strong, Confident, and Empowered at Any Size
Meg Boggs, 2021

The Age of Fitness: How the Body Came to Symbolize Success and Achievement
Jürgen Martschukat, 2021

Fat in Four Cultures: A Global Ethnography of Weight
Cindi SturtzSreetharan, Alexandra Brewis, Jessica Hardin, Sarah Trainer & Amber Wutich, 2021



Your Body Is Not an Apology Workbook: Tools for Living Radical Self-Love
Sonya Renee Taylor, 2021

[Book Excerpt]

Treating Black Women with Eating Disorders

In this excerpt from *Treating Black Women with Eating Disorders: A Clinician's Guide*, Charlynn Small asks: Are we eating because we're hungry or because something's eating us?

CULTURAL COMPETENCE

In exploring the process of cultural competence, it is important to begin with what cultural competence is not. Cultural competence is not acknowledging that people are different. Nor is it taking a colorblind approach to assessment and treatment when working with people from different populations. Williams (2011) asserts, "A colorblind approach merely relieves the therapist of his or her obligation to address racial differences and difficulties." Brooks (2014) accentuates the problem that occurs when therapists do not see color: "By taking a colorblind approach, you end up rendering invisible and not meaningful, what actually is very important." This is particularly true when treating Black women with eating disorders, as the truly unique part of treating these women is in addressing race and identity issues, because identity really is at the heart of eating disorders.

In my other life as an urban school psychologist, whenever I mentored newly graduated, idealistic young White persons who had joined our team, I would drive them around the community and show them the dwellings of some of the children we served. I would share about some of their daily lived experiences, because socially, they were worlds apart from those students. Thus, they needed some exposure to those students' backgrounds. In this way, they could gain an understanding of the qualitative manner in which some Black males obtained their quantitative scores on the WISC (Wechsler, 1949). Contrary to popular belief, Black males are not intellectually deficient in every case; hardly ever, in fact. Sometimes their responses are value laden, for they are often motivated by survival. That is, while their responses may not have been the ones deemed obviously correct, they may have been the ones that made the most sense to them in terms of securing their basic needs (i.e., safety, food, etc.). While the examiner is ethically obligated to report the obtained score, the psychoeducational assessment is more than just testing and measurement. Based on the results of the evaluation, the competent examiner will be able to provide an accurate assessment of students' intellectual ability and their ability to benefit from classroom instruction. Thus, my brief tours through the community were designed to provide some additional perspective and context, intended to aid in the process of linking assessment with intervention and to help prepare novice psychologists for the interactions they would have with Black students. What the new team members learned was that more often than not, their lives were vastly different from those of the students we served. They shared that their exposure in this way increased their sensitivity and appreciation for the potential ways in which culture and circumstances can impact one's life, whether positive or negative.

Engaging cultural competence, among other concepts, reflects a practitioner's decision to accept the responsibility of acknowledging and respecting the traditions and values of the persons she serves (Jongen, McCalman, & Bainbridge, 2018; U.S. Department of Health and Human Services, Office of Minority Health [HHS, OMH], 2013) and working to avoid stereotypes. Culturally sensitive practitioners appreciate the value in gaining new cultural experiences and demonstrate a willingness and the ability to engage within the different communities of persons they serve. My community engagement tours served as one of Havighurst's (1953) teachable moments to help facilitate this engagement. Culturally sensitive practitioners also understand that successful engagement with diverse clients requires improving their sensitivities to their own cultural values and biases. Without a commitment to learning more about their own individual cultures, health care providers can be influenced by both conscious and unconscious biases, yielding misdiagnoses and poor treatment outcomes (HHS, OMH, 2013). Additionally, providers may offend clients by unintentionally saying or doing something considered or interpreted by clients as culturally inappropriate or insensitive. An increase in awareness of self can yield new sensitivities that can help prevent misunderstandings or actions that would hinder or adversely affect the establishment of rapport

IMAGE: UNSPLASH

and trust and that would increase provision of more culturally responsive assessments and treatment plans (HHS, OMH, 2013). Useful for aiding in the creation and maintenance of successful and effective therapeutic alliances, cultural competence is a purposeful, ever-changing developmental process that requires dedicated practitioners' responsibility and promise of continued learning (HHS, OMH, 2013). Two of the most important components in this process that can further encourage development of trusting, therapeutic alliances are linguistic competency and cultural humility.

LINGUISTIC COMPETENCY

Linguistic competency is the ability of practitioners to productively and constructively work with clients, according to HHS, OMH (2013). To do so, clients must be able to easily participate in exchanges of information without apprehension. Plain language is the most easily understandable language. In cases in which clients may present different communication challenges including limited literacy skills, various disabilities, or languages that differ from practitioners' languages, practitioners must be prepared to present information through different modalities (Jongen et al., 2018; HHS, OMS, 2013). Failure to address cultural and linguistic differences can result in negative outcomes including miscommunication (Cass et al., 2002), mistrust, and confusion. Because health care facilities and practitioners should have policies (Cross et al., 1989), procedures, and dedicated resources in place (National Center for Cultural Competence [NCCC], 2006), ethical concerns may be raised with failure to address these concerns.

For effective communication in many cross-cultural situations, practitioners likely need only be proficient in applying previously acquired skills in different ways or to different groups (HHS, OMH, 2013). For example, it may be necessary for them to conduct additional research, to have additional consultations, to expand their referral lists, or to secure services from sign language interpreters (NCCC, 2006) or other translators (HHS, OMH, 2013). However, as the landscape continues to change for groups of underrepresented persons, it may become necessary for practitioners to make greater changes/additions, both qualitatively and quantitatively, including hiring a multilingual/multicultural staff and printing materials in easy-to-read, picture-and-symbol format, Braille, or enlarged print (NCCC, 2006). Cultural competence simply encourages practitioners to be mindful about useful opportunities for employing these cross-cultural skills and about using them with accuracy.

CULTURAL HUMILITY

Cultural humility is an interactive approach toward understanding important aspects of one's cultural identity (Hook, Davis, Owen, Worthington, & Utsey, 2013; HHS, OMH, 2013). Cultural humility emphasizes practitioners' availability and efforts to learn about each client's individual background, development, and experiences as opposed to relying on practitioners' own precepts and conclusions. Also, it involves a commitment to continuous self-reflection on practitioners' own blind spots (Russell, Augustin, & Jones, 2017), assumptions, and practices. The quality or state of being humble in the client–practitioner relationship suggests a nullification of any prestige or power imbalance that might exist between the client and the practitioner (Hook et al., 2013). This kind of open-stance approach emphasizes an acceptance of being unfamiliar or previously uninformed about some of the cultural traditions, values, and ceremonial rites and rituals of other groups. This approach is made interactive by a flexibility to learn from and about others and incorporating this new knowledge into our existing frames of reference, and/or replacing long-held, inaccurate assumptions, beliefs, or stereotypes. However, despite this focus on seeking answers rather than making assumptions, underlying this approach remains the fact that "traditional behavioral health practices in the U.S. are infused with Western, European, and White-American male, heterosexual ideologies" (HHS, OMH, 2013). This point is underscored in the book *White Fragility* (2018) by Robin DiAngelo, who states that she can get through graduate school, law school, or a teacher-education program "without ever discussing racism" (p. 8). This is a point that begs the question, how then is a therapist so trained able to effectively provide, in this case, eating disorder treatment to persons whose lives have been so unfavorably impacted by that very thing—racism—that so greatly increases our risks for developing the disorder? DiAngelo (2018) also states that she "can be seen as qualified to lead a major or minor organization in this country with no understanding whatsoever of the perspectives or experiences of people of color, few if any relationships with people of color, and virtually no ability to engage critically with the topic of race" (p. 8). It is because the particular ideological perspectives of the "traditional behavioral health practices in the U.S." do not give full consideration to aspects of its citizens' cultural identities that they themselves—in this case Black women—consider most important that an interactive approach to cultural humility is so vital to the health care of Black women. ◆

Invisible Women: Eating Disorders at Midlife

By Margo Maine, PhD, FAED, CEDS

The aging process does not immunize women from the body image issues, weight concerns, and eating disorders that plague the younger years. It never has. Today, more than 15 percent of women at midlife and beyond suffer from eating disorders,[1] surpassing the number affected by breast cancer![2] In fact, inpatient admissions between 1999 and 2009 showed the greatest increase in this age group, with women older than 45 accounting for a full 25 percent of admissions.[3]

Despite these hard facts, eating disorders in midlife and older women continue to hide in plain sight in our health care delivery system. These are the Invisible Women, long neglected, whose needs are ignored and/or discounted by modern medicine, simply because we stubbornly cling to the stereotype that these recalcitrant, life-threatening problems belong to young women and no one else.

To this day, so many of my adult patients burst with shame for having an eating disorder at their age, apologizing for needing help. It breaks my heart to hear their stories: decades of pain, suffering, and isolation, as the negative feelings about their bodies and their basic needs for food create an eating disorder that never wants to let go of them. Their eating disorders have flourished, yet medical and mental health professionals have never asked a question about their eating habits, weight control issues, exercise, or body image.

I have been passionate about moving adult eating disorders out of the darkness and into the light of the mainstream approach to women's health and mental health for far too long. My first book about midlife eating disorders, *The Body Myth: Adult Women and the Pressure to Be Perfect*, was published in 2005.[4] My second book, *Pursuing Perfection: Eating Disorders, Body Myths, and Women at Midlife and Beyond*, came out in 2016.[5] Both alone and with my colleagues Karen Samuelson and Mary Tantillo, I have led countless webinars and conference presentations, written journal articles, and collaborated with the media on articles and interviews about this topic. Over the years, we have made some progress, with a bit more research, more publications and presentations, and some mention of this issue in the popular press. But we still have so far to go.

Many years later, we unfortunately have not succeeded in getting adult eating disorders out of the closet. We still devote far too little attention to these Invisible Women; thus, I welcome the publication of Betsy Brenner's beautifully written memoir, *The Longest Match: Rallying to Defeat an Eating Disorder in Midlife*[6] (see excerpt on opposite page). Brenner's story illustrates how the stressors of midlife can knock a high-functioning woman off her feet and into a full-blown eating disorder with little warning. She includes journal entries from her adolescent and earlier adult years revealing occasional negative thoughts about her weight or food, but it was decades later that body shame and despair and fear of food gradually and unexpectedly took over her life.

The Longest Match is a desperately needed teaching tool for clinicians and a guide for women struggling with body image and disordered eating in midlife and later years. Her story shows how an adult woman's eating disorder can hide in plain sight and progress without recognition, reaching a dangerous precipice. With this book shedding light on them, Invisible Women may be identified and supported into recovery.

Eating disorders can affect people of any age and any race or color, with research showing equal incidence across African American, Hispanic, and Caucasian women at midlife.[7] Research also tells us that middle-aged women report the same degree of psychopathology, distress, and impairment, whether their issues meet the full diagnostic criteria for anorexia nervosa, bulimia nervosa, or binge eating disorder, or are subclinical—suggesting that we must take subclinical eating disorders as seriously as we do those that are full spectrum.[8]

THIS ARTICLE CONTINUES AND CAN BE FOUND IN ITS ENTIRETY AT EDCATALOGUE.COM.

[Book Excerpt]

The Longest Match

Betsy Brenner reflects on her eating disorder journey in this riveting excerpt from *The Longest Match: Rallying to Defeat an Eating Disorder in Midlife*.

I feel like a failure that I can't handle this better. I have to be in control and have never been allowed to fail. I can't stop all the racing thoughts. So many emotions.

Meanwhile, if my brewing eating disorder had been a pot of water simmering on the back burner, it was now on the front burner coming to a rapid boil.

My journals confirm that the seeds were being planted throughout my life, and, at some point, a full-blown eating disorder (ED) would bloom. Multiple journal entries reveal that I was overly focused on food and body image. I frequently wrote about guilt experienced after eating certain foods and I commented how certain clothes made me "feel thin." At one point in young adulthood, I mentioned that if I lost five pounds, then I would be happy. In law school, I journaled that I needed to exercise before enjoying pizza with Jeff. And, after a normal pasta dinner:

I ate too much, especially since I didn't exercise. I felt so guilty after eating it.

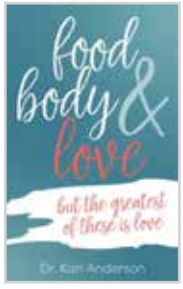
The connection between food and exercise was clearly ingrained long before my eating disorder took hold.

As a child, I learned from Mom that fat was bad. I did not learn intuitive eating as a child, because Mom controlled what I ate, when I ate, and how much I ate. When I got to college, the freedom with food in the "all you could eat" dining hall was wonderful. However, two months later, when the novelty had ended and I was feeling homesick, I began restricting my food intake intentionally. Perhaps I did so to feel in control or to cope with feelings of homesickness. I restricted my food intake despite several hours of tennis and running each week. I began eating the bare minimum at each meal. This was my first memory of intentionally restricting. The behavior marked the development of another ED seed, although the illness was not ready to bloom.

The development of asthma brought the water in the pot on the stove from "simmering" to a "rapid boil." For nearly 40 years, I had internalized painful or difficult thoughts and feelings. From my parents' divorce at age 7, to the complicated grief from my parents' devastating cancer deaths, and everything in between, these life experiences triggered my anxiety, depression, and ultimately full-blown eating disorder. My asthma diagnosis and return to tennis, along with strain in my relationships with my close friend and also with my older daughter, finally broke down my walls and allowed (ED) to take over my life.

ED surfaced as a coping tool in my mid-40s in response to my inability to manage my frequent asthmatic flare-ups adequately. In 2010, when I couldn't breathe well, take care of my children in the way I was accustomed, or play tennis, the eating disorder, personified as ED, came to my rescue. ◆

Excerpted with permission from Betsy Brenner, *The Longest Match: Rallying to Defeat an Eating Disorder in Midlife*, 2021.



RECOMMENDED READING

Food, Body, and Love: But the Greatest of These Is Love
Kari Anderson, 2021

IMAGE: UNSPLASH

Culturally Sensitive Eating Disorders Treatment for Latinas

By Mae Lynn Reyes-Rodríguez, PhD, FAED

Compared with their European White counterparts, the prevalence of eating disorders in Latinxs is equal or greater, particularly with binge-spectrum eating disorders.[1-3] However, the lack of representation of the Latino population in clinical trials for eating disorders raises questions about the feasibility and suitability of the current evidence-based treatments that were developed and tested primarily for European Whites. Language barrier, lack of health insurance, and migratory status are some of the contributing factors related to the lack of representation of Latinxs in clinical trials.[4] In general, Latinxs have underutilized specialized treatment, particularly mental health services.[5] Studies conducted with Latinxs with a history of eating disorders have found that they are less likely to seek professional help compared with non-Hispanic Whites.[1,6] The stigma about having an eating disorder, system barriers (e.g., lack of health insurance, language barrier, and clinician bias), and personal barriers (e.g., lack of motivation, family privacy, fears of not being understood, not ready to change, lack of knowledge of resources) are some of the treatment barriers identified by Latinas with a history of eating disorders.[7] Therefore, it is important to make

IMAGE: ISTOCK

treatment more accessible, relevant, and culturally sensitive for Latinxs in order to tackle those treatment barriers and reduce the health disparity.

Currently, three main studies have been published in the United States focused on cultural adaptations of some form of cognitive behavioral therapy (CBT) for binge-spectrum eating disorders in Latinas.[8-11] These studies concur with the feasibility and appropriateness of the use of CBT in Latinas with binge-spectrum eating disorders; however, some cultural adaptations might enhance the treatment and make it more culturally sensitive. Cultural adaptations seem to be more appropriate and needed for Latinxs with a low level of acculturation.[12] Moreover, the integration of cultural values into treatment is recommended in order to provide culturally sensitive treatment.[13-15] *Familism* and *personalism* are some of the cultural values that are relevant in the delivery of the CBT for binge-spectrum eating disorders. Both are core cultural values in the Latino culture. *Familism* reflects the centrality of family and the interdependency and loyalty among family members independently of the age of family members.[16] On the other hand, *personalism* refers to the emphasis that Latinxs put on close relationships, particularly those that are respectful, caring, and well-meaning.[15]

Consistent with *familism*, these studies have found that adding a family member as a support can enhance engagement and retention[10,15,17] and the overall treatment experience.[11,17] Usually, family members are willing and want to support the loved one who is struggling with an eating disorder, but the lack of information and understanding on how to provide support increases the frustration in both the patient and the family member.[18] Incorporating a family member into treatment has shown multiple benefits.[17] First, receiving psychoeducation about eating disorders from a professional can help to address the stigma and provide specific tools regarding how to support the loved one, particularly in the Latino population, where eating disorders aren't a topic that is openly discussed. Second, in some cases, family members have been key in providing practical support such as transportation or appointment reminders. This practical support can be essential for increasing retention in treatment. Third, the integration of a family member can facilitate positive changes around the eating pattern, as patients can incorporate the recommendations of a meal plan into what the entire family unit eats. To maximize the benefit of the inclusion of a family member in treatment, it would be important to have a collaboration process with the patient to identify the best family member (or significant other) to

INCORPORATING A FAMILY MEMBER INTO TREATMENT HAS SHOWN MULTIPLE BENEFITS.

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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incorporate and what specific issues the family member can help the patient with.

Although no major changes are suggested in the content of CBT for binge-spectrum eating disorders in the cultural adaptation studies conducted with Latinas, the enhancement of the cultural adaptation seems to be more relevant in the delivery process. In addition to the integration of a family member, considering the value of *personalism* during the treatment delivery would make the experience more culturally sensitive to Latinxs. Navigating through a different culture with a different language can be very stressful, particularly for those who are less acculturated. Finding ways to provide additional support (e.g., using an interpreter if the provider isn't bilingual, identifying community resources to supplement treatment, calling for appointment reminders, providing specific instructions to arrive to the clinic, etc.) can be perceived as caring by Latinx patients and, therefore, help with the rapport and therapeutic alliance. Other aspects to take into consideration are the suspicions and fears that undocumented patients have because of their migratory status. Sending a clear message that treatment is a safe space for them would be an important component of developing a trusting therapeutic relationship.

Working with diverse populations, specifically with Latinxs, requires being mindful of cultural values and culturally related stress and context. This population navigates through multiple cultural aspects (e.g., migratory status, acculturation, language barrier, acculturative stress, discrimination, food insecurity, etc.), which adds another level of stress to the treatment process. Although some of these variables are out of our control, just acknowledging and validating the patient's experience would create a nurturing and warm environment for Latinx patients. Identifying community resources that can provide support on those cultural aspects allows for treatment to focus on the eating disorder component. The lack of health insurance can be a huge barrier for those patients who require a higher level of care, making early detection a key factor in properly identifying and treating the eating disorder symptoms in the Latino population. Raising awareness about eating disorders in Latinxs and providing information about resources available and how and where to seek professional help is a crucial part of decreasing the stigma and augmenting early detection. Due to the low service utilization of specialized treatment in Latinxs, primary care setting detection could be a promising avenue. Providing the tools and skills to primary care physicians to screen for eating disorders and make a referral for specialized treatment can be an important step toward decreasing the health disparity in Latinxs struggling with eating disorders. ◆

WORKING WITH DIVERSE POPULATIONS, SPECIFICALLY WITH LATINXS, REQUIRES BEING MINDFUL OF CULTURAL VALUES AND CULTURALLY RELATED STRESS AND CONTEXT.

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[Book Excerpt]

Supporting Autistic People with Eating Disorders

In this excerpt from *Supporting Autistic People with Eating Disorders: A Guide to Adapting Treatment and Supporting Recovery*, Kate Tchanturia, Katherine Smith, and Yasemin Dandil shed light on how clinicians can help make their patients more comfortable in sessions.

What Can Clinicians Do Differently in Sessions?

ADAPTING PSYCHOLOGICAL THERAPIES FOR AUTISTIC PEOPLE WITH EATING DISORDERS

Autistic people with eating disorders (EDs) benefit from psychological therapy; however, it must be adapted to meet the individual's cognitive and communication needs. Modifying therapy to facilitate engagement and build a therapeutic relationship is vital. There is no "one size fits all" approach; nonetheless, Figure 14.1 highlights some possible adaptations that can be applied to psychological therapies for each person. Some of these adaptations were inspired by the core characteristics of autism spectrum condition (ASC) and some are relevant to all people in psychological therapy.

MAKING THE ENVIRONMENT USER-FRIENDLY FOR SOMEONE WITH ASC AND ED

Once you have your scheduled appointment, we suggest you think about the environment of the session.

People on the autism spectrum can be overwhelmed with sensory input, often leading to high anxiety and preoccupation. It is important to be mindful of lighting, background noise, and strong odors. Sometimes just a simple change can make a big difference to a session; it is important to be mindful and to ask.

Below are some possible sensitivities to watch out for:

- Lighting
  - Trying to find a room with no fluorescent lighting is hard. Would it be possible to use natural light?
  - Screen monitors can have a harsh light that some find distracting.
- Noise
  - Corridor noise can be tricky to deal with. This might be something you can take into consideration when planning session times to when footfall would be at a minimum.
  - Are your bracelets clinking? Is the computer humming? Sometimes noises we don't even notice can be excruciating to people on the autistic spectrum. In the busy ward, we found it useful to have keycaps to reduce the noise.
  - Is there a choice of rooms? Try to think about avoiding noises from outside, too, such as traffic.
- Odor
  - Especially to patients with comorbid eating disorders, the smell of food can be particularly anxiety-provoking. It might be worth thinking about session times and them not overlapping with meal preparation times when odors may be particularly strong.
  - Some autistic people can find perfumes and colognes suffocating. It might be an idea to ask the patient or to skip that extra spray on the days of your appointments.
- Physical comfort
  - Consider the temperature: Someone with an ED may be hot but may feel uncomfortable taking off their jumper.
  - Type of chair can be important; perhaps, if possible, offer the patient a cushion.
  - Some patients are very sensitive to food temperature, so try to accommodate this to make it easy to feed them.

Another question worth asking is how they might like to sit; some patients may find it less anxiety-provoking to sit side-by-side to avoid the added pressure to maintain eye contact. This will reduce the amount of extra information processing and attention of the social situation. ◆

Excerpted with permission from Jessica Kingsley Publishers, *Supporting Autistic People with Eating Disorders: A Guide to Adapting Treatment and Supporting Recovery*, edited by Kate Tchanturia, 2021.

IMAGE: iSTOCK

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[Book Excerpt]

The Prevention of Eating Problems and Eating Disorders

In this excerpt from *The Prevention of Eating Problems and Eating Disorders: Theories, Research, and Applications*, Michael P. Levine and Linda Smolak highlight some of the characteristics and factors that often work as protective shields against eating disorders.

EVIDENCE-BASED PROTECTIVE FACTORS

Table 16.1 lists many of the numerous characteristics that have been posited as protective factors. Consistent with the theories, some of them are characteristics of the individual, some of the immediate environment (microsystem), and some of the broader culture (macrosystem). Research in the area of protective factors is generally fairly new, occurring mostly in the 21st century. The available data are often limited and primarily cross-sectional. Therefore, Table 16.1 also indicates what types of data are available for each listed variable. In the remainder of this section, we briefly discuss several potential protective factors that are especially relevant to prevention because they are mutable and have more extensive data, including prospective and experimental, available.

SELF-COMPASSION

A primary component of self-compassion is being kind to oneself in times of stress and threat. This includes avoiding self-criticism and recognizing that everyone has problems and shortcomings. Self-compassion also includes mindfulness, an awareness of the threat without allowing it to overwhelm one's identity (Chapter 7). Neff (2003) further suggests that as a positive emotional state, self-compassion should help to guard against the "negative consequences of self-judgment, isolation, and rumination" (p. 85), as well as attempts to maintain self-esteem through dangerous mechanisms such as denial, narcissism, or self-centeredness. This makes self-compassion inconsistent with several risk factors for EDs, including thin-ideal internalization and negative affect, as well as with DE (Tylka, Russell, & Neal, 2015). Hence, it is reasonable to expect self-compassion to be negatively related to body image disturbances, DE, and EDs.

A substantial number of cross-sectional studies demonstrate a direct relationship between self-compassion, body image dysfunction, and DE (Braun, Park, & Gorin, 2016). Relationships emerged in both clinical and nonclinical samples for a variety of outcomes including thin-ideal internalization, concerns about weight, and DE, including ED symptoms. Self-compassion may also serve as a moderator. For example, Tylka et al. (2015) found that being higher in self-compassion eliminated the relationship between media thinness pressures and both thin-ideal internalization and DE.

Importantly, there are also data, albeit more limited, from experimental studies linking self-compassion to reductions in DE. For example, in a pilot randomized, controlled study (RCT), Kelly and Carter (2015) found that self-compassion training and behavioral strategies training both resulted in a reduction in BED symptoms in a clinical sample

TABLE 16.1 **POSSIBLE PROTECTIVE FACTORS FOR UNIVERSAL PREVENTION PROGRAMS: RESEARCH BASES**

	AVAILABLE DATA		
VARIABLE	**CORRELATIONAL**	**PROSPECTIVE**	**EXPERIMENTAL***
Self-compassion	x		x
Self-esteem**	x	x	x
General family factors**	x	x	
Family meals**	x	x	
Mindfulness**	x		x
Yoga**	x		x
Recognition of internal cues**	x		x
Feminism**	x	x	x
Body appreciation**	x	x	
Emotional self-regulation**	x	x	x
Sports participation**+	x		
Perceived acceptance by God	x		
Perceived body acceptance by others**	x	x	

**Experimental data are often RCT clinical studies or prevention studies. Such programs often have multiple components. The components often are not analyzed separately.*

***Data from child and/or adolescent samples are available.*

++Sports participation may be protective in that it encourages recognizing the body's functionality. However, participation in some sports may be a risk factor for the development of eating disorders.

compared to the control group. However, self-compassion was more effective in reducing eating and weight concerns, as well as eating pathology. This study and others (see Braun et al., 2016) demonstrate that not only may self-compassion protect against EDs and related pathology, self-compassion is mutable and can be increased. ◆

IMAGE: ISTOCK

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.

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*

Considerations in the Diagnosis of Eating Disorders in Males

By Ane A. Balkchyan, BA, and Stuart B. Murray, DClinPsych, PhD

Relative to other psychiatric disorders, eating disorders (EDs) are commonly overlooked. However, EDs are among the most destructive disorders and can manifest in lethal ways for millions of afflicted individuals. More specifically, throughout the course of time, EDs were thought to affect only females. While this has been shown to be far from the case and well-documented reports of EDs in males exist, this population is still frequently left out of the ED discussion. Over time, this underrepresentation of EDs in males has become increasingly problematic. For instance, a significant portion of the literature in recent decades has excluded males from treatment studies (Dally & Sargant, 1966; Goldberg et al., 1979). In the early 1990s, more data began to emerge concerning male EDs, and it became clear that males represented a considerable portion of EDs (Andersen, 1990; Carlat et al., 1997; Fairburn & Beglin, 1990; Sharp et al., 1994).

Contrary to the "female-centric" diagnostic criteria that currently exist for EDs, males often present with EDs differently phenotypically. For example, relative to females with EDs, males with EDs may report a higher variety of psychiatric comorbidities, such as psychotic symptoms, substance use (Carlat et al., 1997; Striegel-Moore et al., 1999), experiences of previous obesity- or weight-related mockery (Carlat et al., 1997; Gueguen et al., 2012), and even later onset (Gueguen et al., 2012; Mitchison & Mond, 2015; Zerwas et al., 2015). More specifically, in anorexia nervosa (AN), a clinical criterion often seen prior to diagnosis is amenorrhea; in males, reduced levels of testosterone and/or decreased levels of sexual interest are observed. Further, in AN, females are more likely to display a drive for thinness, while males are more preoccupied with dietary restraint in the context of leanness and making noticeable changes to bodily musculature (Pope et al., 2000). Another notable difference in how males exhibit AN is the role of compulsive exercise. Overall, many males with AN report using exercise as a means to regulate negative feelings and increase positive feelings (Murray et al., 2014). Clinically, males with AN more frequently engage in practicing stricter exercise habits relative to females with AN (Murray et al., 2014).

As for bulimia nervosa (BN), which is characterized by recurrent episodes of binge eating, the use of one or more compensatory behaviors with the intent of offsetting the effects of binge episodes, and the overvaluation of weight and shape (American Psychiatric Association, 2013), little evidence-based information exists on this ED subtype in males. However, differences between the foods consumed by males and females during binge episodes has been noted, with males being more likely to consume foods with high fat and protein content (Wansink et al., 2003), while females are more likely to binge on foods with sweet flavors. When it comes to the compensatory behaviors component of BN, male patients are more likely to engage in dietary restriction and excessive exercise (Lavender et al., 2010; Striegel-Moore et al.,

2009). Engagement in these types of compensatory behaviors runs contrary to those that are more likely to be used by females with BN, such as purging and laxative use.

In regard to binge eating disorder (BED), which is characterized by recurrent episodes of binge eating and related distress without the presence of compensatory behaviors (American Psychiatric Association, 2013), drastic differences between female and male presentations are less common (Hay et al., 2015; Tanofsky et al., 1997). Interestingly, an early study has documented that males with BED are more likely to simultaneously meet criteria for an Axis I disorder (e.g., major depressive disorder, panic disorder), relative to females with BED (Tanofsky et al., 1997). Finally, an important aspect of BED in males to make note of is the lack of research that acknowledges weight/shape overvaluation, which is contemporarily a core feature of ED diagnoses.

Further, muscularity-oriented disordered eating is its own ED phenotype. The diagnosis of males has been difficult because thinness has often been the focus of EDs. However, males can display muscularity-oriented EDs, in which we see the drive for both muscularity and thinness. To achieve these goals of increased muscularity, males with this subtype of an ED may overregulate their protein consumption, adhering to strict rules (Murray et al., 2010). For leanness-oriented goals, males may engage in restriction of carbohydrates and fats, while simultaneously consuming lean protein (Griffiths et al., 2013). Although there is a considerable amount of published scientific literature about this subtype of disordered eating in males, there is still a lack of clarity as far as what eating-related behaviors and attitudes should be characterized as "disordered" (Murray et al., 2017). Thus, further research is essential to better understand the precise classification features of muscularity-oriented disordered eating.

FOR LEANNESS-ORIENTED GOALS, MALES MAY ENGAGE IN RESTRICTION OF CARBOHYDRATES AND FATS, WHILE SIMULTANEOUSLY CONSUMING LEAN PROTEIN.

In addition, current measures for ED diagnosis and characterization are not sufficient to account for muscularity-oriented disordered eating. The existing framework for recognizing and treating EDs is largely based on female ED samples; thus, current efforts for ED diagnosis are not satisfactory to account for male ED subtypes such as muscularity-oriented disordered eating. For instance, males are more likely to receive an "other ED" diagnosis, as opposed to a diagnosis such as AN, BN, or BED. The measures and diagnostic tools used for evaluating ED symptomatology in males are also insufficient because they have been developed and validated in accord with female populations (Murray et al., 2017). Historically, these tools have emphasized core features of thinness and questions about proportions for bodily features that may not be as relevant for male populations (e.g., hips) (Darcy et al., 2012). Another setting in which inadequate efforts for ED diagnosis in males is seen is in clinical practice. EDs are viewed as a stereotypically "female" diagnosis to have (Griffiths et al., 2015; Griffiths et al., 2014), and the stigma from upholding standards of masculinity can negatively affect whether males with EDs seek help (e.g., delayed treatment-seeking behaviors) (Griffiths et al., 2015).

Finally, proper classification of male EDs is of high concern and has significant research and clinical implications. For instance, male ED presentation has received significantly less traction in peer-reviewed scientific papers, with less

IMAGE: iSTOCK

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.

CURRENT RESEARCH DOES NOT PROVIDE ADEQUATE PRECISION TREATMENTS FOR TREATING MALE ED PATIENTS.

than 1 percent of current papers relating to male presentations of AN (Murray et al., 2016). Clinically, this underrepresentation of male EDs has detrimental effects and contributes to higher nonengagement in treatment and stigmatization of seeking help. Further, current research does not provide adequate precision treatments for treating male ED patients; thus, more research is imperative to better understand how to develop these treatments so that they work within various male subpopulations. Another clinical factor worth considering is the low uptake of mental health care among males with EDs, which is related to levels of distress and disability (Murray et al., 2017). Acknowledging these clinical- and research-related barriers has the potential to alleviate the burden EDs have on all populations, particularly underrepresented groups such as males. As awareness of this disorder class and how it presents in male populations increases over time through thorough research and clinical practice, optimism grows that a better understanding of how it manifests and the best course for easing the distress it causes will be reached. ◆

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[Book Excerpt]

The Girl in the Red Boots

In this excerpt from *The Girl in the Red Boots: Making Peace with My Mother*, Judith Ruskay Rabinor, PhD, reexamines the intentions behind her mother's past actions.

That night, driving home from my office, I found myself mulling over my work with Marcy and Elizabeth. Elizabeth's words had jarred me during the session, and now they jumped back out at me again. "I did drag you to diet doctors, but I was just following doctor's orders." I had seen on her face what I believed was genuine regret when she explained to Marcy, "I only tried to do my best." As I replayed this scene and the words "following doctor's orders" echoed, I felt myself begin to break out in a cold sweat. And I knew why.

I'd mercilessly berated my mother for "following doctor's orders" when she tried to explain the way she deceived me about my tonsillectomy—but now, listening to these words in this new context, I was pushed to reexamine my own reaction. Perhaps my mother's "crime" for deceiving me with a "birthday party" wasn't as out of the box as I might have thought. Like Elizabeth, my mother had followed doctor's orders, instead of preparing 8-year-old me to face a hospitalization and surgery. It didn't take long before it occurred to me that I was able to tap into my compassion to help Marcy offer forgiveness to her mother while I was still chastising my own mother for the same excuse.

As a therapist, I had compassion for both Marcy's suffering and Elizabeth's, but as a daughter, I still sat in judgment of my own mother, as I had for decades. Why, I had to ask myself, was it so hard for me to find compassion for my own mother? I took a deep breath, as I realized this was something I needed to "bookmark," a phrase I used with my patients when it was clear we had not gotten to the bottom of a piece of unfinished business.

By now I was at home, sitting in my driveway, but the two phrases from the session gnawed at me: "following doctor's orders" and "I only tried to do my best." The phrases echoed, at first evoking my painful tonsillectomy experience. I said the words again, slowly, to myself. To my surprise, other thoughts came up. There had been times when I'd been certain I was "doing my best"—getting divorced was one example—only to realize later on that I had gravely underestimated how divorce would impact my children.

Suddenly, my father's face appeared, and I was pulled into another level of pain.

It was Christmas Eve 1971, my father's 54th birthday, and our family was gathered for a celebratory dinner at my childhood home, where my parents still lived. The results of the bladder cancer surgery, initially deemed a godsend, had been reversed. The cancer had spread, and now, unbeknownst to him, he was living with a terminal diagnosis. ◆

The Girl in the Red Boots **excerpt published with permission of the publisher, She Writes Press. 2021.**

IMAGE: UNSPLASH

A Holistic Approach to the Family-Based Treatment Model

in Children and Adolescents with Eating Disorders: The Role of the Registered Dietitian

By Laura Cipullo, RD, CDE, CEDRD, RYT

Eating disorders among children and adolescents have risen as a result of the change in lifestyle and increased stressors from the COVID-19 pandemic. With this rise, dietitians and treatment providers alike are treating more young clients. It is crucial to think ahead and anticipate how this will affect our children in the years to come, especially as they enter college and gain independence. Prior to the pandemic, I received many clients in my private nutrition practice who had participated in the Maudsley method and/or the family-based treatment (FBT) approach as a child or adolescent, yet had never worked with a registered dietitian (RD). In general, they presented at college age with a lot of distrust in authority figures and no idea of how to eat, despite having been weight-stable throughout high school. While these individuals had weight-restored, they had not fully recovered from their eating disorders, never having learned to trust their own bodies and/or feed themselves. As parents and practitioners, please ask yourselves what you can do differently going forward. This article encourages you to make full use of the multidisciplinary team in an effort to truly help the child and adolescent attain a healthy weight, a clear understanding of how to eat, skills for independent feeding and eating, and a solid foundation for their future.

The family model of treating eating disorders in adolescents originated as the Maudsley method after a 1987 randomized, controlled trial at the Maudsley Hospital in London. The foundation of this treatment model was then adapted and made more flexible by the research and clinical expertise of James Lock and Daniel Le Grange, who coined the model known today as FBT. The goal of this treatment is to have the family of the child suffering from an eating disorder, with the guidance and expertise of a trained therapist, take control of feeding their child to achieve a healthy weight. Lock and Le Grange did and do recognize the importance of a well-rounded treatment team incorporating multiple disciplines, such as the pediatric and adolescent physician, psychiatrist, and dietitian.[1] While this is noted in the FBT manual, a script or suggestions on how to use the whole team and/or specifically the RD have yet to be established. This article will augment the ongoing dialogue among professionals and families regarding the holistic approach to treating the whole person—specifically how the family, patient/client, and therapist can work synergistically with the RD and how they can support the FBT model and the recovery of children and adolescents. The following are suggestions and/or recommendations supported by over 20 years of clinical nutrition

IMAGE: iSTOCK

experience with clients diagnosed with eating disorders. Please use this article to ask more questions, to consider when to create a multidisciplinary team, and/or to follow along with the phases of treatment. This article speaks specifically to the FBT model; the expertise of the RD can be used in many ways, whether providing inpatient or outpatient nutrition services.

Parents Raise Nutrition Concerns When Asked to Refeed

Many parents come to the office of the RD and share that their own struggles with food are preventing them from knowing how to feed their teen. Not everyone has had an RD to teach them how to balance meals to prevent blood sugar fluctuations, how to determine what constitutes a snack, and/or what is enough to allow for refeeding and growth. Parents ask for basic education, such as "What are examples of carbohydrates, proteins, and fats?" "What is the difference between a serving and a portion?" and "What makes something like peanuts a protein versus a fat?" Other common nutrition questions parents ask are "How many calories does my child need?" "Should I just push sweets and 'junk food' to get my child to gain weight?" "Is it OK to serve clean, healthy food that I know my child will eat without causing a fuss?" and "Can I just sneak as much food in as possible?" All of these questions can be answered by the RD and will provide the foundation for parents to feed both themselves and their children. Working with the RD is an opportunity for the entire family to receive nutrition education and, hopefully, prevent future food and nutrition issues for all of its members.

The Three Phases of FBT

FBT is a three-phase treatment model, with parents serving as the most useful resource in their child's recovery from the eating disorder. Instead of being blamed for their child's ill health, the parents are supported, taught how to move forward on a timeline with specific roles for each individual (client, parent, and therapist), and equipped with strategies. Phase I is known as **Weight restoration**. This includes the initial evaluation with an FBT therapist and setting up treatment covering weeks one through 10. Phase II, formally known as **Returning control over eating to the adolescent**, lasts five weeks, from sessions 11 through 16. The child gains some freedoms during this phase and can begin to make decisions regarding eating and exercise. Finally, Phase III, **Establishing healthy adolescent identity**, addresses the issues of adolescence from sessions 17 through 20.[1,3]

When to Refer to the RD

In Phase I, according to Lock and Le Grange, "Parents are encouraged to work out for themselves the best way to promote weight gain and normalize eating in their child."[1] This is when parents and the therapist need to expand the treatment team to include the expertise of RDs, most specifically those who are certified eating disorder specialists (CEDS). The parents can set up an initial evaluation with the RD before starting the refeeding process. This should be done after session one with the "lead" FBT therapist. Parents and the RD will discuss the child's past and present state of health, including, but not limited to, laboratory values, blood pressure, menstruation, growth trends plotted on the growth

DIAGNOSING AVOIDANT/ RESTRICTIVE FOOD INTAKE DISORDER

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
2. Significant nutritional deficiency.
3. Dependence on enteral feeding or oral nutritional supplements.
4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.

D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

charts, and individual as well as family medical history as it relates to medical nutrition therapy (breast cancer, osteoporosis, diabetes, heart disease…). The CEDS RD, along with the pediatric and adolescent medical doctor, will collect all of this information to better determine the child's weight goals and the individualized nutrition goals with the parents. Next, the RD will gather information on the family's eating behaviors, the family's diet, and the child's diet. Together, the RD and parents will choose to create a meal program based on "exchanges," also known as nutrition equivalents, or a "meal structure," which outlines meal ideas and specific portions. The calorie range will take into consideration what the child had been consuming and the behaviors in which they had engaged, and whether overexercise, purging, and/or laxatives were active. The RD will determine an individualized calorie range to start the feeding process in order to help prevent electrolyte and metabolic disturbances known as "refeeding syndrome" or fluid overload.

Refeeding Syndrome

When an individual has experienced prolonged starvation, a sudden increase in nutrition can be fatal. Signs of refeeding and/or fluid overload may include, but are not limited to, low phosphorous, potassium, magnesium, and/or thiamine levels, which can result in cardiac arrhythmias, respiratory distress, ataxia, vertigo, and more. The RD and medical doctor (MD, preferably a CEDS) will be evaluating both electrolytes and vitamin levels, as well as weight, on a sometimes daily or weekly basis to ensure refeeding syndrome doesn't go unnoticed or untreated. If the parents, therapist, or RD observes a quick jump in weight gain, it is imperative that the child be medically evaluated and appropriately managed for refeeding syndrome. A child being refed is at higher risk for refeeding syndrome in the first two weeks of treatment.[2] The RD will help parents steadily increase their child's nutrition intake during this period of time (likely sessions two through five) and thereafter. It is a dance—an intimate collaboration between parents, the MD, and the RD.

Nutrition Education and Recommendations

Over the first few weeks, the parents will have formal check-ins with the RD, ranging from 15 minutes to an hour, to address and increase the meal plan, ask questions about the exchanges/meal structures, and assess the nutritional adequacy of what the family is feeding the child. The RD may educate parents on dietary calcium, low sex hormones, and osteoporosis, and then recommend ways to ensure adequate calcium intake. Other educational topics may include iron deficiency and treatment, ensuring adequate levels of vitamin D in the diet, and which strains of probiotics may be helpful for diarrhea, constipation, and the microbiome. Many individuals with eating disorders also experience irritable bowel syndrome, resulting from the brain-gut bidirectional connection—anxiety can cause gastrointestinal upset. When a child is reporting gastrointestinal pain and a change in bowel habits, it is important to acknowledge their observations and consider an evaluation with a doctor specializing in gastrointestinal health to rule out colon impaction or small intestine bacterial overgrowth. Meanwhile, the FBT therapist will address family roles in food shopping, meal preparation, feeding and eating behaviors, and mealtime discussions. The RD supports the lead FBT therapist's efforts to empower the parents to feed their child to weight-restore.

After the first month of treatment, the nutrition session frequency with the RD will likely vary in accordance with the child's weight gain and with the parents' confidence in employing

the exchanges or meal structure. At this point, the therapist and/or MD can refer the parents to see the RD on an as-needed basis.

"SHOULD I JUST PUSH SWEETS AND 'JUNK FOOD' TO GET MY CHILD TO GAIN WEIGHT?"

The RD and Phase II

It is time to resume nutrition sessions when the child is nearing the level of readiness for independent eating during Phase II, sessions 11 through 16. The child and parents would benefit from a family session with both the RD and the lead FBT therapist to assess the current feelings, thoughts, and behaviors around food, exercise, and body image. In this session, the family and team can together identify concrete goals for future nutrition sessions. Typically, the lead therapist and the RD determine what is psychologically appropriate for the child regarding nutrition education and empowerment. The RD may teach the child meal and snack exchanges, create a new meal structure (an outline of meals and snacks with approximate portions), arrange food or social meal exposures, or even join the child for a supported snack. The RD can educate them about how and why an "eating all foods" approach supports overall mental and physical wellness.

The RD and Phase III

The RD will help the client transition from an externally motivated nutrition plan to one that is internally regulated, using nutrition education, mindfulness, and, perhaps, intuition. Eventually, the child will progress from nutrition exchanges (nutritional equivalents) to a meal structure to a more internally focused format, engaging in mindful eating and, possibly, intuitive eating or integrated eating. The nutrition sessions in Phases II and III are similar to those that dietitians do with other outpatient clients. One can use a readily available script from publications such as *Winning the War Within: Nutrition Therapy for Clients with Eating Disorders*[4] or as guided by their CEDS supervisor. Phase III with the RD is essential for teaching the client/patient to be an independent feeder and eater in the present as well as the future.

Every treatment plan, including those that use the FBT model, should be individualized to meet the child and the family's emotional capabilities, physical health, and socioeconomic constraints. The above can serve as a conversation starter, as a consideration when creating a multidisciplinary team, or as a guide for following along with nutrition and FBT sessions.

One of the most important endeavors in finding a team to work holistically is the ability for everyone to respect one another and their roles, whether parent, child, FBT therapist, MD, or RD. Using the services of the RD will ease the burden of the parents and help ensure that the child learns to eat appropriately for life, not just for a short-term weight increase (Phase I). This is not a time to just "bulk up," but rather a time for parents to be empowered to nourish with food and love, soon to be followed by a time for the child to be nourished with food, love, and education. The RD hopes to shorten the eating disorder journey and to ensure that the child is provided with ample food and nutrition knowledge and skills sufficient to feed themselves well into their 20s and beyond. It is important to remember that FBT does not stop at Phase I, but continues on to Phases II and III with the work of the FBT therapist, the MD, and the RD. ◆

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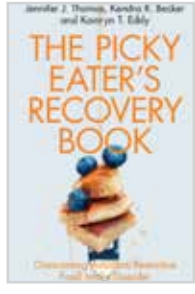
3. Lock, J., & Le Grange, D. *Family-based treatment of adolescent anorexia nervosa: The Maudsley approach.* http://www.maudsleyparents.org/whatismaudsley.html

4. Myers, E. S., & Caperton-Kilburn, C. (2020). *Winning the war within: Nutrition therapy for clients with eating disorders* (3rd ed.). Helm Publishing.

RECOMMENDED READING

The Inside Scoop on Eating Disorder Recovery: Advice from Two Therapists Who Have Been There
Colleen Reichmann & Jennifer Rollin, 2021



The Picky Eater's Recovery Book: Overcoming Avoidant/Restrictive Food Intake Disorder
Jennifer J. Thomas, Kendra R. Becker & Kamryn T. Eddy, 2021

[Book Excerpt]

The Intuitive Eating Journal

In this excerpt from *The Intuitive Eating Journal: Your Guided Journey for Nourishing a Healthy Relationship with Food*, Elyse Resch, MS, RDN, explains the relationship between intuitive eating and what she calls "homeobalance."

Feel Your Fullness

Intuitive Eating honors the brilliant way our bodies maintain something I call homeobalance (rather than homeostasis)—or all the vital physiological processes that keep our bodies going. In just one human cell, there are about a billion chemical reactions every second! Hunger signals remind us that we need food to survive. Fullness signals finish that job by prompting us to eat enough food to meet our body's needs, while not overloading us and making us feel uncomfortable. As an Intuitive Eater, you learn that these signals are accurate and trustworthy.

Besides nourishing ourselves with enough food, eating until we're comfortably full helps us derive the most satisfaction we can from eating. Once you reach comfortable fullness, food just doesn't taste as good as it did when you were hungry and began eating. This chapter will help you hone your fullness awareness so that you can get optimal enjoyment from eating.

Note: It can be difficult to honor, or even notice, fullness if you have food insecurity (a lack of reliable access to enough food), either because of financial limitations or self-imposed restrictions, if you haven't made full peace with food. Making peace with food is a fundamental principle of Intuitive Eating because once you are secure in knowing that you will give yourself a sufficient amount of foods that satisfy your taste buds without judgment or guilt, you will find it less difficult to stop eating when you're comfortably full.

The same chart you used in chapter 3 to look closely at your hunger can be used to find out about your fullness (from 6 to 10).

FEELINGS OF HUNGER & FULLNESS

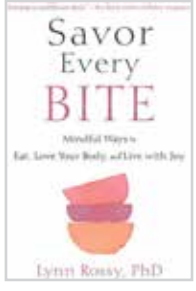
Over Hungry	0	Painfully hungry. This is *primal hunger*. It's very intense and can actually hurt.
	1	Ravenous and irritable. An urgent need to eat.
	2	Extremely hungry. Immediate need to find some food.
Comfortable Eating Range	3	Fully hungry and ready to eat.
	4	Mildly hungry, begin noticing hunger.
	5	Neutral. Neither hungry nor full.
	6	Starting to feel satisfied.
	7	Comfortable fullness, feeling completely satisfied and content—a sign to stop.
Over Full	8	Beginning to feel a little too full. Beyond physically needing food.
	9	Extremely full and uncomfortable—everything feels tight.
	10	Stuffed and in pain. Maybe even nauseous.

For the next few days, set an intention to notice which level of fullness you feel at the end of your meals. Make notes about each meal, including what foods you had and your fullness levels afterward. Remember, you're gathering information about your personal experience of fullness outside of any diet culture messages. Just notice what happens at each meal. Use more paper if you run out of room. ◆

IMAGE: UNSPLASH

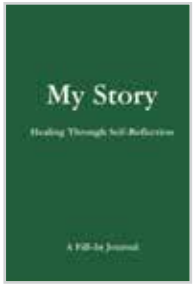
RECOMMENDED READING

The Intuitive Eating Card Deck: 50 Bite-Sized Ways to Make Peace with Food
Elyse Resch & Evelyn Tribole, 2021

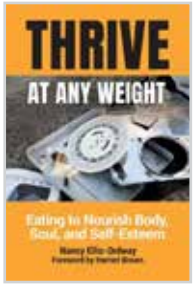


Savor Every Bite: Mindful Ways to Eat, Love Your Body, and Live with Joy
Lynn Rossy, 2021

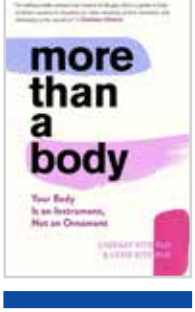
The Making Peace with Food Card Deck: 59 Anti-Diet Strategies to End Chronic Dieting and Find Joy in Eating
Christy Harrison & Judith Matz, 2021



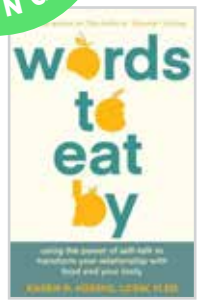
My Story: Healing Through Self-Reflection: A Fill-In Journal
Kathryn Cortese, 2019



Thrive at Any Weight: Eating to Nourish Body, Soul, and Self-Esteem
Nancy Ellis-Ordway, 2019

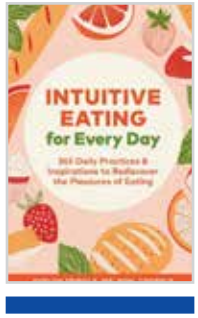


More Than a Body: Your Body Is an Instrument, Not an Ornament
Lindsay Kite & Lexie Kite, 2020



Words to Eat By: Using the Power of Self-Talk to Transform Your Relationship with Food and Your Body
Karen R. Koenig, 2021

Step-by-Step: A Three-Year Daily Journal
Kathryn Cortese, 2018



Intuitive Eating for Every Day: 365 Daily Practices and Inspirations to Rediscover the Pleasures of Eating
Evelyn Tribole, 2021

NATIONAL EATING DISORDERS ORGANIZATIONS

- **Academy for Eating Disorders (AED)**
  aedweb.org
- **Eating Disorders Anonymous (EDA)**
  eatingdisordersanonymous.org
- **Eating Disorders Coalition for Research, Policy & Action (EDC)**
  eatingdisorderscoalition.org
- **EDucation and INsight on Eating Disorders (EDIN)**
  myedin.org
- **Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.)**
  feast-ed.org
- **Fighting Eating Disorders in Underrepresented Populations (FEDUP)**
  fedupcollective.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 Alliance for Eating Disorders**
  allianceforeatingdisorders.com
- **National Association of Anorexia Nervosa and Associated Disorders (ANAD)**
  anad.org
- **National Eating Disorders Association (NEDA)**
  nationaleatingdisorders.org
- **Parents-to-Parents**
  parents-to-parents.org
- **Project HEAL**
  theprojectheal.org

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

Weight Bias Is a Social Justice Issue

By Erin Harrop, LICSW, PhD, and Shira Rosenbluth, LCSW

Over the years, many theories have been formulated to explain why someone might develop an eating disorder. Most people will agree that eating disorders are multifactorial and stem from biological, environmental, and psychological factors. Within these paradigms, we might talk about eating disorders as responses to various experiences (e.g., trauma, other triggers) and personality traits (e.g., over/under-controlled, perfectionism) in individuals with specific vulnerabilities (e.g., genetic, environmental). These theories of eating disorder etiology largely rely on "individualized paradigms"—we look at the individual and examine their specific risk factors, experiences, and biology. What are the traits, choices, behaviors, and individual situations that led to the development of this eating disorder?

The -isms

As social work clinicians, we view human suffering through a slightly different lens. In addition to considering individual factors, we also examine "systemic" factors. Systemic factors are phenomena that function within systems, according to the needs and values of that system. Within systems, when bias exists in an environment, it often seeps into all facets of functioning in that environment. As such, systemic factors can be pernicious, ubiquitous, and difficult to identify; they are often unconscious or unrecognized by participants in the system, yet they influence the system all the same. This systemic-level discrimination then gets reflected in institutional, political, and social interactions. For example, in societies where males are valued (however unconsciously) more than females, this bias seeps into the societal system, leading to the development of policies and environments that produce gender pay gaps "unintentionally," with masculine jobs receiving higher pay than feminine jobs, resulting in women being less financially stable or secure, particularly if they are not partnered with a man.

WE LIVE IN A WORLD WHERE THIN PEOPLE ARE TERRIFIED OF BECOMING FAT AND FAT PEOPLE KNOW THAT THEIR BODIES ARE EVERYONE'S WORST NIGHTMARE.

This type of systemic bias manifests in multiple types of systems-level discrimination, generally coined as "the -isms" (e.g., sexism, racism, ageism, ableism, healthism, weightism, and sizeism, in addition to transphobia, homophobia, and xenophobia). A

common factor among all these systemic forms of discrimination is *when you are in the system, it is hard to recognize the system*. As a result, many systemic issues are misinterpreted as individual shortcomings.

While discussions of the -isms are beginning to happen with more frequency, these conversations are often left out of the eating disorders community. In addition, even when conversations about the -isms do occur, weightism (the systematic valuing of bodies that are thinner compared to fatter) is often left out of the conversation. This is particularly noteworthy within the eating disorders community, since a hallmark symptom of eating disorders has to do with fat phobia, fear of weight gain and "undue influence" of weight.

What Do Weight Stigma and Fat Phobia Look Like?

We live in a world where thin people are terrified of becoming fat and fat people know that their bodies are everyone's worst nightmare. Even the word *fat* has taken on a disparaging meaning (Paine, 2021), though some body liberation advocates are reclaiming the word as a neutral descriptor (Meadows & Daníelsdóttir, 2016). Fat people are paid less than their thinner counterparts (Puhl & Heuer, 2009), are often denied medical care, may not have access to travel or clothes that fit them, and don't have equal rights because of their size (Tomiyama et al., 2018). Nearly everything we consume via the media portrays fat people as the butt of the joke. We rarely see representations of people in larger bodies who are happy and loved, or where the entire plotline isn't a mockery of their weight.

The harsh realities and consequences of weight stigma make it clear that fearing fatness is not an inherently pathological phenomenon, as long as fat bodies are systematically ridiculed, devalued, and harmed by societal stigma with predictable regularity. When stigma is this harmful, fearing aspects of our identity that put us at risk of experiencing deep harm may function as a form of self-preservation. Of course weight stigma is a contributing factor to eating disorders in a world where fat people are denied basic rights!

Weight Stigma Is an Intersectional Phenomenon

It's also important to note here that no one stigma exists within a vacuum. The other identities that we hold influence how we experience weight stigma. For example, women experience weight stigma differently than men; nonbinary people experience weight stigma differently still. Other identity intersections (e.g., racism, ableism)

IMAGE: iSTOCK

also affect people's experience of weight stigma, with weight stigma often exacerbating (or being used as a substitute for) other forms of societal discrimination (Strings, 2019). Thus, looking at weight stigma intersectionality (Crenshaw, 2017) is imperative.

Weight Stigma and Eating Disorders

The proportion of eating disorder patients with low weight is generally less than those with "normal" or higher weight, according to current body mass index standards. However, the proportion of thin patients in higher levels of care for eating disorders is much higher. For example, one recent review found that although atypical anorexia was more commonly found in community samples (compared to low-weight anorexia), low-weight anorexia was more common in treatment studies (Harrop et al., 2021).

There are many potential reasons for this. As in the case of systemic discrimination, weight bias is built into our medical, diagnostic, and insurance systems. We find weight stigma within eating disorder diagnoses, and insurance companies often deny people treatment because of their weight. Research has shown that people with atypical anorexia experience severe medical complications at rates equivalent to those of patients with low-weight anorexia nervosa (Peebles et al., 2010; Sawyer et al., 2016). However, likely because of weight bias, we associate anorexia with patients in thin bodies, and providers (including eating disorder providers) often dismiss eating disorder behaviors in fat patients because the patients don't "look ill" (Harrop, 2019; Harrop, 2020).

Further, in a world where most people still believe the myth that eating disorders only affect thin white women, a person who is Black, queer, fat, or any other marginalized identity may not recognize that they could have an eating disorder or try to seek help. Alternatively, a person in a larger body might be encouraged to incorporate a dangerous diet into their life and be praised for weight loss, even when it's at the expense of their health (Sim et al., 2013).

OF COURSE WEIGHT STIGMA IS A CONTRIBUTING FACTOR TO EATING DISORDERS IN A WORLD WHERE FAT PEOPLE ARE DENIED BASIC RIGHTS!

Weight stigma also shows up in the everyday experiences of eating disorder care (Harrop, 2019). Treatment centers often don't have towels, chairs, or blood pressure cuffs that fit clients in larger bodies. Treatment centers and outpatient dietitians often put larger clients on restrictive meal plans, despite the fact that those clients are malnourished, never giving the client the opportunity to truly heal their body and mind. It is common practice for therapists to reassure clients, saying, "Don't worry, we'd never make you get fat," which reinforces the idea that being fat is the worst thing a person could be. When a client says, "I'd rather die than be fat," in group therapy, rarely does someone gently point out to the client how awful it might be for a person in a larger body to hear that their body is more frightening than death. Generally, as a result of systemic norms and eating disorder stereotypes, eating disorder treatment has been designed with thin white patients in mind.

Healing from an Eating Disorder and Weight Stigma

Everyone in our thin- and fitness-obsessed culture is affected by an environment that villainizes fatness. When it comes to eating disorders specifically, internalized fat phobia (i.e., a fear of weight gain or the belief that one is inherently less good or worthy because of their weight) is a common hallmark. Further, it is often these obsessions around body weight and shape that bolster feelings of shame, obsession, and suffering, as well as the triggering of eating disorder behaviors. To address the harm and suffering of the eating disorder mindset, clinicians must take a systemic approach in addition to an individual approach. We cannot prescribe individual solutions to solve the pathologies of society (e.g., weight discrimination).

While we can commit to taking collective action as eating disorder professionals to resist weight stigma in society to the best of our abilities, we are likely a long way off from solving the problems of modern intersectional discrimination. How, then, should we approach treatment of eating disorders and the problem of the pervasiveness of weight stigma? We suspect that we must begin by helping our patients recognize that their bodies are not the problem;

societal discrimination is. We must help them confront the fact that although attempting to avoid discrimination is understandable and even logical (through efforts at weight loss, disordered eating, and other eating-disordered behaviors), these efforts result in a life-threatening eating disorder that reduces quality of life. We can attempt to help clients see through the veil of societal weight stigma to transform these fat-phobic beliefs at their core—and we can do this difficult work in our own lives as well. We can offer our patients a nuanced view of how body privilege and oppression manifest within society, their families, and our eating disorder treatment systems. And we can insist, with all the power from our positionality as providers, that all bodies are good bodies and deserving of rest, nourishment, gentle touch, and care. ◆

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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?**
- ☐ **Experience guilt or shame around eating?**
- ☐ **Count calories or fat grams whenever you eat or drink?**
- ☐ **Feel "out of control" when it comes to food?**
- ☐ **Binge eat twice a week or more?**
- ☐ **Still feel fat when others tell you that you are thin?**
- ☐ **Obsess about the size of specific body parts?**
- ☐ **Weigh yourself several times daily?**
- ☐ **Exercise to lose weight even if you are ill or injured?**
- ☐ **Label foods as "good" and "bad"?**
- ☐ **Vomit after eating?**
- ☐ **Use laxatives or diuretics to keep your weight down?**
- ☐ **Severely limit your food intake?**

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.

WARNING SIGNS

- **An obvious increase or decrease in weight not related to a medical condition**
- **Abnormal eating habits, such as severe dieting, ritualized mealtime behaviors, fear of dietary fat, secretive bingeing, or lying about food**
- **An intense preoccupation with weight and body image**
- **Mood swings, depression, and/or irritability**
- **Compulsive or excessive exercising, especially without adequate nutritional intake or when injured or ill**

[Book Excerpt]

The Renfrew Unified Treatment for Eating Disorders and Comorbidity

In this excerpt from *The Renfrew Unified Treatment for Eating Disorders and Comorbidity: An Adaptation of the Unified Protocol, Workbook*, the authors take a deeper look at "emotion avoidance." Written by **Heather Thompson-Brenner, Melanie Smith, Gayle Brooks, Dee Ross Franklin, Hallie Espel-Huynh, and James F. Boswell**.

Emotion Avoidance

The key concept for this session is emotion avoidance. *Emotion avoidance* means any strategies we use to avoid feeling strong emotions or to prevent our emotions from becoming more intense. Although these responses may be useful in some situations, they rarely work well in the long term and they can even increase the intensity of our emotions when we encounter a similar situation in the future. In this session, you will develop greater awareness of your own patterns of emotion avoidance and prepare to challenge these responses through emotion exposures.

Emotion-driven behaviors (EDBs) are a strategy of emotion escape. Strong emotions can drive us to engage in specific behaviors sometimes before we even have a chance to think about it. This can be helpful and adaptive, for instance when we are in immediate danger (e.g., seeing a bear in the woods). However, sometimes EDBs are not consistent with the situation at hand (e.g., having the same response when we see a plate of spaghetti, or when we are asked a question by our boss, as we would when seeing a bear in the woods). These same avoidant behaviors, while relieving us from the experience of intense or uncomfortable emotions in the short term, can actually limit our lives in important ways, or even be harmful. …

What Is the Problem with Avoidance?

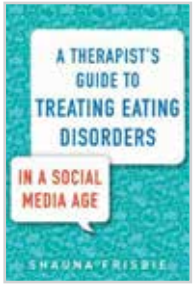
If avoidance worked really well to manage our emotions, then there wouldn't be a problem. Actually, it does serve a purpose in the short term—if we are able to avoid the emotion that we find distressing, then why not? The problem is that over the long term, chronic avoidance causes problems in a number of ways:

…

- When we habitually avoid an emotion or the situation that provokes the emotion, **we give ourselves negative messages**—like "I can't handle that emotion" or "That situation is dangerous to me"—and this backfires to cause more fear or distress the next time we face a similar situation.
- This process can become **progressive over time**, so we have to avoid more and more situations and find the emotion more and more difficult to deal with. For example, someone with a fear of driving a car might start with not driving on the highway, but then he finds the city starts to make him nervous, and finally he decides it is too scary to drive at all.
- Some of the things we do to avoid emotions **really hurt us**, like eating symptoms, substance abuse, cutting, or suicidal gestures on the extreme side, and not being able to meet demands of life or missing out on certain opportunities more subtly. ◆

IMAGE: UNSPLASH

Hidden and Lesser-Known Disordered Eating Behaviors in Medical and Psychiatric Conditions
Emilia Manzato, Massimo Cuzzolaro & Lorenzo Maria Donini, editors, 2022



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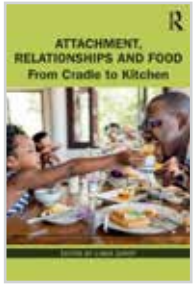
Shauna Frisbie, 2020



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Linda Cundy, editor, 2021

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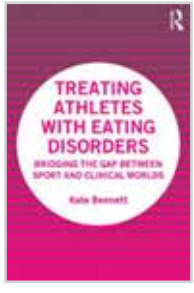

Treating Athletes with Eating Disorders: Bridging the Gap Between Sport and Clinical Worlds
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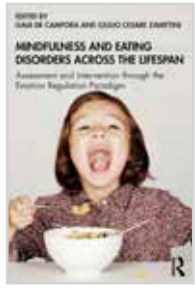
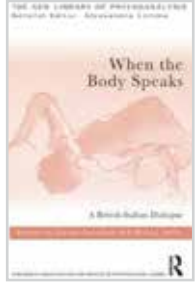
Cognitive Behavior Therapy for Adolescents with Eating Disorders
Riccardo Dalle Grave & Simona Calugi, 2020



Mindfulness and Eating Disorders Across the Lifespan: Assessment and Intervention Through the Emotion Regulation Paradigm
Gaia de Campora & Giulio Cesare Zavattini, editors, 2021



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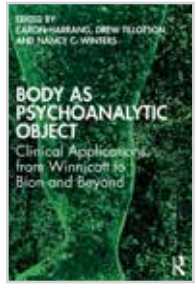
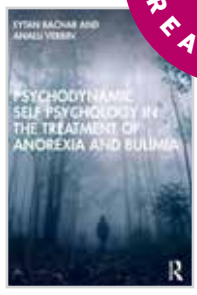


Body as Psychoanalytic Object: Clinical Applications from Winnicott to Bion and Beyond
Caron Harrang, Drew Tillotson & Nancy C. Winters, editors, 2022



Psychodynamic Self Psychology in the Treatment of Anorexia and Bulimia
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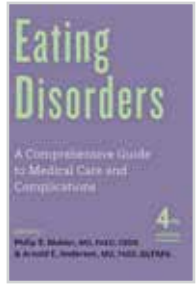
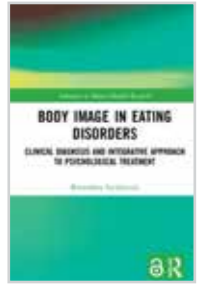


Eating Disorders, Fourth Edition: A Comprehensive Guide to Medical Care and Complications
Philip S. Mehler & Arnold E. Andersen, editors, 2022



Body Image in Eating Disorders: Clinical Diagnosis and Integrative Approach to Psychological Treatment
Bernadetta Izydorczyk, 2021

Editor's Picks

ANOREXIA

- **Almost Anorexic: Is My (or My Loved One's) Relationship with Food a Problem?** by Jennifer J. Thomas & Jenni Schaefer, 2013.
- **Anorexia Nervosa, Second Edition: A Recovery Guide for Sufferers, Families, and Friends** by Janet Treasure & June Alexander, 2013.

ARFID

- **Cognitive-Behavioral Therapy for Avoidant/ Restrictive Food Intake Disorder: Children, Adolescents, and Adults** by Jennifer J. Thomas & Kamryn T. Eddy, 2018.

BINGE EATING DISORDER

- **Binge Control: A Compact Recovery Guide** by Cynthia M. Bulik, 2015.
- **Binge Eating: A Transdiagnostic Psychopathology** by Guido K.W. Frank & Laura A. Berner, editors, 2020.
- **Binge Eating Disorder: The Journey to Recovery and Beyond** by Amy Pershing with Chevese Turner, 2018.

BODIES

- **Body Image, Second Edition: A Handbook of Science, Practice, and Prevention** by Thomas F. Cash & Linda Smolak, 2012.
- **Embodiment and the Treatment of Eating Disorders: The Body as a Resource in Recovery** by Catherine Cook-Cottone, 2020.
- **Handbook of Positive Body Image and Embodiment: Constructs, Protective Factors, and Interventions** by Tracy L. Tylka & Niva Piran, editors, 2019.
- **Pursuing Perfection: Eating Disorders, Body Myths, and Women at Midlife and Beyond** by Margo Maine & Joe Kelly, 2016.

BULIMIA

- **Getting Better Bite by Bite, Second Edition: A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders** by Ulrike Schmidt, Janet Treasure & June Alexander, 2015.

FAMILIES, LOVED ONES, AND CARERS

- **Ed Says U Said: Eating Disorder Translator** by June Alexander & Cate Sangster, 2013.
- **Father Hunger, Second Edition: Fathers, Daughters, and the Pursuit of Thinness** by Margo Maine, 2004.
- **Help Your Teenager Beat an Eating Disorder, Second Edition** by James Lock & Daniel Le Grange, 2015.
- **If Your Adolescent Has an Eating Disorder, Second Edition: An Essential Resource for Parents** by B. Timothy Walsh & Deborah R. Glasofer, 2020.
- **Skills-Based Caring for a Loved One with an Eating Disorder, Second Edition: The New Maudsley Method** by Janet Treasure, Gráinne Smith & Anna Crane, 2016.
- **When Your Teen Has an Eating Disorder: Practical Strategies to Help Your Teen Recover from Anorexia, Bulimia, and Binge Eating** by Lauren Muhlheim, 2018.
- **Your Dieting Daughter, Second Edition: Antidotes Parents Can Provide for Body Dissatisfaction, Excessive Dieting, and Disordered Eating** by Carolyn Costin, 2013.

HEALTHY BEHAVIORS

- **The Body Is Not an Apology, Second Edition: The Power of Radical Self-Love** by Sonya Renee Taylor, 2021.
- **Embody: Learning to Love Your Unique Body (and Quiet That Critical Voice!)** by Connie Sobczak, 2014.
- **Intuitive Eating, Fourth Edition: A Revolutionary Anti-Diet Approach** by Evelyn Tribole & Elyse Resch, 2020.
- **Radical Belonging: How to Survive and Thrive in an Unjust World (While Transforming It for the Better)** by Lindo Bacon, 2020.

KIDS/ TEENS/ YOUNG ADULTS

- **The Body Image Book for Girls: Love Yourself and Grow Up Fearless** by Charlotte Markey, 2020.
- **Can I Tell You About Eating Disorders? A Guide for Friends, Family, and Professionals** by Bryan Lask & Lucy Watson, illustrated by Fiona Field, 2014.
- **The Intuitive Eating Workbook for Teens: A Non-Diet, Body Positive Approach to Building a Healthy Relationship with Food** by Elyse Resch, 2019.
- **Letting Go of ED – Embracing Me: A Journal of Self-Discovery** by Maria Ganci & Linsey Atkins, 2019.
- **Shapesville** by Andy Mills & Becky Osborn, illustrated by Erica Neitz, 2003.

PERSONAL STORIES

- **A Girl Called Tim: Escape from an Eating Disorder Hell** by June Alexander, 2019.
- **Goodbye Ed, Hello Me: Recover from Your Eating Disorder and Fall in Love with Life** by Jenni Schaefer, 2009.
- **Life Without Ed, 10th Anniversary Edition: How One Woman Declared Independence from Her Eating Disorder and How You Can Too** by Jenni Schaefer with Thom Rutledge, 2014.

PREVENTION

- **Journeys of Embodiment at the Intersection of Body and Culture: The Developmental Theory of Embodiment** by Niva Piran, 2017.

PROFESSIONAL TREATMENT

- **Beyond a Shadow of a Diet, Second Edition: The Comprehensive Guide to Treating Binge Eating Disorder, Compulsive Eating, and Emotional Overeating** by Judith Matz & Ellen Frankel, 2014.
- **A Brain-Based Approach to Eating Disorder Treatment** by Laura Hill, 2017.
- **Clinical Handbook of Complex and Atypical Eating Disorders** by Leslie K. Anderson, Stuart B. Murray & Walter H. Kaye, editors, 2017.
- **The Comprehensive Learning Teaching Handout Series for Eating Disorders** by Sondra Kronberg, 2009.
- **Eating Disorders, Fourth Edition: A Comprehensive Guide to Medical Care and Complications** by Philip S. Mehler & Arnold E. Andersen, editors, 2022.
- **Eating Disorders, Addictions, and Substance Use Disorders: Research, Clinical, and Treatment Perspectives** by Timothy Brewerton & Amy Baker Dennis, editors, 2014.
- **Eating Disorders in Special Populations: Medical, Nutritional, and Psychological Treatments** by Jonna Fries & Veronica Sullivan, editors, 2017.
- **Emotion-Focused Family Therapy: A Transdiagnostic Model for Caregiver-Focused Interventions** by Adele Lafrance, Katherine A. Henderson & Shari Mayman, 2019.
- **Exposure Therapy for Eating Disorders** by Carolyn Black Becker, Nicholas R. Farrell & Glenn Waller, 2019.
- **Family-Based Treatment for Restrictive Eating Disorders: A Guide for Supervision and Advanced Clinical Practice** by Sarah Forsberg, James D. Lock & Daniel Le Grange, 2018.
- **Handbook of Assessment and Treatment of Eating Disorders** by B. Timothy Walsh, Evelyn Attia, Deborah R. Glasofer & Robyn Sysko, editors, 2015.
- **Sick Enough: A Guide to the Medical Complications of Eating Disorders** by Jennifer L. Gaudiani, 2018.
- **The Skills Training Manual for Radically Open Dialectical Behavior Therapy: A Clinician's Guide for Treating Disorders of Overcontrol** by Thomas R. Lynch, 2018.
- **Trauma-Informed Approaches to Eating Disorders** by Andrew Seubert & Pam Virdi, editors, 2018.
- **Treating Eating Disorders in Adolescents: Evidence-Based Interventions for Anorexia, Bulimia, and Binge Eating** by Tara L. Deliberto & Dina Hirsch, 2019.
- **Treating the Eating Disorder Self: A Comprehensive Model for the Social Work Therapist** by Mary Anne Cohen, 2020.
- **Treatment Manual for Anorexia Nervosa, Second Edition: A Family-Based Approach** by James Lock & Daniel Le Grange, 2012.
- **Understanding Anorexia Nervosa in Males: An Integrative Approach** by Tom Wooldridge, 2016.

RECOVERY

- **8 Keys to Recovery from an Eating Disorder: Effective Strategies from Therapeutic Practice and Personal Experience (8 Keys to Mental Health)** by Carolyn Costin & Gwen Schubert Grabb, 2011.
- **Recovery Is: Stories of Healing** by Liana Rosenman & Kristina Saffran, 2015.
- **Starting Monday: Seven Keys to a Permanent, Positive Relationship with Food** by Karen R. Koenig, 2013.

IMAGE: iSTOCK

- **Understanding Teen Eating Disorders: Warning Signs, Treatment Options, and Stories of Courage** by Cris E. Haltom, Cathie Simpson & Mary Tantillo, 2018.
- **Using Writing as a Therapy for Eating Disorders: The Diary Healer** by June Alexander, 2016.
- **Words to Eat By: Using the Power of Self-Talk to Transform Your Relationship with Food and Your Body** by Karen R. Koenig, 2021.
- **Yoga and Eating Disorders: Ancient Healing for Modern Illness** by Carolyn Costin & Joe Kelly, editors, 2016.

RECOVERY WORKBOOKS

- **8 Keys to Recovery from an Eating Disorder Workbook** by Carolyn Costin & Gwen Schubert Grabb, 2017.
- **The Body Image Workbook, Second Edition: An Eight-Step Program for Learning to Like Your Looks** by Thomas F. Cash, 2008.
- **The Food and Feelings Workbook: A Full Course Meal on Emotional Health** by Karen R. Koenig, 2007.
- **The Intuitive Eating Workbook for Teens: A Non-Diet Body Positive Approach to Building a Healthy Relationship with Food** by Elyse Resch, 2019.

SOURCE BOOKS

- **Anorexics and Bulimics Anonymous: The Fellowship Details Its Program of Recovery for Anorexia and Bulimia,** 2002.
- **Eating Disorders: What Everyone Needs to Know®** by B. Timothy Walsh, Evelyn Attia & Deborah R. Glasofer, 2020.

SPIRITUALITY

- **Spiritual Approaches in the Treatment of Women with Eating Disorders** by P. Scott Richards, Randy K. Hardman & Michael E. Berrett, 2007.

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