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The Impact of Weight Stigma on Children

CULTIVATING POSITIVE BODY IMAGE

2021

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Welcome!

Dear Readers,

We hope our 2021 catalogue brings support and valuable resources to your doorstep.

It has certainly been a unique and trying year, and the eating disorders community has been particularly hard hit as a result of the isolation measures put in place in response to COVID-19. Fortunately, as researchers amassed data on the challenges the virus has imposed, many providers rose to the occasion and made a smooth transition to virtual care. We send a big thank-you to these providers and all the caregivers and support teams who continue their roles from a distance.

In this issue, we have included exciting research on newer treatments, specifically the use of psychedelics and Floatation-REST. Curiosity and questions will help our field move forward in developing evidence-based treatments. If you have questions, the authors welcome your feedback.

The past few seasons offered the market many quality books relating to eating disorders. For the first time, we have chosen to highlight new books that have never been featured in our catalogue before. Please know that many additional and excellent options are listed on our website, **EDcatalogue.com**, under the "Books" tab. There truly is a world of resources at your fingertips.

We hope you'll benefit from the enclosed knowledge shared by our writers, book authors, and the many facilities who make this resource available to you. We are so appreciative of our contributors!

We also send our endless gratitude for your ongoing support for this magazine, our podcast, and all our related endeavors. Your support helps keep our energy up, and **the entire Gürze/Salucore team thanks you!**

With best wishes for your wellness,

Kathy Cortese

LCSW, ACSW, CEDS
Editor-in-Chief

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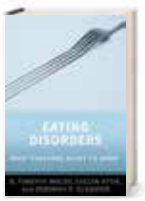
Book Excerpt



Eating Disorders: *What Everyone Needs to Know®*

In this excerpt from *Eating Disorders: What Everyone Needs to Know®*, B. Timothy Walsh, MD, FAED, Evelyn Attia, MD, and Deborah R. Glasofer, PhD, discuss the much-debated topic of what causes eating disorders.

Are They Caused by Dieting?

There is little doubt that dieting (that is, attempting to reduce one's intake of calories) is involved in important ways in the development and persistence of eating disorders. Most people who develop an eating disorder say that they were attempting to diet when they first developed symptoms of the eating disorder. In anorexia nervosa, restriction of caloric intake is a defining characteristic. And, although the key behaviors of bulimia nervosa and subthreshold bulimia nervosa (considered an OSFED) are binge eating and inappropriate attempts to compensate for binge eating (such as inducing vomiting), individuals with bulimia nervosa usually diet between episodes of binge eating. It is unclear to what degree people with purging disorder pursue rigorous dieting.

The question of causation is trickier. For example, the overwhelming majority of American teenage girls diet at some point. But only a small minority of them develop an eating disorder. If eating disorders were simply caused by dieting, they would be much more common than they are. Similarly, although the frequency of dieting among young people has likely increased in the last 50 years, our best estimates tell us that the frequency of anorexia nervosa has not, and the frequency of bulimia nervosa has probably declined. For these reasons, dieting is best viewed as one of a number of risk factors for the development of eating disorders, but not as the cause. For people who have additional but unclear vulnerabilities, dieting triggers the development of symptoms that may evolve into an eating disorder.

Are They Caused by Families?

As discussed already, we do not know what causes eating disorders. Nonetheless, for many years, families were blamed. It is likely that this mistaken notion developed because when parents took their child to get help, the parents were in great distress. But as all parents can imagine, such distress is perfectly normal when a child has a serious illness, whether it's an eating disorder or a purely physical problem! Professionals likely misinterpreted the distress as indicating there was dysfunction in the family that preceded the eating disorder and led to its development. This line of thinking has now been discarded.

Put simply: Since we do not know what causes eating disorders, we cannot blame the family.

Are They Caused by the Media?

The answer to this question is not simple. The images that the media presents of individuals, especially women, who are suggested to be attractive and popular are, almost without exception, much thinner (and younger) than the average person. This phenomenon contributes to the near-universal desire among young women to be thin (or at least thinner). For boys and men, the images in popular media suggest that attractiveness is linked to being muscular and buff. So overall, this is good reason to believe that the images portrayed in the media contribute to unrealistic and unattainable ideals of what people should look like and, by extension, an environment in which eating disorders are more likely to develop.

But, this does not mean that the media alone has the power to cause eating disorders. In industrialized countries, young people are flooded with images in the media, but only a few of those exposed develop an eating disorder. Furthermore, eating disorders were clearly described long before the current media environment—the term *anorexia nervosa* was coined 150 years ago! ◆

The Impact of Weight Stigma on Children

BY LESLEY WILLIAMS, MD, CEDS

Children come in all shapes and sizes, and they are not immune to the impact of weight stigma and the development of eating disorders. Even young elementary school kids are spending their playground time talking about size and shape instead of swinging on the swings or playing on the slides. Weight stigma and fatphobia are everywhere.

Children in larger bodies often feel alienated by the bullying and overt "sizeism" they experience. Schools, homes, and health care settings have been identified as common places where weight stigma exists. Strides have been made to address stigma in other areas. Despite this, weight stigma typically remains uncharted waters. In fact, it was only a few years ago that some schools in this country were weighing students and sending "golden tickets" home with children above a certain BMI. The alleged goal was to improve health and address the "childhood obesity epidemic" by informing children and their parents that something needed to be done re: their weight. The primary outcome was that children felt humiliated and helpless. Few options are available for young children being told that their size is unacceptable. They didn't make their genetics, and they rarely make their own meals. Many begin engaging in restriction in an effort to make their bodies smaller. Others begin to eat more as a way to reduce the negative feelings they have about themselves. Weight stigma is not harmless. It can serve as a catalyst for years of disordered eating and body dissatisfaction. If the health and happiness of our youth is the goal, we need to work together to reduce weight stigma and support happy and healthy living for children of all sizes.

What Is Weight Stigma?

- It's also known as weight bias or weight discrimination.
- It involves discrimination or stereotyping based on size.
- Weight stigma can also manifest as fatphobia, which is the dislike of or fear of becoming fat.
- Weight stigma is both a public health and social justice issue.

How Does Weight-Based Victimization Show Up?

1. Teasing/name-calling
2. Cyberbullying/negative comments on social media
3. Physical aggression
4. Relational victimization: being ignored, excluded, or the target of rumors

The trend of increasing pediatric body sizes is indisputable. As of 2016, 13.7 million children in the

U.S. were classified as overweight or obese. This number is nearly triple what it was in 1963. Although we recognize that the number is increasing, the plan regarding what to do about it is up for debate. In fact, some question whether anything needs to be done at all. Singularly focusing on decreasing the number of individuals who meet these weight criteria feels like a misguided quest. We could also recognize that the number of LGBTQ youth has increased over that same period of time. This fact is regarded as a trend that reflects our evolving world and something that we need to be more sensitive and attuned to. It is not regarded as something that needs to be eradicated. When it comes to increasing size, health care professionals should take a similar approach. Instead, many have elected to address the issue by waging a war on "childhood obesity," citing a quest to improve the health of our youth as their motivation. Improving the health of our youth is something we can all agree on. However, if health is our goal, we can't address the potential health issues associated with higher body weights while at the same time ignoring the equally deleterious impact of weight stigma on health. We cannot profess our concern for health while ignoring the negative impact that weight stigma also has on health. According to a 2020 *American Psychologist* report, weight stigma has been linked to depression, maladaptive eating behaviors, decreased engagement in physical activity, and psychological stress, as well as body dissatisfaction and weight gain. None of that sounds very healthy to me. Is it possible to help children feel accepted just the way they are while simultaneously encouraging healthy lifestyle habits that could benefit children of all sizes?

All too often, health care providers tell children in larger bodies they simply need to "eat less, exercise more." This basic prescription is ineffective and does not take into account how multifactorial weight and shape are. Children are given the impression that their size is somehow their fault. They are told that the blame for their size rests solely with them. It is rarely acknowledged that even if every child in America ate the same thing every day and did the same amount of activity, sizes would vary greatly. If we want to promote health, we need to start by recognizing that efforts to blame and shame children into weighing less are causing harm. These tactics have been used by some health care professionals because they believe it will help motivate the child or their parents to

PHOTO: UNSPLASH

NATIONAL EATING DISORDERS ORGANIZATIONS

- **Academy for Eating Disorders (AED)** aedweb.org
- **The Alliance for Eating Disorders Awareness** allianceforeatingdisorders.com
- **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
- **The International Association of Eating Disorders Professionals Foundation (IAEDP)** iaedp.com
- **Maudsley Parents** maudsleyparents.org
- **Multi-Service Eating Disorders Association, Inc. (MEDA)** medainc.org
- **National Association 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
- **Trans Folx Fighting Eating Disorders (T-FFED)** transfolxfightingeds.com

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

make necessary dietary and lifestyle changes. I can assure you, this is not the case. A child who is fat-shamed by a doctor or someone else whom they hold in high regard does not go home and eat a salad and join a sports team. They go home filled with humiliation and self-loathing. The experience has a negative impact on them. If we want our youth to lead happy, healthy lives, we must eliminate weight stigma and make them feel valued and capable of greatness, no matter their size.

Navigating overlapping stigmas is especially challenging for children of color in larger bodies. Given the current racial climate in our country, it is imperative that we understand how impactful dealing with cumulative stigmas can be. If we are advocating for the reduction of weight stigma, we need to simultaneously advocate for reducing racial stigma as well. Some old studies have suggested that children of color are immune to body image dissatisfaction and disordered eating. This is not the case. It is evident that children of color are less likely to be diagnosed and treated. They also struggle to find mental health professionals that understand the negative psychological impact of living in a society that rejects you based on your skin color as well as your size. All children should be given an opportunity to grow up in a world that supports their strengths and successes regardless of their size or color.

How can we combat diet culture, racism, and weight stigma while cultivating a new generation of children who love and accept one another and all of the unique sizes, shapes, and colors that they come in? That's a big task. One proposed step in that direction is having an open dialogue with children about the true meaning of health. The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." We should be teaching our children that it is possible to achieve this globally accepted definition of health regardless of what size you are.

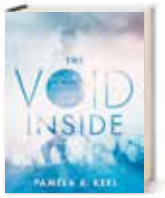
> **WE CANNOT PROFESS OUR CONCERN FOR HEALTH WHILE IGNORING THE NEGATIVE IMPACT THAT WEIGHT STIGMA ALSO HAS ON HEALTH.**

Physical, mental, and social well-being are available to all of us. Imagine a new world where children of all sizes feel free to engage in the good things that life has to offer without the fear of stigma or discrimination. Wouldn't that be a happier, healthier world for all of us?

Goals for Reducing Weight Stigma in Pediatrics:

1. Assess internalized weight bias in adults
2. Educate children that their bodies come in all shapes and sizes
3. Tell children that promoting health and happiness is important
4. Encourage all children to love and support one another
5. Discuss what weight stigma is and the variety of ways it can show up
6. Brainstorm ways to reduce weight stigma ◆

Book Excerpt



The Void Inside:
Bringing Purging Disorder to Light

In this excerpt from *The Void Inside*, Pamela K. Keel, PhD, explains what purging disorder is and what makes it different from other eating disorders.

You wouldn't be able to tell that a person has purging disorder just by looking at them. They eat enough food to maintain a minimally healthy body weight. This distinguishes them from individuals with anorexia, in whom restricted food intake causes medically low body weight. On the outside, people with purging disorder look just like people without eating disorders. As one girl explained, "To all, I appeared to be a healthy, normal girl, but I was secretly destroying my body." Their bodies can range from being somewhat thin to being significantly overweight or even obese, just like the bodies of people without eating disorders.

Individuals with purging disorder don't consume more food than most people eat—distinguishing them from individuals with bulimia and BED, in whom bingeing involves a loss of control while eating an excessive quantity of food. For example, a person with bulimia or BED might eat an entire package of store-bought cookies and a box of sugary cereal with milk, consuming over 3,000 calories in a single sitting, because they couldn't stop eating until all the food was gone. The average size of binges is approximately 3,600 calories in bulimia and BED, according to feeding lab studies. This represents an abnormally large amount of food that most people would experience as undesirable and unpleasant. Those with purging disorder eat no more food than most people eat, which means less than 1,000 calories in two hours, according to feeding lab studies. If you're wondering how much food goes into 1,000 calories, this could accommodate a blueberry scone and a Matcha Green Tea Frappuccino at Starbucks. However, this is an upper limit. In purging disorder, the average consumption prior to purging is around 500 to 750 calories (meaning people purge after either the blueberry scone *or* the Frappuccino—neither of which is excessive).

Some individuals with purging disorder experience a loss of control over their eating and may even subjectively experience their food intake as large. For example, one woman described how she had eaten an "entire bag of potato chips." With additional probing, she shared that she had gotten the bag from a vending machine. But for her, this single serving represented an enormous amount of food. Another woman's largest out-of-control "binge" involved 40 calories. These perceptions represent distortions of reality and a feature of the illness. However, not all people with purging disorder experience their eating as out of control. Some just need to purge to feel control over the effects of food on their bodies: "We threw up because we ate normally and felt fat, or felt that it would make us fat." So, if purging disorder is not captured by any of the three existing disorders, why aren't there four eating disorders—anorexia, bulimia, BED, and purging disorder? ◆

Book Excerpt

Body Positive: *Understanding and Improving Body Image in Science and Practice*

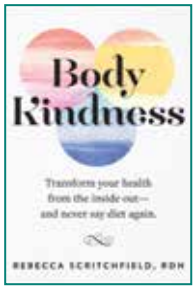
In this excerpt from *Body Positive,* Elizabeth A. Daniels, PhD, and Tomi-Ann Roberts, PhD, discuss the many interrelated elements involved in cultivating a positive body image.

The construct of positive body image is multifaceted. It includes: (1) appreciating one's body and its functions; (2) accepting and admiring one's body despite sociocultural appearance pressures; (3) feeling comfortable, confident, and happy with one's body; (4) focusing on the strong points of one's body while rejecting negative information (Wood-Barcalow, Tylka, & Augustus-Horvath, 2010; see Chapter 1). Since the articulation and development of this construct in the literature, research on positive body image has flourished (Tylka & Wood-Barcalow, 2015a; see Chapter 1). Piran and Teall (2012) outlined a related multifaceted construct termed *positive embodiment*, which includes the following five processes: (1) positive connection to the body via positive self-talk in the face of aversive experiences such as threats to body image; (2) experiences of functionality and agency related to the body; (3) attuned self-care (i.e., awareness of internal cues, such as hunger, and action based on such cues, e.g., eating); (4) positive experiences and expressions of the body's desires (e.g., sexual desire); and (5) experiencing the body from a subjective rather than an objective position (see Chapter 6). Building on Piran and colleagues' original work, Menzel and Levine (2011) proposed the Embodiment Model of Positive Body Image, which identified participation in embodying activities, such as sport or yoga, as an important mechanism in the development of positive body image. Embodying activities are proposed to increase the frequency of mind-body integration, body awareness and responsiveness, and feelings of physical competence and empowerment; these experiences may, in turn, foster positive body image. Taken together, these conceptual models illuminate the various components of positive body image as well as pathways to cultivating positive image.

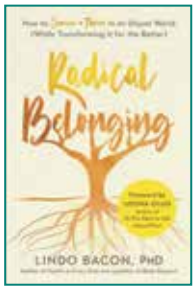
In this chapter, we will review the existing literature on programmatic approaches to cultivating positive body image in youth, typically adolescents. Unfortunately, nearly all body image programs remain disconnected from the theoretical and empirical work on positive body image and positive embodiment. Little if any programmatic emphasis on positive body concepts appears in most prevention/intervention work, and outcome measures tend to focus exclusively on the relief of body dissatisfaction or eating disorder symptomatology, as opposed to assessing positive cognitive, emotional, and experiential elements of the body. However, as Tylka (see Chapter 1) has argued, positive body image is not simply the opposite of negative body image on a continuum, but rather is its own distinct construct, and is therefore worth cultivating separately in programmatic work aimed at enhancing body image in youth.

Indeed, research on coping and emotion regulation provides reason to suspect that enhancing positive feelings and cognitions about the body may be essential to truly successful programmatic body image intervention work. First, research on repressive coping has shown that suppressing negative body-related thoughts and emotions may provide short-term improvements in well-being for some, but for many can, paradoxically, yield a preoccupation with such thoughts, leading to behavioral rebound effects that engender long-term unfavorable outcomes. ◆

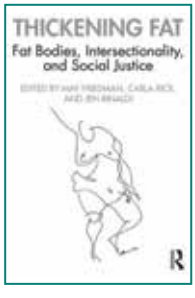
Excerpted with permission from Cambridge University Press, *Body Positive: Understanding and Improving Body Image in Science and Practice*, Elizabeth A. Daniels, PhD, Meghan M. Gillen, PhD & Charlotte H. Markey, PhD, editors, 266 pages, hardcover/paper/e-book, 2018.



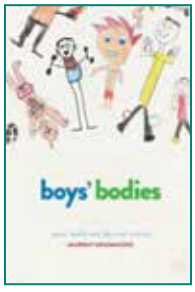
Body Kindness: Transform Your Health from the Inside Out—and Never Say Diet Again
Rebecca Scritchfield, 2016



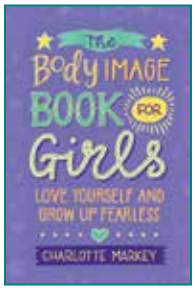
Radical Belonging: How to Survive and Thrive in an Unjust World (While Transforming It for the Better)
Lindo Bacon, 2020



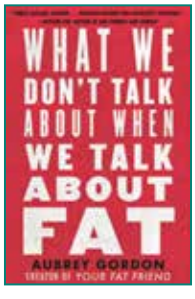
Thickening Fat: Fat Bodies, Intersectionality, and Social Justice
May Friedman, Carla Rice & Jen Rinaldi, editors, 2019



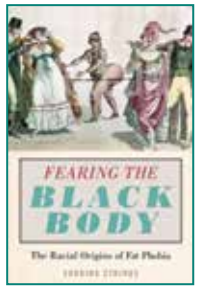
Boys' Bodies: Sport, Health and Physical Activity
Murray Drummond, 2019



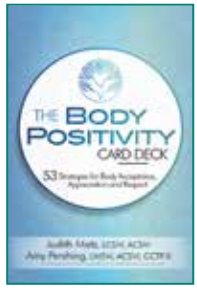
The Body Image Book for Girls: Love Yourself and Grow Up Fearless
Charlotte Markey, 2020



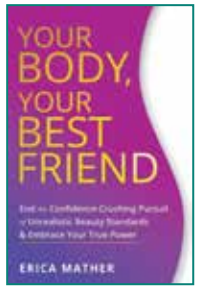
What We Don't Talk About When We Talk About Fat
Aubrey Gordon, 2020



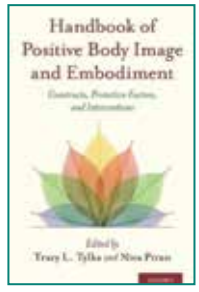
Fearing the Black Body: The Racial Origins of Fat Phobia
Sabrina Strings, 2019



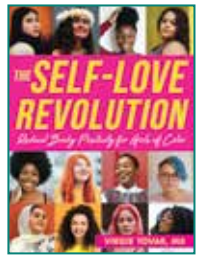
The Body Positivity Card Deck: 53 Strategies for Body Acceptance, Appreciation, and Respect
Judith Matz & Amy Pershing, 2020



Your Body, Your Best Friend: End the Confidence-Crushing Pursuit of Unrealistic Beauty Standards and Embrace Your True Power
Erica Mather, 2020



Handbook of Positive Body Image and Embodiment: Constructs, Protective Factors, and Interventions
Tracy L. Tylka & Niva Piran, editors, 2019



The Self-Love Revolution: Radical Body Positivity for Girls of Color
Virgie Tovar, 2020

Understanding Body Dissatisfaction in Ethnic Minority Women: Do We Have an Incomplete Picture?

BY MARISOL PEREZ, PHD, FAED

Body dissatisfaction and disordered eating occur across women of diverse racial and ethnic identities. With this understanding has come an increase in research within the past two decades. However, the majority of this research focuses on generalizing existing theoretical models and assessments to women of racial and ethnic identities.

Although this is informative and it is important to know the generalizability and universality of our theoretical models, a limitation is that we do not know to what extent our models are missing common symptoms and risk factors specific to non-White individuals. In the United States, 40 percent of the population is non-White (U.S. Census, 2019). A prominent theoretical model is the Tripartite

Model of disordered eating, a model developed based on studies with predominantly White girls and women. This model proposes that the internalization of appearance ideals predicts body dissatisfaction and disordered eating (Thompson et al., 1999). Appearance ideals are the physical features or characteristics considered attractive within a culture (Thompson et al., 1999). Internalization of appearance ideals is the extent to which an individual subscribes to a culture's appearance ideal and engages in behaviors to attain the ideal (Thompson et al., 1999).

The literature describes two appearance ideals: the thin ideal and the muscular ideal. The thin ideal is when a feminine physique appearing slender with a small waist and low body fat is attractive in a culture (Thompson et al., 1999). A myriad of experimental studies, as well as longitudinal and intervention research, documents thin ideal internalization as an impactful and significant risk factor for body dissatisfaction and disordered eating behaviors. The muscular ideal is another appearance ideal documented in the literature, in which a slender, toned, and fit feminine physique is attractive in a culture (Gruber, 2007). Although there is less research on the muscular ideal relative to the thin ideal, what does exist demonstrates an association between muscular ideal internalization and the pursuit of unhealthy behaviors and disordered eating behaviors.

Research studies examining the thin and muscular ideals consist of predominantly White samples. There is a small amount of research that supports the existence of another ideal among racial and ethnic minority women. The hourglass ideal is when a curvy body shape with bigger breasts and hips/buttocks and an indented waist is attractive in a culture. In a qualitative study, 16 Black women described a shapely and curvaceous body image as the ideal for their culture (Kelch-Oliver & Ancis, 2011). Similarly, 27 Latina adolescents endorsed a slender but curvy body shape as the cultural appearance ideal (Romo, Mireles-Rios, & Hurtado, 2016). Another study with a diverse sample of women found that some subscribed to a thin ideal and some subscribed to an hourglass ideal, while others subscribed to both (Hunter et al., 2020).

Our research supports the existence of an hourglass appearance ideal and its association with body dissatisfaction and disordered eating. We conducted two studies: the first with 916 women of racial and ethnic minority identities, between the ages of 18 and 48 years old, recruited from the community; the second with 195 undergraduate women of diverse racial and ethnic minority identities. We assessed hourglass ideal internalization through a six-item self-report questionnaire featuring a score range of 1 to 5, with higher scores indicating more internalization. Interestingly, 88 percent of the entire sample reported some endorsement of hourglass ideal internalization. High levels of hourglass ideal internalization were reported by 23.2 percent of women with Asian American identities, 20.4 percent of women with Black identities, and 21.4 percent of women with Hispanic/Latinx identities. It's important to note that hourglass ideal internalization was associated with body dissatisfaction and disordered eating behaviors. Across all racial/ethnic groups, women who endorsed more hourglass ideal internalization also reported more body dissatisfaction. Women who reported more hourglass ideal internalization also reported more impairment in daily functioning as a result of body shape and weight concerns. Further, those who reported endorsing the hourglass ideal with another ideal, such as the thin or muscular ideal, had higher body dissatisfaction and more severe disordered eating behaviors than those who reported just one ideal.

Do We Have an Incomplete Picture? The answer is yes. Collectively, studies with women and girls of racial and ethnic identities report a third appearance ideal absent in the body dissatisfaction and disordered eating literature. Similar to other appearance ideals, the hourglass ideal relates to body dissatisfaction and disordered eating behaviors among women of racial and ethnic minority identities. These findings have important implications. First, current theoretical models such as the Tripartite Model of disordered eating need refinement to include an hourglass ideal internalization to better represent women from diverse cultures. However, future research needs to examine the extent to which the type of appearance ideal internalization matters. It may be that the presence of an ideal, regardless of what it is, contributes to body dissatisfaction and the pursuit of unhealthy behaviors to attain the ideal. In that case, whether a woman endorses a thin versus a muscular versus an hourglass ideal becomes less relevant.

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

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Book Excerpt

Multifamily Therapy Group for Young Adults with Anorexia Nervosa: *Reconnecting for Recovery*

In this excerpt, Mary Tantillo, Jennifer L. Sanftner McGraw, and Daniel Le Grange shed light on the Reconnecting for Recovery approach to Multifamily Therapy Group treatment.

Over a decade of clinical observation, patient and family feedback, and preliminary research supports Reconnecting for Recovery's (R4R) promise as a Multifamily Therapy Group (MFTG) treatment for young adults with AN. R4R combines the benefits of family and group therapy and is rooted in relational and motivational theories that can foster healing, psychological change, and ongoing recovery. It is based on a new and innovative conceptual scheme (AN as a disease of disconnection) that provides a credible explanation for AN symptoms and offers a prescribed approach believed to resolve these symptoms and restore health. R4R aims to create a therapeutic community of healing that allows patients and families to view disconnections associated with AN as opportunities to strengthen their relationships and resolve for recovery.

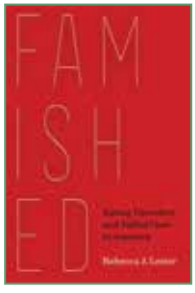
R4R MFTG creates a diverse, abundant, and sustainable therapeutic community that capitalizes on and maximizes the strengths, resources, and adaptive coping strategies of its members (Tantillo, 2006; Tantillo, McGraw, Hauenstein, & Groth, 2015; Tantillo, McGraw, Lavigne, Brasch, & Le Grange, 2019; Tantillo, Sanftner, & Hauenstein, 2013). AN works against these efforts, hoping to isolate young adult patients and leave them feeling deficient and disconnected from themselves and others.

Without a community surrounding us, we lack the growth-fostering connections that help us more fully become who we really are. R4R provides this community, allowing young adults and their families to name their fears and disconnections and focus on the abundance of gifts and strengths they have to navigate recovery. In making patient and family gifts and sorrows explicit, R4R makes them available for sharing (McKnight & Block, 2012). This sharing feeds back into our relationships with one another, further strengthening connectedness with oneself and others and increasing young adults' resolve to reclaim their health and their lives. When patients with AN are able to be in their bodies and in the world more comfortably, they become more active participants in their communities. Without the overwhelming preoccupation with food and their bodies, which serves to disconnect them from themselves and others, they are able to achieve developmental milestones and contribute their unique skills and abilities to the world around them. They are empowered to find their purpose, live out their passions, and make a difference in our world that AN tries to thwart. We end this treatment manual with a reminder from McKnight and Block (2012) about the importance of connections in recovery and life:

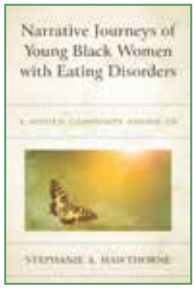
> "All of these people have gifts we need for a really strong community. And many of them desperately need to be asked to join and contribute. Their only real deficiency is the lack of connection to the rest of us.… We have often ignored or even feared them. And yet their gifts are our greatest undiscovered treasure!".… Therefore … [we] need to pay special attention to the people at the edge, the people with the names that describe their empty half rather than their gifted full half.… For the strength of our [community] is greatest when we all give all our gifts. (McKnight & Block, 2012, p. 138). ◆

Excerpted with permission from *Multifamily Therapy Group for Young Adults with Anorexia Nervosa: Reconnecting for Recovery,* Routledge/Taylor & Francis, Mary Tantillo, Jennifer L. Sanftner McGraw & Daniel Le Grange, 304 pages, hardcover/paper/e-book, 2020.

resources



Famished: Eating Disorders and Failed Care in America
Rebecca J. Lester, 2019



Narrative Journeys of Young Black Women with Eating Disorders: A Hidden Community Among Us
Stephanie A. Hawthorne, 2019

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**

Eating Disorders and Substance Abuse Disorders: Is There a Genetic Overlap?

BY JESSICA BAKER, PHD

Individuals with an eating disorder are at higher risk for an alcohol or substance use disorder compared with people who do not have an eating disorder. For example, in a previous study examining how frequently a variety of substance use disorders occurred in females with an eating disorder, we found that 24 percent and 18 percent of women with bulimia nervosa had a history of an alcohol use disorder and an illicit drug use disorder, respectively.

In addition, 22 percent of women with anorexia nervosa had a history of an alcohol use disorder, and 17 percent had a history of an illicit drug use disorder. For comparison's sake, only 14 percent of females in the sample had an alcohol use disorder and 8 percent had an illicit drug use disorder. Thus, women with an eating disorder were significantly more likely to have a history of a substance use disorder. Interestingly, this increased risk is observed in both directions. People with alcohol or substance use disorders are also more likely to have a history of an eating disorder compared with people without an alcohol or substance use disorder. This pattern of comorbidity (or having more than one disorder) is most commonly observed in binge-eating-type eating disorders, such as bulimia nervosa or binge eating disorder; however, individuals with anorexia nervosa are also more likely to experience a substance use disorder compared with individuals without anorexia nervosa. But when we compare the prevalence of substance use disorders among the eating disorders, substance use disorders are generally observed at a higher rate among bulimia nervosa and binge eating disorder compared with anorexia nervosa.

Over the past five decades or so, research has established that people with an eating disorder are at increased risk for an alcohol or substance use disorder (and vice versa). What we still know very little about is *why* this increased risk exists. A review paper on this topic, published almost 20 years ago, described three possible explanations for why this comorbidity between eating disorders and alcohol and substance use disorders occurs:

1. "Addictive" personality: An addictive personality style may predispose individuals to both eating disorders and substance use disorders—certain personality traits may make certain individuals vulnerable to addictive-like behaviors (e.g., alcohol, drugs, eating, gambling).
2. Shared family risk: There is a family component that predisposes risk for both eating disorders and substance use disorders. For example, an individual with a family history of an alcohol use disorder may have heightened risk for an alcohol use disorder and/or an eating disorder.
3. Shared societal factors/pressures: Certain individuals, girls specifically, may be more vulnerable to external societal or cultural pressures, such as social pressures toward thinness and experimenting with alcohol or drugs.

For this article, we will dive into #2 more in-depth—is there a family component that predisposes risk for both eating disorders and alcohol and substance use disorders? Such a shared family component could be genetic and/or environmental in nature. Genetic would refer to the genes passed down to you from your biological parents. Family environment would refer to the environment/home you grew up in, regardless of whether you grew up with your biological parents. In perhaps more familiar terms, this could be referred to as nature and nurture.

To date, research examining such a shared family risk has been completed using a twin study research design. And this research provides convincing evidence that a shared family component exists between eating disorders and alcohol and substance use disorders. Twin study designs capitalize on the natural fact that identical twins share, on average, 100 percent of their DNA and fraternal twins share, on average, 50 percent of their DNA. Therefore, in basic terms, the traits that identical twins are twice as likely to *both exhibit* (i.e., concordance) compared with fraternal twins are said to have a genetic component. Twin studies also allow us to calculate a genetic correlation, which represents the correlation between the genetic factors that influence risk for one trait and the genetic factors that influence risk for a second trait. In other words, this can help answer the question of whether there is shared genetic overlap between two traits (and how much).

We have completed a number of twin studies examining the genetic association between various eating-disorder-related traits and various aspects of alcohol and substance use and misuse. A majority of this work to date has focused on bulimia nervosa and related symptoms (e.g., binge eating), and the data are clear: **A genetic overlap exists between eating disorders and alcohol and substance use disorders.** For example, we have observed a genetic correlation of 0.53 between bulimia nervosa and an alcohol use disorder and of 0.39 between bulimia nervosa and an illicit drug use disorder. The take-home message of these genetic correlations is similar to that of other types of statistical correlations—the strength of the association between two traits.

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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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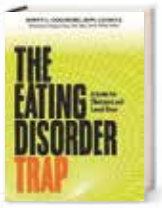
Book Excerpt



The Eating Disorder Trap: *A Guide for Clinicians and Loved Ones*

In this excerpt from *The Eating Disorder Trap,* **Robyn L. Goldberg, RDN, CEDRD-S,** describes how malnutrition affects the heart.

Healing the Broken Heart

We all know that the heart is the life source of our body. It is a muscle that works 24/7, every second of a person's life. Just as with any machine, its parts wear down with time and use. However, this wear and tear is significantly expedited when illness or malnutrition comes into play.

Bradycardia (slowing down of the heart rate) is one of the first adjustments the heart will make when faced with malnutrition. To get a picture of how much energy it takes for the heart to beat, imagine yourself squeezing a ball strongly and rapidly every second of every day for an undetermined amount of days. That's a lot of energy!

The brain is aware of this, and in times of deficit, will send a signal via the vagus nerve (one of the cranial nerves that influences the heart, lungs, and digestive system) to slow down these organs. The heart can slow down from a normal range of 60 to 100 beats per minute to as low as 20 beats per minute. As a point of reference, a well-trained "healthy" athlete's heart can beat as low as 50 beats per minute. However, this slow of a heart rate isn't always a sign of fitness and may indicate there is more to the story. The result of a slowed heart rate is that not enough oxygen reaches organs, leading to some of the following symptoms: fainting, dizziness, fatigue, chest pain, confusion, and exhaustion.

Malnutrition can also result in the muscle of the heart shrinking, and its inside chamber size decreasing. When the heart beats slower, less blood is pumped per beat, so it has to work harder to get the same work done. Hence, the heart becomes strained, stuck between needing to simultaneously slow down and speed up.

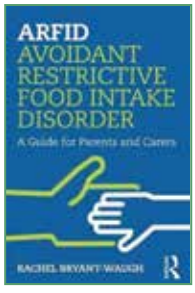
If that were not enough to weaken the heart, malnutrition from eating disorders affects the electrical activity of the heart. The electrical activity of the heart conducts its muscle contraction. This dysregulation results in dysrhythmias (abnormal heartbeat) that can become severe enough to cause death. An ECC/EKG can detect this and should be part of the cardiac workup of a person with malnutrition. These rhythm changes can make one feel like their heart is racing and beating stronger (called palpitations), or can occur without symptoms, be sudden, and be fatal.

The heart pumps blood throughout the body, hence a weak and strained heart impacts blood pressure. As the body is trying to save energy, blood is pumped primarily to vital organs. As a result, people will often report that their extremities (fingers, toes, hands, and feet) are cold. Eventually, the whole body becomes cold.

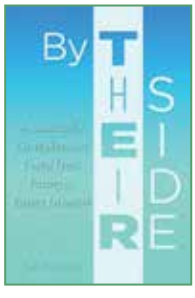
This can be demonstrated by a capillary refill delay. You can test this by squeezing your hand into a fist for a few seconds, opening it, and seeing how fast pink color returns to the hand. If it takes more than two seconds or so, it can be an indication of this delay. ◆

Reprinted with permission from Robyn L. Goldberg, *The Eating Disorder Trap: A Guide for Clinicians and Loved Ones,* 180 pages, paper/e-book, 2020.

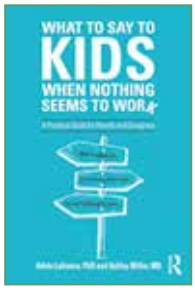
families, loved ones, and carers



ARFID Avoidant Restrictive Food Intake Disorder: A Guide for Parents and Carers
Rachel Bryant-Waugh, 2019



By Their Side: A Resource for Caretakers and Loved Ones Facing an Eating Disorder
Lara Lyn Bell, 2019



What to Say to Kids When Nothing Seems to Work: A Practical Guide for Parents and Caregivers
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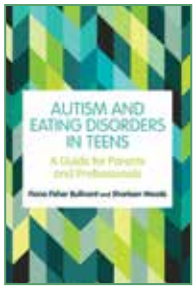

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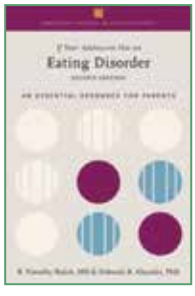

If Your Adolescent Has an Eating Disorder, Second Edition: An Essential Resource for Parents
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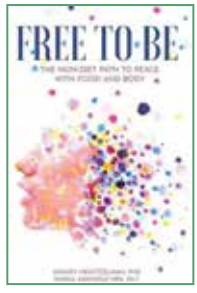
healthy behaviors



Free to Be: The Non-Diet Path to Peace with Food and Body
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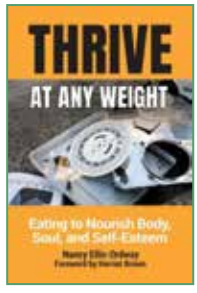

Thrive at Any Weight: Eating to Nourish Body, Soul, and Self-Esteem
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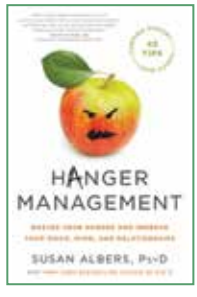

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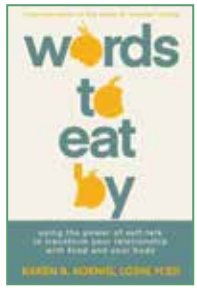
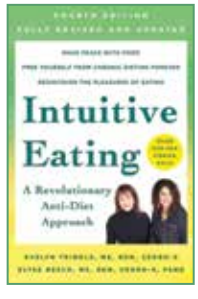


Words to Eat By: Using the Power of Self-Talk to Transform Your Relationship with Food and Your Body
Karen R. Koenig, 2021



Intuitive Eating, Fourth Edition: A Revolutionary Anti-Diet Approach
Evelyn Tribole & Elyse Resch, 2020

Progression of Anorexia Nervosa: Longitudinal Staging Framework

BY JOANNA STEINGLASS, MD & ENZO FANTIN-YUSTA, BS

Anorexia nervosa (AN) is a complex and devastating illness. The lifetime prevalence of AN in women is estimated at about 1 percent. The crude mortality rate is among the highest of any psychiatric illness, estimated at 5 percent per decade of illness, and approximately six times that expected among young women, with death most commonly resulting from medical complications of starvation, or from suicide.

In addition to mortality costs, AN carries a high global burden of disease owing to disability, the need for medical and psychiatric hospitalizations, high relapse rates, and, often, the need for chronic treatment. Important advances in research have led to increased understanding of some biological and neural mechanisms of illness. And yet, treatment outcomes unfortunately have not improved significantly in recent decades. As interest in personalized medicine increases, the eating disorders field has shown renewed interest in improving understanding of the course of illness in AN.

Acute treatment of AN focuses on renourishment (weight restoration) and often includes inpatient, residential, or day treatment programs (or, for adolescents, family-based therapy). Adolescents commonly have a better prognosis in terms of recovery than adults do, and if it persists, the illness can be difficult to treat. Ongoing outpatient treatment is recommended after weight restoration. Medications have not generally been found to be helpful, though a recent large randomized, controlled trial indicated that olanzapine can help with weight gain among outpatients with AN. Presentation of illness ranges from mild to severe, and course of illness ranges from short-term to chronic.

An illness staging framework may help advance both clinical care and scientific understanding of AN. Staging models aim to characterize illness, with the intent to refine treatment recommendations to fit the stage of illness. The prototypical example of staging models in medicine comes from cancer, where staging is useful in guiding treatment. Some models define discrete stages based on symptom severity, while other models define stages based on an assumption of longitudinal progression. In psychiatric illness, longitudinal progression may mean that the brain changes over time. These changes, in turn, can affect symptom severity. In AN, neuroprogression may relate

to (or result from) the effects of starvation.

A longitudinal staging framework for AN has been proposed by Treasure and colleagues (2015). This framework considers both risk factors and neurobiological progression of illness. Recently, our group convened a panel of experts and, through an online, iterative process, achieved consensus about the value of using a longitudinal framework (largely overlapping with the Treasure et al. model). The panel agreed that a longitudinal model of AN would usefully include a subsyndromal phase that can progress to AN, which can either remit or become persistent—and that after remission, relapse can occur. Here, we describe these stages and discuss the potential clinical and research utility. Empirical data are needed to substantiate the reliability and validity of these phases.

Subsyndromal AN

An eating disorder is characterized, in large part, by maladaptive eating behavior. These symptoms may begin with disordered eating or distorted cognitions, or a combination. Restrictive eating is defined as caloric intake that is less than an individual's energy requirements and is a common behavior (e.g., dieting). Yet weight loss, which is a defining component of AN, can occur only if restrictive eating behavior is recurrent. As such, for many individuals, there may be a phase of subsyndromal cognitions and behaviors that precedes the underweight, acute illness—by which time restrictive eating has become maladaptive.

In the proposed framework, subsyndromal AN is defined by the presence of restrictive eating, though the individual is not significantly underweight. Descriptively, restrictive eating can include limits on amount or type of food. Excessive or compensatory exercise may also occur, though energy balance is sufficient to maintain weight. Cognitive symptoms in subsyndromal AN (as in AN) can include a disturbance in the perception and experience of one's body, a desire to lose weight despite being of normal or low weight, intense fears of weight gain, and obsessions with thinness and/or dieting.

Identifying subsyndromal AN may be challenging. If binge eating, purging, or laxative use is present, it may be difficult to distinguish subsyndromal AN from a subsyndromal phase of a different eating disorder. In addition, it may be difficult to distinguish subsyndromal pathological cognitions from those of a normal dieter. Yet many patients with AN are able to describe a subsyndromal phase of their illness, in which they experienced maladaptive cognitions and behaviors prior to meeting criteria for AN. Epidemiological studies indicate high rates of eating disorders that have not required treatment, suggesting that for some individuals, subsyndromal AN may resolve without progressing to full AN. It is tempting to consider that identification of subsyndromal AN, and delivery of targeted interventions, might serve to prevent the onset of severe illness.

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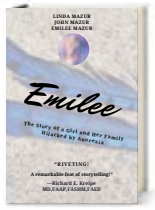
Book Excerpt



Emilee:
The Story of a Girl and Her Family Hijacked by Anorexia

In this excerpt from *Emilee*, Linda, John, and Emilee Mazur describe how all-encompassing eating disorders can be for a family unit.

Unbelievable

During this time, Jack and I live in a state of constant crisis. Our phone often rings in the middle of the night, and we wake to hear Emilee's barely audible voice: "I need help," she says. I love my daughter and want to help her in any way that I can, but my efforts aren't appreciated, and they aren't making a difference. The numerous emergencies and hospitalizations have wreaked havoc with my work schedule, and I find myself having to change appointments much more often than feels professional. When I'm at work, I'm exhausted, physically there, yet mentally, I'm perpetually distracted. I know Jack feels the same way, and his work has been negatively impacted as well.

Though we don't realize it at the time, Jack and I are using all of our energy, navigating through the daily craziness and putting one foot in front of the other. We have no time, energy, or desire to do anything extracurricular. Emilee is all we think about. No one we know can comprehend what we're living, and regular conversations with people suddenly feel like small talk to us.

I can't blame people for not understanding. After all, even the medical community has limited knowledge about eating disorders. And there are so many myths: Many believe eating disorders are a choice, that parents are to blame, that only rich white girls have eating disorders. But an eating disorder is never a choice. No one would torture themselves on purpose. The truth is, you can't always tell when someone has an eating disorder. Families can provide support and be the best allies in the treatment and recovery of someone with an eating disorder, but it's extremely hard on everyone. The disease affects people of all genders, ages, races, ethnicities, and all socio-economic classes.

Meanwhile, alcohol is making everything worse. I still believe Emilee wants to get better and live the life she's dreamed of, but over time, the controlling eating disorder and the numbing alcohol become her two best friends. And everyone else, the enemy.

At her next hospitalization, Emilee winds up in the Intensive Care Unit. Her potassium level is so low, doctors are afraid she will have a heart attack. Over time, her brain, heart, kidneys, and digestive tract become increasingly compromised. It's amazing to all of us how resilient her body is with the abuse she's putting it through. As Emilee's condition continues to deteriorate, we beg the doctors, psychiatrists, and social workers for help.

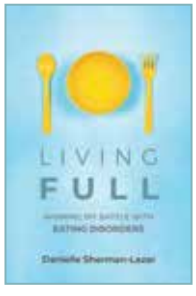
"She has to reach her rock bottom and beg for help," one social worker says.

But my fear is that Emilee won't survive her rock bottom. ◆

Excerpted with permission from Linda Mazur, John Mazur & Emilee Mazur, *Emilee: The Story of a Girl and Her Family Hijacked by Anorexia*, independently published, 294 pages, paper/e-book, 2019.

personal stories

Empty: A Memoir
Susan Burton, 2020

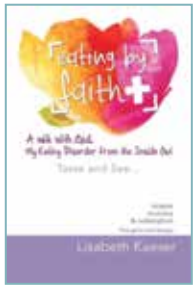


Living FULL: Winning My Battle with Eating Disorders
Danielle Sherman-Lazar, 2019

anorexia

Negotiating Thinness Online: The Cultural Politics of Pro-Anorexia
Gemma Cobb, 2020

spirituality



Eating by Faith: A Walk with God. My Eating Disorder from the Inside Out
Lisabeth Kaeser, 2016

Restored: A Biblical Healing Journey from Your Eating Disorder to Freedom
Angelica Gonzalez & Christina Sendiña Garbati, 2019

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.

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

Psychedelics and Eating Disorders

BY ADELE LAFRANCE, PHD & REID ROBISON, MD

Clinicians working with eating disorders are well aware that these conditions can be the most difficult to treat. The stakes are high, as millions of individuals are affected, they have a significant impact on quality of life, and they can be lethal in some cases. While there are a variety of promising treatment options, despite everyone's best efforts—clinicians, clients, and families alike—too many individuals continue to suffer, even after several courses of treatment. Pharmacotherapy options for eating disorders are also lacking—anorexia nervosa has no Food and Drug Administration–approved medications, and bulimia nervosa and binge eating disorder each have only one recognized option (fluoxetine and lisdexamfetamine, respectively). In severe and enduring cases of eating disorders, palliative care approaches are even considered. There exists an urgency to continue to develop treatment modalities to help address these unmet needs.

There has been a remarkable resurgence of research in the past two decades that supports the therapeutic use of psychedelic medicines in the treatment of emotion-based disorders, including post-traumatic stress disorder (PTSD), major depressive disorder, and addictions, to name a few. Psychedelic-assisted psychotherapy is emerging as a promising new treatment paradigm, in which the use of psychedelics, paired with psychotherapy, has the potential to yield significant breakthroughs for individuals with difficult-to-treat mental health conditions, including eating disorders. A number of psychedelic clinical research studies for eating disorders are in preparation or have begun, including emotion-focused ketamine-assisted psychotherapy (EF-KAP) for anorexia nervosa (Cedar Psychiatry by Novamind), psilocybin-assisted psychotherapy for anorexia nervosa (Johns Hopkins University; Imperial College London; University of California, San Diego), and MDMA-assisted psychotherapy for anorexia nervosa and for binge eating disorder (Multidisciplinary Association for Psychedelic Studies).

How Might Psychedelics Help with Eating Disorders?

Though theoretical mechanisms of action of psychedelic medicines are still being investigated, a growing body of research points toward the following ways psychedelics might help individuals with eating disorders in particular: 1) the potential to alleviate symptoms that relate to serotonergic signaling and cognitive inflexibility, and 2) the induction of desirable brain states that might accelerate therapeutic processes.

Classic psychedelics—like psilocybin, LSD, and ayahuasca—are thought to interrupt what is

called the default mode network (DMN), which is often considered the neurobiological seat of the "ego" in the brain. The DMN is a collection of pathways that govern our self-image, our autobiographical memories, and our deeply ingrained beliefs and thought patterns. While results from brain imaging studies in eating disorders are diverse, findings seem to converge on a common theme of overactivity in the DMN, showing up in our clients as rumination over caloric intake and food rules, compulsive exercise or eating behavior patterns, body checking, etc. And, like a ski slope, the mind develops and strengthens pathways as we repeat patterns. Every time the thoughts and actions are engaged, the grooves get deeper and deeper, and before long, no matter where we start, we're likely to slip into the same ruts and end up following the same path down the mountain. When a psychedelic medicine is ingested, the DMN is downregulated, and it's like the mind benefits from a fresh coat of powder. This fresh coat of powder provides a blank slate—offering a welcome break from the eating disorder patterns, allowing for increased connectivity between other neuronal networks, and creating the potential to move beyond self-imposed limitations that can be so debilitating in those affected. In other words, the individual has the opportunity to travel down a new set of tracks, allowing them to consciously chart a course that isn't governed entirely by eating disorder thoughts and urges.

The second theorized mechanism in support of psychedelics as a treatment tool for eating disorders involves the way in which psychedelics can help foster desirable brain states that might accelerate therapeutic processes. Specifically, the increased neuroplasticity observed with classic psychedelics and ketamine can also be leveraged in the context of psychotherapy. For example, when we use ketamine as a treatment for eating disorders, we schedule psychotherapy sessions within the 24- to 48-hour window of potential for neurogenesis to optimize outcomes. Also facilitative in the therapy setting, MDMA, while not a classic psychedelic, is unique among consciousness-altering substances in its ability to promote acceptance of and empathy for self and others. In addition to elevating oxytocin levels, MDMA stimulates the release of the monoamines serotonin, norepinephrine, and dopamine, resulting in an improved mood and increased sociability. Brain imaging after being administered MDMA shows decreased amygdala activation, and the reduced fear response that follows allows the client to emotionally engage in therapy without becoming overwhelmed by anxiety or negative

PHOTO: PIXABAY

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*

affective states. As of September 2020, the Multidisciplinary Association for Psychedelic Studies is conducting phase 3 trials of MDMA-assisted psychotherapy for treatment-resistant PTSD, under the FDA's breakthrough therapy designation, and the results are quite striking. An analysis of phase 2 data showed that at 12-month follow-up, 67 percent of participants no longer met criteria for PTSD.

"I'm tempted to say MDMA gave me 'hope,' but that word isn't right—the insight was more substantive than hope. I'd held the sensation in my body; I understood, at a visceral level, what might someday be mine: the sense of peace and joy within my body. For me, the therapeutic process could unfurl from there."
—MDMA participant

We've also been analyzing data gathered from interviews of individuals with eating disorders who participated in ceremonial ayahuasca use. When asked to describe the positive effects of this traditional Amazonian tea, similar themes emerged in that individuals shared that participation led to an ability to face and work through challenging emotions and memories. They also reported decreases in symptoms of anxiety and depression, including urges to self-harm and suicidal ideation.

"I still experience periods of feeling anxiety, but I feel like they don't last as long, whereas before, I would spiral downward and get depressed and then start to restrict and start to purge and binge and all of that. I feel like I can notice when my energy is changing, and then I am more able to be with it and sort of resist it, and then it moves after."
—Ayahuasca participant

Several respondents also shared that they benefited from increased capacities for mindfulness, improved body image, and strengthened relationships with important others, including a new or deeper connection with nature and/or God or Spirit. Participants even described an "embodied knowing" of self-love, where they were able to recognize from a deeper place that: "I am worthy. I am beautiful as I am inside and out"—a powerful antidote to the harsh inner critic so common in eating disorders.

"I seem to think about myself and talk about myself a lot more kindly than I previously did. And I'm a lot gentler [to myself]."
—Ayahuasca participant

Family-Based Psychedelic Medicine for Eating Disorders

One of the unique facets of treatment in the field of eating disorders is the recognition of the importance of caregiver involvement. Thanks to several different lines of research, and the tireless efforts of parent advocacy groups, contemporary approaches to eating disorder treatment have evolved to include families as active supports in the recovery process. Recent research outcomes have confirmed the benefits of carer involvement, including improved outcomes for both the sufferer and their family members, and it is our goal to continue this important work in the context of psychedelic psychotherapies for eating disorders.

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

Book Excerpt

Unpack Your Eating Disorder: *The Journey to Recovery for Adolescents in Treatment for Anorexia Nervosa and Atypical Anorexia Nervosa*

In this excerpt from *Unpack Your Eating Disorder,* Maria Ganci and Dr. Linsey Atkins explain why parents and caregivers are vital to recovery.

Why You Need Your Parents

Regardless of the treatment you choose, your parents are a vital part of your treatment. You will not be able to recover on your own—the anorexic voice is just too strong for you to manage without their support.

There will be times when the anorexia will tell you that your parents don't understand you and that they are your enemies who are trying to make you fat. Anorexia may also tell you that it alone has your best interests at heart and that everyone else, including your therapist, is trying to make you fat. Anorexia will also tell you not to listen to anyone, that nobody can be trusted, and that the people around you are taking away everything you have worked so hard for. These anorexic thoughts will probably make you feel angry and not trust what others say, especially your parents.

Your parents, on the other hand, will say that they are just trying to get you back on track and are only helping you to eat so you can recover. Who do you listen to; who will you trust? These conflicting messages can leave you confused and perhaps feeling a little guilty. Such feelings and confusion are normal. If you listen to anorexia, your parents won't and can't back off because they love you and want you to get better. If you listen to your parents, anorexia will give you a really hard time telling you how weak and pathetic you are. And so, the battle begins. Anorexia tells you that if they really loved you, they would not do this to you, as it is hurting you. Your parents' pain at seeing you so distressed is just as devastating as your pain in completing your meal. Their job is to get you through this horrible illness, and they won't stop until they see their once happy and carefree child back. You are caught up between anorexia and your parents, which is a horrible place to be. At this time, we encourage you to remember that this confusion is normal, and it will get better as you get stronger during treatment.

Your parents will not oversee renourishing you forever, but only in the initial stages of treatment until you get back on track. Adolescence is a time when healthy independence is encouraged, not controlled, but healthy independence is not about starving yourself. It's about understanding what your body needs to function effectively. If you do not take care of yourself across all areas of your life, your parents will always be concerned and want to help you. So, it is not just about food. It is their job to support you until you become independent. **Remember, parents are your safety net until adulthood.** They want to be there with you and support you. They want you to reach your full potential and can see that anorexia is limiting that potential. They know you better than anyone else, so let them help you. If there are any aspects of their support that you find difficult, let them know or let your therapist know so things can be tweaked to make their support more bearable. They also want to make recovery as easy as possible for you. ◆

Reprinted with permission from *Unpack Your Eating Disorder: The Journey to Recovery for Adolescents in Treatment for Anorexia Nervosa and Atypical Anorexia Nervosa,* LM Publishing, Maria Ganci & Dr. Linsey Atkins, 180 pages, paper/e-book, 2019.

Floating Toward Recovery

BY REBECCA BRUMM, LPC, CEDS-S

Floatation-REST (Reduced Environmental Stimulation Therapy) is a novel, non-pharmacological intervention that is being investigated for those suffering with mental health disorders. Within the eating disorder treatment community, floating offers a unique opportunity for patients to experience greater attunement with their bodies, to habituate to programmed distressing triggers within the body, and to experience a serenity that can serve as a template for them as they learn to live with anxious temperaments. Recent eating-disorder-specific research supports Floatation-REST not only as a safe intervention, but also as one that might have a surprisingly positive effect on body image. By understanding the value of Floatation-REST as a supplement to mental health treatment, practitioners can offer it as a tool that may provide an opportunity to dig further into interventions while serving as a unique and powerful instrument to enhance well-being.

Floatation-REST dates back to the 1950s, when doctors Jay Shurley and John Lilly at the National Institute of Mental Health became interested in understanding how the brain would respond to environments completely devoid of external sensory input (Feinstein et. al, 2018). Since that time, floating has experienced periods of dormancy. Before the 2010s, research investigating Floatation-REST was sporadic, occurring widely in the 1980s and 1990s, and mostly on healthy individuals. These studies affirmed its role in the reduction of stress levels, heart rate, and blood pressure. In the past decade, research has started to explore floating as a tool for helping those suffering from mental health conditions. Initial findings offered hope, and further research was spurred. In 2015, the Laureate Institute for Brain Research (LIBR) established the first lab dedicated to researching Floatation-REST.

The Float Clinic and Research Center at LIBR was the first of its kind, with a laboratory containing floatation tanks next to a functional magnetic resonance imaging (fMRI) facility, allowing researchers to have a firsthand view of the neurological effects of floating. The initial studies from the institute have demonstrated the effects of float therapy on lowered anxiety, muscle tension, and stress-related pain in clinically anxious individuals. Ongoing research has demonstrated impressive results showing that the lack of sensory stimulation found in a float tank can "shut down" sensory cortices, leading to decreased anxiety and elevated interoception. In addition, the degree to which these effects persist over longer durations of up to six months are being investigated.

LIBR is also uniquely positioned to study eating disorder populations. The institute resides on the first two floors of the LIBR building, and the nationally renowned Laureate Eating Disorders Program operates on the third and fourth floors. This symbiotic partnership has facilitated important neurobiological findings relevant to individuals struggling with eating disorders, as well as to those who love, support, and treat these individuals.

THE INITIAL STUDIES FROM THE INSTITUTE HAVE DEMONSTRATED THE EFFECTS OF FLOAT THERAPY ON LOWERED ANXIETY, MUSCLE TENSION, AND STRESS-RELATED PAIN IN CLINICALLY ANXIOUS INDIVIDUALS.

Regarding Floatation-REST and eating disorders, a recent clinical trial found that floating was safe and well tolerated by weight-restored outpatients with a history of anorexia nervosa. Research on these subjects showed no evidence of orthostatic blood pressure changes or dizziness following the float. Evidence also demonstrated that participants experienced reduced anxiety, enhanced interoception, and improved mood.

In addition, body image distortion did not worsen; in fact, researchers found preliminary signs of reduced body dissatisfaction via improvements in the visual perception of participants' body size. Utilizing the Photographic Figure Rating Scale pre- and post-float, researchers noted that floating acutely improved body dissatisfaction scores. These findings have prompted further research, including an ongoing randomized clinical trial looking into whether Floatation-REST can assist individuals at earlier stages of the recovery process, particularly with the challenging aspects, such as body image distortion.

Anecdotal accounts from those in recovery from eating disorders also support positive reports of this intervention. Author Emily Noren shares how floating served an integral role in her recovery from an eating disorder in her book, *Unsinkable: My Story of Discovering Float Tanks and Reaching Full Recovery from Anorexia and Bulimia.* Shane Stott also recounts in his book, *The Float Tank Cure,* how his floating experience was unmatched in aiding his recovery from crippling anxiety. Because anxiety so often precedes eating disorders, interventions aimed at these symptoms also support eating disorder recovery.

Practitioners looking to better understand this treatment should focus on several key factors. First, clinicians will want to understand the experience inside the tank and how to prepare their patients for it. It is important to equip patients with knowledge of what options they have to help them ease into the experience and to make it as comfortable as possible. Clinicians should also understand barriers for use of this intervention. In addition, therapists will want to identify skills with patients pre-float that will assist them in riding out the initial increase in anxiety that sometimes happens upon entering the tank. Finally, clinicians will want to prepare patients to thoughtfully pair talk therapies with floatation for gains in insight and self-reflection.

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PHOTO: UNSPLASH

Book Excerpt

Embodiment and the Treatment of Eating Disorders: *The Body as a Resource in Recovery*

In this excerpt from *Embodiment and the Treatment of Eating Disorders*, Catherine Cook-Cottone, PhD, explains the purpose and meaning behind embodiment.

Embodied Meaning

Purpose and Mission

> *Tell me, what is it you plan to do*
> *with your one wild and precious life?*
> —Mary Oliver, "The Summer Day"

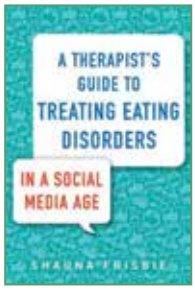
What is your embodied *why*? The answer can be a sense of mission that you have known since you were little, or it can be something that you contemplate for years. It can be one thing, or many. It integrates the heart, the belly, and the soles of our feet. Living and embodying our why is all about orienting our mind toward considering that there is reason for doing what we do, thinking what we think, and creating what we create. It is bigger than we are, bigger than this moment, and most certainly bigger than any ED symptom. I have found, through my own experience and through working with clients with EDs, that figuring out the value, meaning, and purpose of life after recovery can make a substantial difference in treatment outcomes.

Part of the ED psychopathology is giving meaning to things that don't really mean that much in the big picture (e.g., calories, carbohydrates, inches, pounds). It leads to a self-perpetuating, insidious migration or displacement of meaning that becomes increasingly validated the more entrenched the disorder becomes. Suddenly everyone is talking about calories and macronutrients like it is life or death—because for some patients, it is. Viktor Frankl (1978) describes it this way:

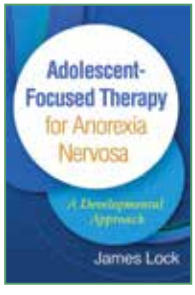
> It turned out that, if a neurosis was removed, more often than not when it was removed a vacuum was left. The patient was beautifully adjusted and functioning, but the meaning was missing. The patient had not been taken as a human being, that is to say, a being in steady search for meaning; and this search for meaning, which is so distinctive of [humans], had not been taken seriously. (p. 20)

Getting to the *Why*: Mission and Reason for Being

Cultivating a mission and purpose is one of the four pillars of the embodiment approach to the treatment of EDs (EAT-ED), along with mindful self-care, being-with and working-with skills, and honoring effort and struggle. It involves clients both looking more deeply into their reason for being and developing a personal mission statement—they can do both or either. Some clients prefer to explore a broad sense of meaning in their lives (e.g., love and connection), whereas others prefer a more linear approach, such as developing a mission statement and a set of goals and plans to achieve them. Offer both as possibilities, and consider that, at any given stage of recovery, one or the other might be a better fit. When working on existential being from an embodied perspective, allow agency and self-determination to be primary drivers. In this way, questions of meaning, value, and purpose are based on what clients want their life to be about (Hayes, 2006; Manlick, Cochran, & Koon, 2013; Sandoz, Wilson, & Dufrene, 2010; Scritchfield, 2016). ◆

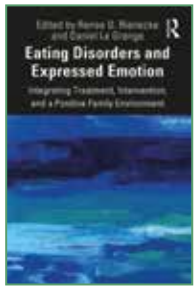


A Therapist's Guide to Treating Eating Disorders in a Social Media Age
Shauna Frisbie, 2020



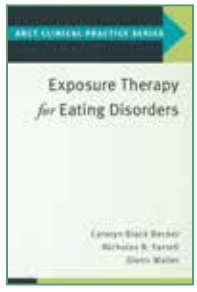
Adolescent-Focused Therapy for Anorexia Nervosa: A Developmental Approach
James Lock, 2020

Binge Eating: A Transdiagnostic Psychopathology
Guido K.W. Frank & Laura A. Berner, editors, 2020



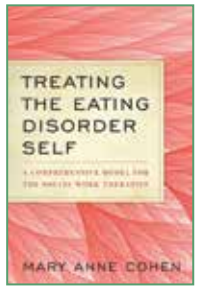
Eating Disorders and Expressed Emotion: Integrating Treatment, Intervention, and a Positive Family Environment
Renee D. Rienecke & Daniel Le Grange, editors, 2020

Compulsive Eating Behavior and Food Addiction: Emerging Pathological Constructs
Pietro Cottone, Valentina Sabino, Catherine F. Moore & George F. Koob, editors, 2019



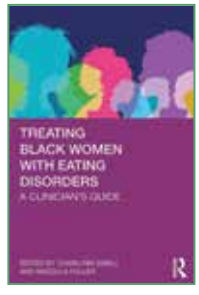
Exposure Therapy for Eating Disorders
Carolyn Black Becker, Nicholas R. Farrell & Glenn Waller, 2019

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

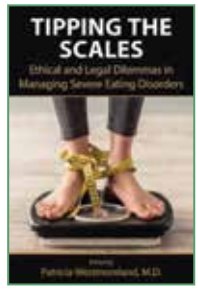


Treating the Eating Disorder Self: A Comprehensive Model for the Social Work Therapist
Mary Anne Cohen, 2020

Emotion-Focused Family Therapy: A Transdiagnostic Model for Caregiver-Focused Interventions
Adele Lafrance, Katherine A. Henderson & Shari Mayman, 2019

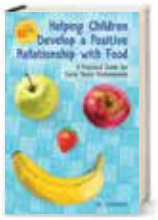


Treating Black Women with Eating Disorders: A Clinician's Guide
Charlynn Small & Mazella Fuller, editors, 2020



Tipping the Scales: Ethical and Legal Dilemmas in Managing Severe Eating Disorders
Patricia Westmoreland, editor, 2020

Book Excerpt



Helping Children Develop a Positive Relationship with Food: *A Practical Guide for Early Years Professionals*

In this excerpt from *Helping Children Develop a Positive Relationship with Food*, Jo Cormack discusses the importance of how we talk about food.

How We Talk About Food

Language matters. The words we use—especially the words we use in the presence of children—describe and even create the world we inhabit. Many ways of talking about food are culturally normal, and we are not in the habit of questioning (or noticing) them. For example, we might say we "deserve" a cake or "can't have" a biscuit. We might describe food as "good" or "naughty." Children pick up on these subtle cues as they develop their own relationship with food.

In this chapter, we'll be looking at how what we say about food can influence children. We'll consider the moral messages we accidently convey; messages caught up with body image and messages that split food into "good food" and "bad food." We'll also think about messages involving our own food preferences. Throughout the chapter, we'll explore psychologically healthy ways of talking about food in front of children. This chapter does not explore how to talk to children about food in relation to teaching about nutrition. That will be covered in Section 6.

Moral Messages

Someone offers you a biscuit. Even if you are planning to take one, you might still say, "I shouldn't." Let's examine this response. By saying, "I shouldn't," you are implying that it is wrong to take the biscuit. By taking it anyway, you imply that it is so tempting, you can't resist.

Thinking back to the concept of self-regulation, we know that a positive relationship with food is one where a child (or adult) eats in response to their body's signals. If an adult uses language that implies guilt ("naughty but nice") or demonstrates eating decisions that contradict their initial intentions ("oh…go on, then!"), they are not demonstrating self-regulation. More than that, they are modeling guilt in relation to eating and framing that food as something both bad and desirable. The biscuit becomes laden with moral and emotional meaning.

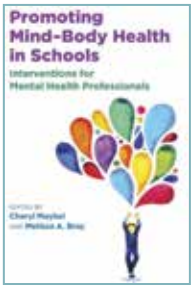
If you are offered a biscuit and say, "Yes, please," all a watching child will learn is that you wanted a biscuit. If you say, "No, thank you," they will learn that you didn't want a biscuit. Either of these is fine—whether or not you accept the biscuit is immaterial. But as soon as words like "shouldn't" or "naughty" are used, children will begin to absorb a sense that sweet, calorific foods have a specific status and are mixed up with complex feelings about the self.

Body Image

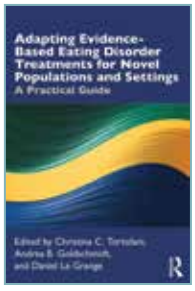
These days, body image is a hot topic, and recent research from the Professional Association for Childcare and Early Years (PACEY) found that children as young as 3 are not happy with their bodies. Nearly a quarter of early years practitioners surveyed had seen signs of body dissatisfaction in 3- to 5-year-olds in their care.

Body image is complex. Children's views of what constitutes an ideal body (as well as their beliefs and feelings about their own bodies) will be heavily influenced by home and wider societal factors. ◆

Excerpted with permission from Jessica Kingsley Publishers, *Helping Children Develop a Positive Relationship with Food: A Practical Guide for Early Years Professionals,* by Jo Cormack, 208 pages, paper/e-book, 2017.

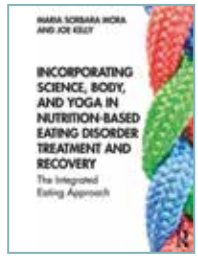


Promoting Mind–Body Health in Schools: Interventions for Mental Health Professionals
Cheryl Maykel & Melissa A. Bray, editors, 2019



Adapting Evidence-Based Eating Disorder Treatments for Novel Populations and Settings: A Practical Guide
Christina C. Tortolani, Andrea B. Goldschmidt & Daniel Le Grange, editors, 2020

Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, and Adults
Jennifer J. Thomas & Kamryn T. Eddy, 2019



Incorporating Science, Body, and Yoga into Nutrition-Based Eating Disorder Treatment and Recovery: The Integrated Eating Approach
Maria Sorbara Mora & Joe Kelly, 2019

Eating Pathology and Bariatric Surgery: Important Implications

BY CHRISTINE PEAT, PHD

In recent years, the term *bariatric* (weight loss) *surgery* has become commonplace. Many of us have family members, friends, neighbors, or coworkers who have undergone these types of procedures. There are even entire television programs dedicated to chronicling the lives of people who elect to have these surgeries. Thus, collectively, our society has become accustomed to learning about bariatric surgery and the impact it has on a person's physical health.

There has also been considerable discussion about the impact these types of surgeries have on one's mental health, including the role that eating disorders might play both before and after surgery. Extant literature indicates that eating pathology is not uncommon among bariatric candidates; however, there is less consensus about the impact these conditions might have on postsurgical outcomes. Clinicians and researchers should, however, be mindful of the potential for eating problems both before and after bariatric surgery. The latter is a particularly unique issue, as postsurgical life is changed dramatically with regard to physical anatomy, lifestyle, and behavioral recommendations. The following represents important (but not exhaustive) insights about eating pathology in the management and study of bariatric patients.

Presurgical Considerations

Binge eating is common among bariatric candidates, with up to 53 percent of individuals meeting threshold criteria for binge eating disorder (BED) and an even greater number reporting subthreshold symptoms. Given the association between weight-loss attempts and eating disorders, the prevalence of binge eating among bariatric candidates (who are required to have a history of dieting prior to undergoing surgery) is perhaps unsurprising. Research also suggests that the risk for BED increases with weight, which might also account for the association, given that many people seeking bariatric surgery are at their highest lifetime weight. Although less common, a history of anorexia nervosa (AN) and bulimia nervosa (BN) is reported among 0.5 percent and 3.5 percent of bariatric candidates, respectively. In addition, grazing and compulsive overeating/emotional eating are commonly reported among bariatric candidates; however, these conditions are studied less frequently, so prevalence estimates are less well-defined.

As reflected in the above, current evidence indicates that eating pathology prior to undergoing bariatric surgery is common. Thus, best practices recommend that bariatric candidates undergo a thorough mental health evaluation prior to undergoing surgery. During these evaluations, clinicians should be screening for the presence and/or history of eating pathology, and if there is any evidence of active eating disorder behaviors, clinicians are encouraged to refer patients to appropriate care. Although doing so is not a standardized component of mental health evaluations for weight-loss surgery, the savvy clinician might also discuss the extent to which weight stigma has affected each bariatric candidate. Ample evidence suggests that weight stigma itself can be an important factor that contributes to negative mental and physical health outcomes, including eating pathology. Bariatric candidates may be somewhat reluctant to

discuss the extent to which they have faced weight stigma, particularly given its prevalence in health care settings; however, a careful discussion about the impact of this stigmatization may help patients achieve a better understanding of how these factors may influence their health both before and after surgery.

Postsurgical Considerations

In contrast to the data on the impact of presurgical eating pathology, the literature is more conclusive about the negative prognostic indication of eating pathology after bariatric surgery. Postsurgical binge eating is frequently associated with adverse outcomes; however, there are inherent challenges in both diagnosing and treating binge eating after bariatric surgery. First, "binge eating" is a challenging construct to define in post-bariatric patients. While loss of control (considered a crucial component of binge eating) is certainly reported among these individuals, the extent to which they can consume "an unusually large amount of food" is still debated. Thus, no firm guidelines on the assessment and diagnosis of binge eating in post-bariatric patients have been established, and firm prevalence estimates remain elusive. Furthermore, the treatment of binge eating in post-bariatric patients requires modifications to a standardized approach (e.g., cognitive behavioral therapy), given the dietary restrictions, frequency of meals, and possible food intolerances that might occur in this patient population. Such modifications to clinical practice are not always commonplace, and it can thus be difficult for patients to access the care they need. Further research is certainly necessary to first define the construct of binge eating so we can better determine its prevalence, and then also to determine best practices for its treatment.

In addition to binge eating, other forms of eating pathology can occur after surgery and have been associated with poorer surgical outcomes. Grazing (defined as a pattern of repeatedly eating smaller quantities of food over a long period of time with accompanying feelings of loss of control) and eating in the absence of hunger have both been associated with suboptimal outcomes in post-bariatric patients. Threshold eating disorders have also been documented across several case studies of bariatric patients. Although not a frequent outcome, AN and BN have been reported among post-bariatric patients as both a reoccurrence of previous symptoms (prior to surgery) and as de novo cases. In fact, many of the patients described in these reviews/case studies required inpatient hospitalization, which underscores the extent to which eating pathology can quickly become severe among post-bariatric patients. Similar to managing binge eating, the management of other forms of postsurgical eating pathology also requires a nuanced approach to treatment, given the differences in physical anatomy and associated dietary restrictions. The interested reader is encouraged to read two excellent reviews and case studies of eating disorders and bariatric surgery published by Marino and colleagues and Conceição et al.

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

PHOTO: UNSPLASH

Smartphone Apps for Eating Disorders Recovery

BY EMILY PRESSELLER & KELSEY E. CLARK

Traditional in-person treatment is inaccessible for many of the thousands of people with eating disorders. This may be due to any number of barriers, including lack of specialized treatment providers, limited treatment options, high cost, insurance restrictions, stigma, and health care disparities. The current COVID-19 coronavirus pandemic adds yet another potential barrier. Many individuals, families/caregivers, and treatment providers are being forced to transition to remote care. Furthermore, early evidence suggests that the pandemic is contributing to a worsening of mental health symptoms, including stress, anxiety, and depression.

Early research has also found evidence of worsening eating disorder symptoms, including dietary restriction, binge eating, excessive exercise, and food-related fears, as well as risk for relapse among people with eating disorders. Those with eating disorders may be particularly affected by pandemic-related stressors, such as media coverage of food shortages, articles about curbing "emotional eating" and the "Quarantine 15," lack of structure in eating and sleep routines, disruption of daily activities and physical activity, reduced social support, heightened negative emotions, and increased practical demands of families/caregivers.

With COVID-19 disrupting treatment delivery and increasing need, interest in telehealth services has skyrocketed. Telehealth refers to services delivered using electronic information and communication technologies. It is an umbrella term that includes health care delivered via phone, video, the internet, or smartphone applications (apps), as well as online record-keeping and billing tools. In recent years, there has been an explosion of new mental health smartphone apps. As of 2019, more than 10,000 mental health apps were available, with the rate of new releases growing. Goals of these smartphone apps include making treatment more interactive and collaborative, improving adherence to treatment outside of the therapy office, offering more opportunities to practice treatment skills, and giving treatment providers more information upon which to base treatment decisions. In this article, we'll focus on the use of smartphone apps for eating disorder recovery. First, we will share a broad overview of the benefits and key features of eating disorder recovery apps. Next, we will discuss challenges with these apps and things to consider when choosing one. Finally, we will highlight some of the most popular eating disorder recovery apps.

5 Benefits of Apps for Eating Disorder Recovery

1. Wide availability. Smartphone apps are available all around the world. As of 2019, more than 81 percent of American adults owned smartphone devices. Zooming out, as of 2020, there are 3.5 billion smartphone users worldwide. Many people, including individuals with eating disorders, have positive, optimistic attitudes toward using telehealth apps and already plan to use them.

2. Convenience. Most people keep their smartphones within arm's

reach. The convenience of apps relative to traditional treatment is clear: Apps don't require appointments, travel, child care, or other arrangements. You can use an app almost anywhere, anytime, and in daily life immediately before/after eating disorder behaviors.

3. Ability to reach underserved populations. Apps are one potential solution to make treatment accessible to systemically underserved groups. Apps for eating disorders provide opportunities to overcome barriers to seeking treatment in individuals with diverse socioeconomic or racial/ethnic backgrounds, and with genders other than female. Many apps are cost-effective, if not free. Apps may also allow people who feel ambivalent about treatment to ease into it, as they are low-intensity and self-paced. Apps enable anonymity and may reduce feelings of shame or stigma linked to seeking help.

4. Potential to boost traditional in-person treatment. Mental health apps are not always intended to replace professional clinical treatment. However, they can be useful for individuals who cannot receive standard care. Blending in-person with app-based approaches may offer additional benefits. Apps offer extra support between outpatient treatment sessions and when stepping down from higher levels of care. Much of the "work" in treatment happens outside of the therapy office, without the therapist present. For instance, many of the behavior changes required for eating disorder recovery include doing things differently when eating meals and snacks, grocery shopping, exercising, using compensatory behaviors, and when experiencing urges. Smartphone apps may help individuals practice making changes and cope effectively as they go about daily life.

5. Some established research support. Making research-supported treatment broadly accessible is a key priority in the mental health field. Existing apps vary greatly, but a few meta-analytic studies (which combine data from many scientific studies to summarize the overall findings) have found support for some existing apps. One meta-analytic study found mental health treatment apps to generally be effective relative to control treatment conditions. Another found that users can learn acceptance, mindfulness, and self-compassion skills from treatment apps. Single studies show that some eating disorder recovery apps are feasible to use and believed to be helpful, and that patients and clinicians are willing to use them. Eating disorder recovery apps can reduce eating disorder symptoms, reduce body dissatisfaction, and improve body satisfaction and body image, and these effects can continue over time.

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Book Excerpt

The Binge Eating Prevention Workbook: *An Eight-Week Individualized Program to Overcome Compulsive Eating and Make Peace with Food*

In this excerpt from *The Binge Eating Prevention Workbook*, Gia Marson, EdD, and Danielle Keenan-Miller, PhD, offer some ways to stop obsessive thinking.

Obsessive Thoughts

Obsessive thinking about food or planning for the next binge is also a barrier to breaking the binge cycle. Binge eating is often preceded by preoccupation with thoughts about food (Lingswiler and Crowther 1989), and many people find that once they're on the mental train of planning a binge, it's difficult to get off.

One of the best ways to stop obsessive thinking is to engage in an absorbing, somewhat challenging activity that requires your concentration. Some examples of activities that can stop obsessive thoughts are playing a musical instrument, learning a foreign language, working on a puzzle or timed game, playing a sport, doing tai chi, reading an engaging book, or meditating.

List here at least three activities that you can use to refocus your mental energy when you are obsessively planning a binge.

_____

_____

_____

Avoiding Food Thoughts

The last kind of unhelpful thought pattern that contributes to binge eating is trying *not* to think about food at all. Although an obsessive focus on food is not helpful, trying to banish thoughts of food altogether is unlikely to help and may, in fact, make the situation worse. A large body of research has shown that *thought suppression* backfires (Wegner et al. 1987).

Want to see the failure of thought suppression in action? Right now, close your eyes and try really hard not to think about a bright yellow giraffe for two minutes. Set a timer on your watch or phone, and don't do anything in particular other than avoid thinking about giraffes. Come back once you've done the experiment.

Did those pesky giraffes make an appearance in your thoughts? Chances are that they did pop up a few times even though they probably weren't on your mind at all today before reading this chapter. That's because trying to suppress a thought actually creates a preoccupation with the thought you're trying to avoid, a sort of mental radar that's constantly scanning to check if the banished thought has popped up (Wegner 1997).

So what are you supposed to do if you aren't supposed to obsess about food but you also aren't supposed to avoid thinking about food? Instead, try acknowledging the thought by naming it. You might say, *There are those doughnuts again!* and let your mind move on naturally to the next topic in your stream of consciousness. ◆

RECOMMENDED READING

recovery

Hope for Recovery: Stories of Healing from Eating Disorders
Catherine Brown & Christina Tinker, editors, 2019

MeaningFULL: 23 Life-Changing Stories of Conquering Dieting, Weight, and Body Image Issues
Alli Spotts-De Lazzer, 2021

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

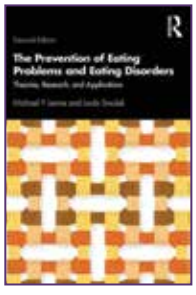
The Deeper Fix: For Your Growth and Empowerment
Ilene V. Fishman, 2020

Thriving After Trauma: Stories of Living and Healing
Shari Botwin, 2019

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

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

prevention



The Prevention of Eating Problems and Eating Disorders, Second Edition: Theories, Research, and Applications
Michael P. Levine & Linda Smolak, 2020

DIAGNOSING BINGE EATING DISORDER

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

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

B. The binge-eating episodes are associated with three (or more) of the following:

1. Eating much more rapidly than normal.
2. Eating until feeling uncomfortably full.
3. Eating large amounts of food when not feeling physically hungry.
4. Eating alone because of feeling embarrassed by how much one is eating.
5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

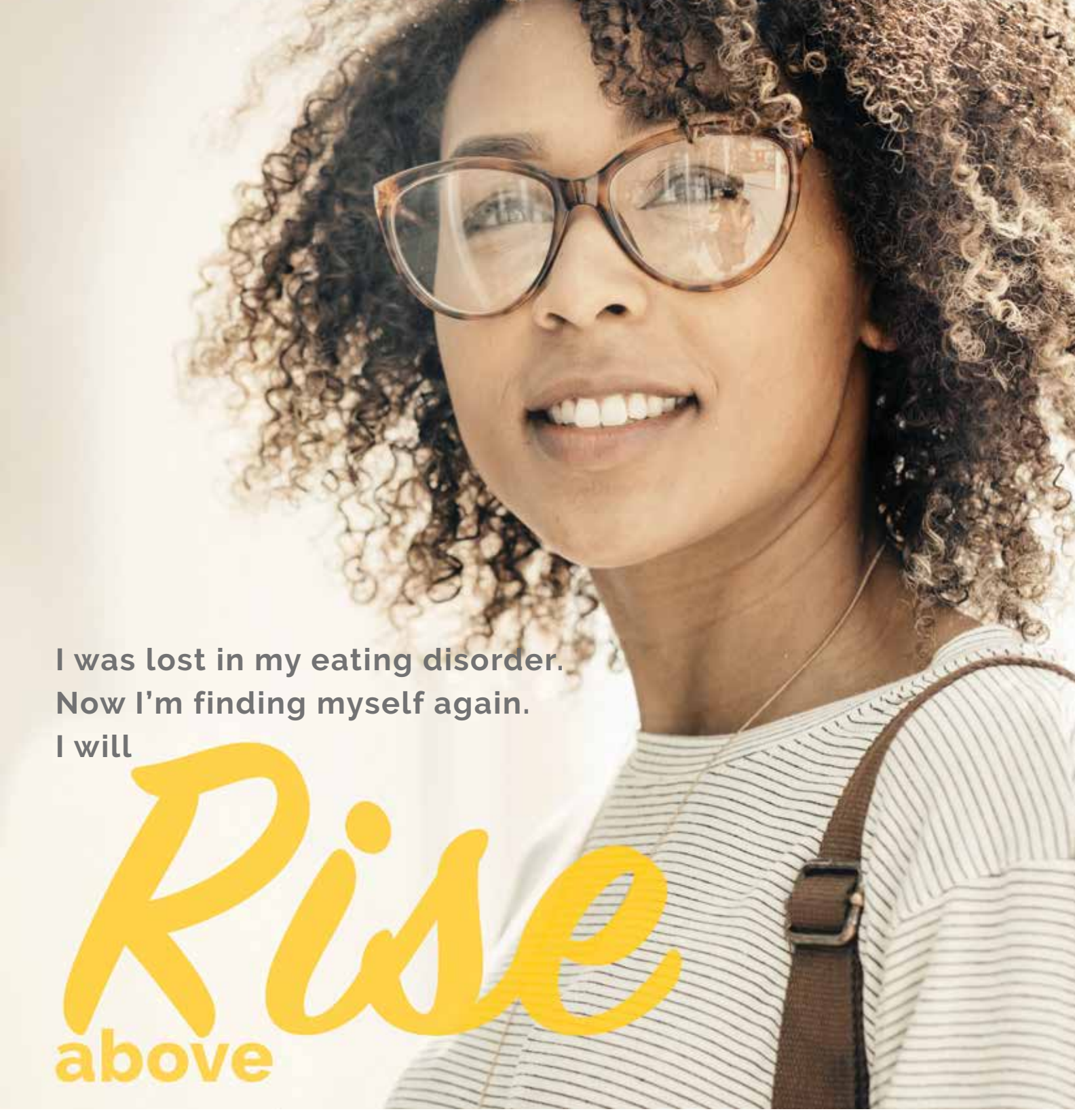
D. The binge eating occurs, on average, at least once a week for 3 months.

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

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

TREATMENT CENTER	STATE	PG	CHILDREN	TEENS	ADULTS	FEMALES	MALES	ALL GENDERS*
Center for Change (males PHP, IOP, and Outpatient)	ID, UT	42		●	●	●	●	●
EDCare	CO, KS, NE	42		●	●	●	●	●
The Healthy Teen Project	CA	43		●		●	●	●
Hidden River Eating Disorder Treatment	NJ	44	●	●	●	●		
Laureate Eating Disorders Program (males outpatient only)	OK	48		●	●	●	●	
McLean Klarman Eating Disorders Center	MA	43		●	●	●		
Penn Medicine Princeton Center for Eating Disorders	NJ	45	●	●	●	●	●	●
Reasons Eating Disorder Center	CA	42		●	●	●	●	●
The Renfrew Center	CA, FL, GA, IL, MA, MD, NJ, NY, NC, PA, TN	40		●	●	●		●
Rogers Behavioral Health	FL, IL, MN, TN, WI	41	●	●	●	●	●	●
Veritas Collaborative	GA, NC, VA	3	●	●	●	●	●	●

* All genders is a designation for individuals who do not identify as a binary gender.



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Editor's Picks

ANOREXIA

- **Anorexia Nervosa, Second Edition: A Recovery Guide for Sufferers, Families, and Friends** by Janet Treasure & June Alexander, 2013.

ARFID

- **Food Refusal and Avoidant Eating in Children, Including Those with Autism Spectrum Conditions: A Practical Guide for Parents and Professionals** by Gillian Harris & Elizabeth Shea, 2018.

BINGE EATING DISORDER

- **Binge Control: A Compact Recovery Guide** by Cynthia M. Bulik, 2015.
- **Binge Eating Disorder: The Journey to Recovery and Beyond** by Amy Pershing with Chevese Turner, 2018.
- **Outsmarting Overeating: Boost Your Life Skills, End Your Food Problems** by Karen R. Koenig, 2015.

BODIES

- **Body Image, Second Edition: A Handbook of Science, Practice, and Prevention** by Thomas F. Cash & Linda Smolak, 2012.
- **No Weigh! A Teen's Guide to Positive Body Image, Food, and Emotional Wisdom** by Signe Darpinian, Wendy Sterling & Shelley Aggarwal, 2018.
- **Pursuing Perfection: Eating Disorders, Body Myths, and Women at Midlife and Beyond** by Margo Maine & Joe Kelly, 2016.

BULIMIA

- **My Name Is Caroline, Second Edition: A Candid, Hard-Hitting Account of a Seven-Year Descent into Bulimia, Leading Up to a Final Victorious Triumph over the Addiction** by Caroline Adams Miller, 2014.
- **Positively Caroline: How I Beat Bulimia for Good... and Found Real Happiness** by Caroline Adams Miller, 2013.

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.
- **Helping Your Child with Extreme Picky Eating: A Step-by-Step Guide for Overcoming Selective Eating, Food Aversion, and Feeding Disorders** by Katja Rowell & Jenny McGlothlin, 2015.
- **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.
- **Surviving an Eating Disorder, Third Edition: Strategies for Family and Friends** by Michele Siegel, Judith Brisman & Margot Weinshel, 2009.
- **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: The Power of Radical Self-Love** by Sonya Renee Taylor, 2018.
- **Embody: Learning to Love Your Unique Body (and Quiet That Critical Voice!)** by Connie Sobczak, 2014.
- **Health at Every Size: The Surprising Truth About Your Weight** by Linda Bacon, 2010.
- **Intuitive Eating: A Revolutionary Program That Works** by Evelyn Tribole & Elyse Resch, 2012.

KIDS/TEENS/ YOUNG ADULTS

- **Amanda's Big Dream** by Judith Matz, illustrated by Elizabeth Patch, 2015.
- **Can I Tell You About Eating Disorders? A Guide for Friends, Family and Professionals** by Bryan Lask & Lucy Watson, illustrated by Fiona Field, 2014.
- **Getting Over Overeating for Teens: A Workbook to Transform Your Relationship with Food Using CBT, Mindfulness, and Intuitive Eating (Teen Instant Help)** by Andrea Wachter, 2016.
- **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

- **Almost Anorexic: Is My (or My Loved One's) Relationship with Food a Problem?** by Jennifer J. Thomas & Jenni Schaefer, 2013.
- **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

- **Body Respect: What Conventional Health Books Get Wrong, Leave Out, and Just Plain Fail to Understand About Weight** by Linda Bacon & Lucy Aphramor, 2014.

- **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.
- **The Clinical Guide to Fertility, Motherhood, and Eating Disorders: From Shame to Self-Acceptance** by Kate B. Daigle, 2019.
- **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, Third Edition: A Guide to Medical Care and Complications** by Philip S. Mehler & Arnold E. Andersen, editors, 2017.
- **Eating Disorders, Addictions, and Substance Use Disorders: Research, Clinical, and Treatment Perspectives** by Timothy Brewerton & Amy Baker Dennis, editors, 2014.
- **The Eating Disorders Clinical Pocket Guide, Second Edition: Quick Reference for Healthcare Providers** by Jessica Setnick, 2013.
- **Eating Disorders in Children and Adolescents: A Clinical Handbook** by Daniel Le Grange & James Lock, editors, 2011.
- **Eating Disorders in Special Populations: Medical, Nutritional, and Psychological Treatments** by Jonna Fries & Veronica Sullivan, editors, 2017.
- **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, 2015.
- **Helping Patients Outsmart Overeating: Psychological Strategies for Doctors and Health Care Providers** by Karen R. Koenig & Paige O'Mahoney, 2017.
- **Innovations in Family Therapy for Eating Disorders: Novel Treatment Developments, Patient Insights, and the Role of Carers** by Stuart B. Murray, Leslie Karwoski Anderson & Leigh Cohn, editors, 2016.
- **Managing Severe and Enduring Anorexia Nervosa: A Clinician's Guide** by Stephen Touyz, Daniel Le Grange, J. Hubert Lacey & Phillipa Hay, editors, 2016.
- **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.
- **Treatment Manual for Anorexia Nervosa, Second Edition: A Family-Based Approach** by James Lock & Daniel Le Grange, 2012.
- **Treatment of Eating Disorders: Bridging the Research-Practice Gap** by Margo Maine, Beth Hartman McGilley & Douglas W. Bunnell, 2010.
- **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.
- **French Toast for Breakfast, New Revised Edition: Declaring Peace with Emotional Eating** by Mary Anne Cohen, 2016.
- **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.
- **Lasagna for Lunch: Declaring Peace with Emotional Eating** by Mary Anne Cohen, 2013.
- **Midlife Eating Disorders: Your Journey to Recovery** by Cynthia M. Bulik, 2013.
- **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.
- **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.
- **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: 10 Principles for Nourishing a Healthy Relationship with Food** by Evelyn Tribole & Elyse Resch, 2017.
- **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.
- **The Wiley Handbook of Eating Disorders** by Linda Smolak & Michael P. Levine, 2015.

SPIRITUALITY

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

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

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- 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.

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

Laureate
Eating Disorders Program
A part of Saint Francis Health System