**Eating Disorders Assessment and Treatment**

**A Comprehensive 6-Hour Continuing Education Course for Mental Health Professionals**

**Course Introduction and Overview**

**Welcome to Clinical Excellence in Eating Disorders Care**

Welcome to "Eating Disorders Assessment and Treatment," a comprehensive 6-hour continuing education course designed to transform mental health professionals into competent, confident practitioners capable of providing life-saving care to individuals struggling with eating disorders. This course recognizes that eating disorders represent some of the most complex, medically dangerous, and psychologically challenging conditions in mental health practice—requiring specialized knowledge that extends far beyond general clinical training.

Consider this scenario that illustrates the life-or-death stakes of competent eating disorder treatment:

*Dr. Rachel Morrison, an experienced therapist with 12 years of general practice, accepts her first eating disorder client—19-year-old Emma, referred for "anxiety and perfectionism." During intake, Emma mentions "eating healthy" and exercising daily. Dr. Morrison, focusing on the presenting anxiety symptoms, doesn't probe deeper into eating patterns. Three months into treatment, Emma's roommate calls frantically: Emma collapsed during a run, her heart rate dangerously low. At the emergency room, Emma's BMI is 15.2, she has severe bradycardia, and her potassium levels are critically low. The ER physician asks Dr. Morrison, "How did you miss this?" Dr. Morrison realizes with horror that she's been treating the symptom—anxiety—while missing the life-threatening eating disorder driving it.*

This vignette, based on actual cases, illustrates why eating disorder competency isn't optional—it's essential. Emma's life depended on proper assessment, and the lack of specialized knowledge nearly cost her everything.

**The Unique Complexity of Eating Disorders**

Eating disorders challenge everything we know about typical psychotherapy:

**They require medical knowledge beyond typical therapy training:**

* Every organ system can be affected
* Medical complications can be immediately life-threatening
* Starvation creates brain changes that impede psychological treatment
* Vital signs matter as much as mental status

**They demand specialized therapeutic approaches:**

* Standard CBT or psychodynamic therapy often proves insufficient
* Family involvement may be essential, especially for younger clients
* Nutritional rehabilitation must parallel psychological treatment
* Weight restoration itself is therapeutic, not just a side effect

**They involve profound ambivalence about recovery:**

* Unlike most disorders where suffering motivates change, eating disorders provide perceived benefits
* Identity often becomes fused with the disorder
* Fear of change exceeds fear of death in severe cases
* Motivation fluctuates moment to moment

**They require multidisciplinary collaboration:**

* Physicians monitor medical status and complications
* Dietitians guide nutritional rehabilitation
* Psychiatrists manage medication and comorbidities
* Therapists address psychological maintaining factors
* Families provide crucial support and structure

**Course Learning Objectives**

By the completion of this 6-hour course, participants will be able to:

1. **Conduct comprehensive eating disorder assessments** that identify diagnostic criteria, evaluate medical risk, assess psychological maintaining factors, and determine appropriate level of care
2. **Recognize and respond to medical complications** including cardiovascular, gastrointestinal, metabolic, and neurological effects, knowing when immediate medical intervention is required
3. **Implement evidence-based treatment approaches** including Cognitive-Behavioral Therapy for Eating Disorders (CBT-E), Family-Based Treatment (FBT), Dialectical Behavior Therapy (DBT), and Enhanced Cognitive Behavioral Therapy with appropriate adaptation to individual cases
4. **Address comorbid conditions** commonly co-occurring with eating disorders including trauma, anxiety, depression, substance use, and personality disorders through integrated treatment approaches
5. **Work effectively with diverse populations** including males, LGBTQ+ individuals, people in larger bodies, athletes, and clients from various cultural backgrounds, recognizing how eating disorders manifest across demographics
6. **Collaborate within multidisciplinary teams** to provide coordinated care, understanding each team member's role and maintaining effective communication
7. **Develop relapse prevention strategies** and support sustainable recovery by addressing underlying psychological factors, building resilience, and involving support systems
8. **Navigate ethical challenges** unique to eating disorder treatment including forced treatment considerations, informed consent with ambivalent clients, and balancing autonomy with safety

**Course Structure and Philosophy**

This 6-hour course is divided into six comprehensive modules:

* **Module 1:** Understanding Eating Disorders: Definitions, Epidemiology, and Etiology (60 minutes)
* **Module 2:** Comprehensive Assessment and Differential Diagnosis (60 minutes)
* **Module 3:** Medical Complications and Multidisciplinary Collaboration (60 minutes)
* **Module 4:** Evidence-Based Treatment Approaches (90 minutes)
* **Module 5:** Special Populations, Comorbidities, and Complex Cases (60 minutes)
* **Module 6:** Recovery, Relapse Prevention, and Family Involvement (30 minutes)

Each module includes:

* Detailed theoretical foundations with current research
* Extensive clinical applications with real-world scenarios
* Therapeutic dialogue demonstrating intervention techniques
* Case conceptualizations showing clinical reasoning
* Assessment questions testing comprehension and application

**The Life-Saving Imperative**

**Why This Training Matters:**

Eating disorders have the **highest mortality rate** of any psychiatric condition:

* Anorexia nervosa: 5-10% mortality rate
* Crude mortality rate approximately 6 times higher than general population
* Deaths from medical complications: 50%
* Deaths from suicide: 25%
* Deaths from substance abuse: 25%

Yet despite this severity:

* Only **1 in 10** people with eating disorders receive treatment
* Average time from symptom onset to treatment: **2-3 years**
* 50% of individuals with eating disorders **never diagnosed**
* Many clinicians feel **unprepared** to treat eating disorders

**The Impact of Competent Care:**

Evidence-based eating disorder treatment produces remarkable outcomes:

* **50-60%** achieve full recovery with appropriate treatment
* **30-35%** experience significant improvement
* Early intervention dramatically improves prognosis
* Specialized treatment reduces time to recovery by **years**
* Proper medical monitoring prevents **preventable deaths**

**Your Role in Saving Lives:**

As a mental health professional completing this course, you have the opportunity to:

* Recognize eating disorders that others miss
* Provide treatment that saves lives
* Guide families through impossible situations
* Prevent the progression from early symptoms to chronic illness
* Restore hope where despair has taken hold

**Module 1: Understanding Eating Disorders—Clinical Presentations, Epidemiology, and Biopsychosocial Etiology**

**Duration: 60 minutes**

**Defining Eating Disorders: Beyond "Food Issues"**

The term "eating disorder" is itself somewhat misleading. While these conditions manifest through disordered eating behaviors, they are fundamentally complex psychiatric illnesses involving distorted cognitions, emotional dysregulation, neurobiological factors, and often severe medical complications. Dr. Walter Kaye, a leading eating disorder researcher, emphasizes that "eating disorders are brain disorders with nutritional consequences, not nutritional disorders with psychological consequences."

**What Eating Disorders Are NOT:**

Before defining what eating disorders are, let's dispel dangerous misconceptions:

**NOT lifestyle choices or "diets gone wrong"**

* Eating disorders are serious mental illnesses with genetic, neurobiological, and psychological roots
* No one chooses to develop an eating disorder
* Willpower cannot overcome an eating disorder

**NOT about vanity or wanting attention**

* Eating disorders serve complex psychological functions: control, emotion regulation, identity, safety
* Most individuals with eating disorders experience profound shame and secrecy
* The visible symptoms (weight changes) represent the tip of an enormous psychological iceberg

**NOT only affecting young, white, affluent females**

* Eating disorders affect all genders, ages, races, ethnicities, socioeconomic statuses, and body sizes
* Stereotypes about who "looks like" they have an eating disorder cause dangerous delays in diagnosis and treatment
* Males comprise 25-30% of cases but are significantly underdiagnosed
* People of color experience eating disorders at similar rates but face greater barriers to treatment
* Eating disorders occur across the weight spectrum—many individuals at "normal" or higher weights have serious eating disorders

**NOT simply about food and weight**

* Food and weight represent symptoms of deeper psychological distress
* Eating disorder behaviors serve functions: managing anxiety, achieving control, expressing identity, coping with trauma
* Effective treatment addresses underlying psychological factors, not just eating behaviors

**What Eating Disorders ARE:**

**Serious, potentially fatal mental illnesses** characterized by:

* Persistent disturbances in eating behaviors
* Distorted thoughts and emotions about food, weight, and body
* Often severe medical complications
* Significant impairment in physical health and psychosocial functioning

**Biopsychosocial conditions** resulting from interaction of:

* **Biological factors:** Genetic predisposition, neurobiological vulnerabilities, temperamental traits
* **Psychological factors:** Emotion regulation difficulties, perfectionism, trauma history, cognitive patterns
* **Social factors:** Cultural beauty ideals, weight stigma, diet culture, family dynamics

**Treatable conditions** with evidence-based interventions when appropriate, specialized care is provided.

**DSM-5-TR Eating Disorder Diagnoses: Clinical Presentations**

**1. Anorexia Nervosa (AN): The Relentless Pursuit of Thinness**

**DSM-5-TR Diagnostic Criteria:**

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

**Criterion 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.

**Criterion C:** Disturbance in the way 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 current low body weight.

**Subtypes:**

* **Restricting type:** No regular binge eating or purging during the last 3 months. Weight loss accomplished through dieting, fasting, and/or excessive exercise.
* **Binge-eating/purging type:** Regular binge eating or purging behavior (self-induced vomiting, laxative/diuretic misuse) during the last 3 months.

**Severity Specifiers** (based on BMI for adults; BMI percentile for children/adolescents):

* **Mild:** BMI ≥ 17 kg/m²
* **Moderate:** BMI 16-16.99 kg/m²
* **Severe:** BMI 15-15.99 kg/m²
* **Extreme:** BMI < 15 kg/m²

**Clinical Presentation—The Complete Picture:**

**Physical Signs:**

* Progressive weight loss or failure to gain expected weight
* Emaciation (visible bones, sunken cheeks, prominent clavicles)
* Hypothermia (body temperature <96°F)—client constantly cold, wearing layers
* Bradycardia (heart rate <60 bpm, often <50 bpm in severe cases)
* Hypotension (blood pressure <90/60 mmHg)
* Orthostatic changes (dizziness upon standing, syncope)
* Lanugo (fine, downy hair on face, arms, back)—body's attempt to preserve warmth
* Hair loss from scalp (telogen effluvium)
* Dry, cracked skin; brittle nails
* Amenorrhea or irregular menses
* Fatigue, weakness, difficulty concentrating
* Constipation, bloating
* Sleep disturbances
* Edema (swelling), particularly in refeeding

**Cognitive/Psychological Manifestations:**

* **Intense fear of weight gain:** "If I gain even one pound, I'll lose all control and become obese"
* **Body image distortion:** Seeing self as fat despite emaciation
* **Overvaluation of weight/shape:** Self-worth entirely determined by weight and ability to restrict
* **Preoccupation with food:** Constant thoughts about food, calories, recipes; collecting recipes, watching cooking shows
* **Cognitive rigidity:** Black-and-white thinking, difficulty with flexibility, perseveration
* **Perfectionism:** Impossibly high standards, self-criticism, fear of failure
* **Need for control:** Food restriction provides sense of control in chaotic internal/external world
* **Denial of illness severity:** Minimization of symptoms, resistance to treatment
* **Distorted hunger/satiety cues:** Loss of ability to recognize hunger and fullness
* **Emotional blunting:** Numbness, difficulty accessing emotions
* **Anxiety and depression:** Particularly regarding food, eating, weight
* **Obsessive-compulsive features:** Rituals around food, counting, checking

**Behavioral Patterns:**

* **Restrictive eating:**
  + Skipping meals entirely
  + Eating minimal amounts ("just picking")
  + Eliminating entire food groups
  + Rigid food rules ("nothing after 6 PM," "no carbs," "only 'clean' foods")
  + Measuring/weighing food obsessively
  + Eating same foods repeatedly in exact amounts
* **Food rituals:**
  + Cutting food into tiny pieces
  + Eating extremely slowly
  + Arranging food on plate in specific patterns
  + Chewing and spitting
  + Eating foods in specific order
  + Using tiny utensils
* **Excessive exercise:**
  + Compulsive daily exercise regardless of weather, illness, injury
  + Distress if unable to exercise
  + Exercising in secret (pacing, doing calisthenics in room)
  + Exercise eclipsing other activities
* **Body checking:**
  + Frequent weighing (multiple times daily)
  + Measuring body parts with tape measure
  + Pinching areas to assess fat
  + Mirror checking or complete mirror avoidance
  + Comparing body to others constantly
* **Social withdrawal:**
  + Avoiding social situations involving food
  + Isolating from friends and family
  + Dropping out of previously enjoyed activities
  + Avoiding situations where body might be seen (swimming, changing rooms)

**Extended Clinical Vignette—Anorexia Nervosa:**

*Dr. Sarah Kim meets with 17-year-old Lily and her parents for an initial evaluation. Lily appears gaunt, wearing an oversized sweatshirt despite the warm office. She sits rigidly, hands folded tightly in her lap, avoiding eye contact.*

*Dr. Kim: "Lily, I understand your pediatrician referred you here. Can you tell me what's been going on?"*

*Lily: [defensive tone] "Nothing's going on. My parents are overreacting. I'm just eating healthy."*

*Mother: [tearful] "Lily, you've lost 40 pounds in five months. You're disappearing. We can see your bones."*

*Lily: "I needed to lose weight. I was overweight before."*

*Dr. Kim: [gently] "Lily, I have your growth chart here from your pediatrician. At your highest weight, you were at the 60th percentile—completely normal for your height and age. You're now at the 5th percentile and still losing. What are your thoughts about that?"*

*Lily: "The percentiles don't account for individual differences. I just have a small frame."*

*Dr. Kim: "I'm noticing you're wearing a heavy sweatshirt. How are you feeling temperature-wise?"*

*Lily: "I'm freezing. I'm always cold now. But that's fine."*

*Dr. Kim: "That's actually a sign your body is struggling—when weight gets too low, your body temperature drops to conserve energy. Your pediatrician mentioned your heart rate was 48 beats per minute. That's quite low. Have you been dizzy or lightheaded?"*

*Lily: [hesitant] "Sometimes when I stand up. And I fainted once during PE. But I just didn't drink enough water that day."*

*Dr. Kim: "Can you walk me through what you eat in a typical day?"*

*Lily: "I have half a cup of oatmeal for breakfast, made with water. For lunch, I have vegetables—like steamed broccoli and carrots. Maybe an apple. For dinner, I have grilled chicken breast—about three ounces—and more vegetables."*

*Dr. Kim: "And that's everything for the whole day?"*

*Lily: "Yes. It's healthy eating. There's nothing wrong with eating healthy."*

*Father: [frustrated] "She's eating maybe 500 calories a day! We try to get her to eat more but she has a complete meltdown. Last week we insisted she eat a piece of birthday cake at her grandmother's, and she locked herself in the bathroom and ran in place for an hour."*

*Dr. Kim: "Lily, what goes through your mind when your parents want you to eat more?"*

*Lily: [becoming tearful] "I can't. If I eat more, I'll lose all control. I'll gain weight and become... disgusting. This is the only thing I can control in my life. Everything else is falling apart—school is stressful, my friends are moving on without me, college applications are overwhelming. But this—what I eat—I can control this."*

*Dr. Kim: "So food restriction has become a way of managing really difficult feelings about other areas of your life."*

*Lily: [crying now] "I know everyone thinks I'm crazy. I know I'm too thin. When I look in the mirror, I can see my bones. But I also see fat—on my stomach, my thighs. And the thought of eating more terrifies me. I'd rather die than gain weight."*

*Dr. Kim: "I appreciate your honesty. That fear is very real to you, and it's part of what makes anorexia so dangerous. Your brain is sending signals that gaining weight is the worst thing that could happen, when actually, continuing to lose weight could end your life. Your heart is struggling, your body temperature is dropping, you're fainting. These are signs your body is shutting down."*

*Mother: "What do we do? We're terrified we're going to lose her."*

*Dr. Kim: "Lily needs intensive treatment. Given her medical symptoms—the low heart rate, orthostatic changes, continued weight loss—I'm concerned outpatient treatment isn't sufficient. I'm recommending either partial hospitalization or residential treatment where she can receive medical monitoring, structured meals, and intensive therapy. Lily, I know this isn't what you want to hear."*

*Lily: [panicked] "No! I can eat more at home. I don't need to go anywhere. Please."*

*Dr. Kim: "I understand you're frightened. The eating disorder is telling you that treatment means losing control. But right now, the eating disorder has control—not you. Real control is living your life, going to college, spending time with friends, not being dominated by thoughts about food and weight. That's what treatment can help you reclaim."*

**Clinical Note:** This vignette illustrates key features of anorexia nervosa:

* Denial of illness severity
* Fear of weight gain despite medical danger
* Food restriction rationalized as "health"
* Loss of functional life (social withdrawal, academic struggles)
* Medical complications (bradycardia, orthostasis, hypothermia)
* Underlying psychological distress (anxiety, need for control)
* Family distress and attempted accommodations
* The disconnect between intellectual knowledge ("I know I'm too thin") and emotional experience ("I see fat")

**2. Bulimia Nervosa (BN): The Binge-Purge Cycle**

**DSM-5-TR Diagnostic Criteria:**

**Criterion A:** Recurrent episodes of binge eating characterized by BOTH:

1. Eating, in a discrete period (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat during a similar period under similar circumstances
2. A sense of lack of control over eating during the episode (e.g., feeling unable to stop eating or control what or how much one is eating)

**Criterion B:** Recurrent inappropriate compensatory behaviors to prevent weight gain, such as:

* Self-induced vomiting
* Misuse of laxatives, diuretics, or other medications
* Fasting
* Excessive exercise

**Criterion C:** The binge eating and compensatory behaviors both occur, on average, at least once per week for 3 months.

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

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

**Severity Specifiers** (based on frequency of compensatory behaviors):

* **Mild:** 1-3 episodes per week
* **Moderate:** 4-7 episodes per week
* **Severe:** 8-13 episodes per week
* **Extreme:** 14+ episodes per week

**Clinical Presentation—Understanding the Cycle:**

**Physical Signs:**

* Weight typically normal or slightly above/below normal (fluctuates)
* **Russell's sign:** Calluses, scars, or abrasions on knuckles/back of hand from repeated vomiting induction
* **Dental erosion:** Enamel loss, cavities, tooth sensitivity, yellowing teeth from acid exposure
* **Parotid gland enlargement:** "Chipmunk cheeks" from swollen salivary glands
* Chronic sore throat, hoarseness
* Bloodshot eyes, broken blood vessels in face from vomiting strain
* Esophageal irritation and potential damage
* Electrolyte imbalances (particularly hypokalemia—low potassium)
* Gastrointestinal issues: constipation, diarrhea (especially with laxative abuse), bloating
* Irregular menstruation
* Dehydration
* Facial swelling/puffiness
* Cold hands/feet

**Cognitive/Psychological Manifestations:**

* **Overvaluation of weight/shape:** Self-worth contingent on weight, shape, and ability to control eating
* **All-or-nothing thinking:** "I've already ruined my diet, so I might as well eat everything"
* **Body dissatisfaction:** Distorted body image, constant comparison to others
* **Preoccupation with food:** Constant thoughts about what/when to eat, when to purge
* **Shame and guilt:** Profound shame about behaviors, secrecy
* **Negative self-evaluation:** Self-loathing, feeling "disgusting," "out of control"
* **Mood instability:** Emotional dysregulation, irritability, depression
* **Impulsivity:** Difficulty with impulse control in other areas (substance use, spending, relationships, self-harm)
* **Perfectionism:** High standards, fear of failure
* **Fear of weight gain:** Intense anxiety about weight increasing

**Behavioral Patterns:**

**The Binge-Purge Cycle:**

**Phase 1: Restriction/Control**

* Attempting to restrict food intake
* Strict dietary rules ("no carbs," "under 1200 calories")
* Skipping meals
* "Being good"
* Increasing tension and deprivation

**Phase 2: Trigger**

* Breaking dietary rule (eating "forbidden" food)
* Emotional distress (stress, anxiety, loneliness, boredom, anger)
* Interpersonal conflict
* Negative thought spiral
* Physical hunger from restriction

**Phase 3: Binge Episode**

* Eating large amount of food rapidly
* Sense of loss of control
* Often eating past comfortable fullness to painful distension
* Eating alone due to embarrassment
* Consuming foods typically restricted (high-calorie, high-carb, "forbidden" foods)
* Dissociative quality—"zoning out," not fully present
* Temporary emotional relief or numbness

**Phase 4: Distress**

* Physical discomfort (extreme fullness, nausea, pain)
* Panic about weight gain
* Self-disgust, shame, guilt
* Fear and anxiety
* Desperation

**Phase 5: Compensatory Behavior**

* Self-induced vomiting to "undo" the binge
* Laxative or diuretic use
* Excessive exercise
* Fasting for next 24+ hours
* Temporary relief from anxiety

**Phase 6: Recommitment to Restriction**

* Vowing "never again"
* Renewed strict dieting
* Increased rules and restriction
* Setting up conditions for next binge

**Then the cycle repeats...**

**Social/Interpersonal Patterns:**

* Secretive behaviors (hiding food, disappearing after meals)
* Evidence of binges (missing food, empty packages/wrappers hidden)
* Social isolation or withdrawal, especially around meals
* Bathroom use immediately after eating
* Fluctuating relationships (often intense and unstable)
* Difficulty with emotional intimacy
* People-pleasing and external validation-seeking

**Extended Clinical Vignette—Bulimia Nervosa:**

*Mia, 28, self-refers for therapy after "hitting rock bottom." She sits in Dr. Thompson's office, visibly anxious, alternating between making eye contact and staring at her hands.*

*Dr. Thompson: "Thank you for reaching out, Mia. What brings you to therapy?"*

*Mia: [voice shaking] "I think I have bulimia. I've been dealing with this for ten years, and I can't do it anymore. It's ruining my life."*

*Dr. Thompson: "It takes courage to say that. Tell me what's been happening."*

*Mia: "I binge and purge. Every single day, usually multiple times. I've tried to stop so many times, but I can't. The longest I've gone is maybe three days, and then something happens and I'm right back in it."*

*Dr. Thompson: "Walk me through a typical day. Start from when you wake up."*

*Mia: "Okay. I wake up and immediately weigh myself. If the number is acceptable, I feel okay for maybe five minutes. If it's up even half a pound, the whole day is ruined. I tell myself I'm not going to eat anything today—I need to make up for yesterday's binge. I have black coffee for breakfast. Nothing else."*

*Dr. Thompson: "And then?"*

*Mia: "I go to work. I'm a marketing manager, so I have to be 'on' all day—meetings, presentations, managing my team. Inside I'm obsessing about food and weight, but I can't show it. Lunch time comes and everyone goes to the cafeteria. I say I brought lunch from home, but really I just stay at my desk. By 2 PM, I'm starving and irritable and can't concentrate. I tell myself I'll just have a protein bar."*

*Dr. Thompson: "What happens when you have the protein bar?"*

*Mia: [starting to cry] "That's when it starts. I eat the protein bar and immediately think, 'You failed. You couldn't even make it one day. You're so weak.' And then this switch flips in my brain. If I've already ruined the day, I might as well really ruin it. So on my way home, I stop at three different stores so no one sees how much I'm buying. I get ice cream, cookies, pizza, chips, bread—all the things I don't let myself eat normally."*

*Dr. Thompson: "And when you get home?"*

*Mia: "I eat all of it. I don't even taste it really. I'm shoving food in my mouth so fast. It's like I'm not even there—I'm watching myself do it but I can't stop. I eat until I'm so full I can barely breathe, until it hurts. And the whole time, part of me is thinking about how I'll get rid of it."*

*Dr. Thompson: "What happens next?"*

*Mia: "I purge. I make myself throw up until there's nothing left, until I'm just dry heaving. And for maybe ten minutes afterward, I feel relief. The panic is gone. But then the shame comes crashing in. I look at myself in the mirror and I'm disgusting. I see the broken blood vessels in my eyes, my puffy face, and I hate myself. I promise myself tomorrow will be different. Tomorrow I'll eat normally. But tomorrow never comes."*

*Dr. Thompson: "How often is this cycle happening?"*

*Mia: "Every day. Sometimes twice a day—once after work, once before bed. On weekends it's worse because I have more time alone. Last weekend I binged and purged five times on Saturday."*

*Dr. Thompson: "What impact is this having on your life beyond the physical act?"*

*Mia: [sobbing now] "It's everything. I spend hundreds of dollars a week on food I'm just going to throw up. I'm in debt from it. I've stopped seeing friends because I'm afraid to eat around people. I broke up with my boyfriend because I couldn't handle the intimacy—I was too ashamed of my body and terrified he'd find out. My teeth are falling apart despite dental work. My throat hurts constantly. I'm exhausted all the time. And I'm so lonely. This eating disorder is the only relationship I have, and it's destroying me."*

*Dr. Thompson: "You mentioned you've been dealing with this for ten years. When did it start?"*

*Mia: "In college. I gained the 'freshman 15' and started dieting. At first it was just restricting, but then I discovered purging. It felt like a solution—I could eat what I wanted and not gain weight. But it stopped being a choice really fast. Now I can't stop even when I desperately want to."*

*Dr. Thompson: "What function does the binge-purge cycle serve for you? I know it causes tremendous pain, but there's usually something it's helping you manage, even temporarily."*

*Mia: [thoughtful] "I never thought of it that way. I guess... it's the only time I'm not thinking. My job is stressful, I'm lonely, I feel like I'm failing at life. But when I'm binging, my brain shuts off. There's no anxiety, no sadness, no thoughts about how I'm not good enough. It's just eating. And purging makes me feel like I've taken back control, even though I know that's an illusion."*

*Dr. Thompson: "So the eating disorder has become a way of managing really difficult emotions and experiences—stress, loneliness, feelings of inadequacy."*

*Mia: "Yes. But the cost is too high now. I can't live like this anymore."*

*Dr. Thompson: "I'm glad you're here. What you're describing is bulimia nervosa, and it's a serious condition. But it's also treatable. With the right approach, you can break this cycle and reclaim your life. That will involve understanding the underlying factors maintaining the behaviors, learning new ways of managing emotions, normalizing eating patterns, and addressing the thoughts about weight and shape driving this. Are you ready to do that work?"*

*Mia: "I'm terrified, but yes. I have to try."*

**Clinical Note:** This vignette illustrates:

* The restrict-binge-purge cycle and its reinforcing nature
* Loss of control during binges
* Use of food/purging for emotional regulation
* Shame and secrecy
* Social and functional impairment
* Financial consequences
* Physical complications (dental, throat, facial signs)
* Insight into the function of symptoms (emotion management, temporary relief)
* Ambivalence (both wanting to stop and fearing change)
* The progression from "solution" to prison

**3. Binge Eating Disorder (BED): When Food Becomes the Escape**

**DSM-5-TR Diagnostic Criteria:**

**Criterion A:** Recurrent episodes of binge eating characterized by BOTH:

1. Eating, in a discrete period, an amount of food that is definitely larger than what most people would eat in a similar period under similar circumstances
2. A sense of lack of control over eating during the episode

**Criterion B:** 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 when not feeling physically hungry
4. Eating alone due to embarrassment about how much one is eating
5. Feeling disgusted with oneself, depressed, or very guilty afterward

**Criterion C:** Marked distress regarding binge eating is present

**Criterion D:** Binge eating occurs, on average, at least once weekly for 3 months

**Criterion E:** Binge eating is NOT associated with recurrent compensatory behavior (as in bulimia nervosa) and does not occur exclusively during anorexia nervosa or bulimia nervosa

**Severity Specifiers:**

* **Mild:** 1-3 binge episodes per week
* **Moderate:** 4-7 binge episodes per week
* **Severe:** 8-13 binge episodes per week
* **Extreme:** 14+ binge episodes per week

**Clinical Presentation—Beyond the Stereotype:**

**CRITICAL UNDERSTANDING:** BED is NOT defined by body weight or size. While media often portrays BED as only affecting people in larger bodies, this is both inaccurate and harmful. BED occurs across the entire weight spectrum. The diagnosis is based on behavior patterns and psychological distress, not BMI.

**Physical Signs (when present—may vary widely):**

* Weight may be stable, increasing, or fluctuating
* If in higher weight category, may experience weight-related medical conditions (type 2 diabetes, hypertension, sleep apnea, cardiovascular disease)
* Gastrointestinal discomfort and symptoms
* Fatigue
* Joint pain (if carrying excess weight)
* Sleep disturbances

**Cognitive/Psychological Manifestations:**

* **Loss of control:** Core feature—feeling unable to stop eating or control what/how much is eaten
* **Emotional eating:** Using food to manage feelings (stress, anxiety, sadness, loneliness, boredom, anger)
* **Shame and self-loathing:** Intense shame about eating behaviors and often about body
* **Negative body image:** Body dissatisfaction, often internalized weight stigma
* **All-or-nothing thinking:** "I've already blown it, so I might as well eat everything"
* **Preoccupation with food and weight:** Constant thoughts about eating, weight, dieting
* **Depression and anxiety:** High rates of comorbid mood disorders
* **Low self-esteem:** Often related to weight and eating but extending to overall self-worth
* **Sense of being out of control:** Not just with food but often in other life areas
* **Diet mentality:** History of repeated dieting, weight cycling

**Behavioral Patterns:**

**Binge Episodes:**

* Eating large amount of food in discrete period (often 2 hours or less)
* Eating much more rapidly than normal
* Often eating past comfortable fullness to painful distension
* Eating when not physically hungry (eating driven by emotions, not hunger)
* Eating alone due to embarrassment
* Planning binges (buying specific foods, waiting until alone)
* Hiding evidence (wrappers, containers)
* Eating continues despite discomfort

**Between Episodes:**

* Attempts to restrict or diet
* Grazing (continuous eating throughout day)
* Secretive eating
* Hoarding food
* Shopping for large quantities of food
* Avoiding social situations involving food
* Isolating due to shame

**The Absence of Compensation:** Unlike bulimia nervosa, individuals with BED do NOT regularly engage in compensatory behaviors (purging, fasting, excessive exercise). This is a key diagnostic distinction. However, this doesn't mean BED is "less serious"—the psychological distress and medical risks (when present) are significant.

**Social/Interpersonal Patterns:**

* Social withdrawal and isolation
* Difficulty with intimacy (shame about body and behaviors)
* Avoidance of situations where body might be judged (beaches, pools, gym)
* Avoiding situations involving food due to fear of loss of control
* Experiences of weight stigma and discrimination in healthcare, workplace, social settings
* Internalized weight bias

**Extended Clinical Vignette—Binge Eating Disorder:**

*Michael, 45, enters Dr. Rodriguez's office after his physician recommended therapy for "stress eating and depression." He appears uncomfortable, settling heavily into the chair and avoiding eye contact.*

*Dr. Rodriguez: "Michael, your doctor thought therapy might be helpful. What's been going on?"*

*Michael: [hesitant] "My doctor thinks I have... a binge eating problem. I don't know. I just eat too much sometimes. It's not like I'm throwing up or anything serious like that."*

*Dr. Rodriguez: "Tell me about your eating. What happens when you 'eat too much'?"*

*Michael: "It's usually at night. I work long hours—I'm a CPA, and tax season just ended, but honestly, it's stressful year-round. I come home exhausted, and my wife and kids have already eaten. I tell myself I'll just have a normal dinner, but then..."*

*Dr. Rodriguez: "Then what happens?"*

*Michael: [voice dropping] "I can't stop. I start with dinner—maybe a full plate of pasta. But it doesn't satisfy me. So I have seconds. And then I'm looking in the fridge, the pantry. I eat leftover pizza, ice cream, a bag of chips, cookies, whatever's there. I'm eating standing up, shoving food in my mouth. My wife has walked in a few times and the look on her face... she's horrified."*

*Dr. Rodriguez: "What are you feeling during these episodes?"*

*Michael: "Nothing. That's the thing. All day I'm stressed about work, worried about money, feeling inadequate as a husband and father. But when I'm eating, my brain shuts off. There's no thoughts, no feelings. It's just... numb."*

*Dr. Rodriguez: "And after?"*

*Michael: [angry at himself] "I feel disgusting. I look down and see all the empty containers and I can't believe I ate all that. I'm so full I can barely move. I feel sick. And then the self-hate comes. I look in the mirror and see this fat, pathetic man who can't even control himself around food. I promise myself tomorrow will be different, but tomorrow never is."*

*Dr. Rodriguez: "How often is this happening?"*

*Michael: "Five, six times a week? More during particularly stressful times. Last month during audit season, it was every single night, sometimes multiple times—once after work and again before bed."*

*Dr. Rodriguez: "You mentioned this started during stressful periods. When did you first notice this pattern?"*

*Michael: "College, I think. I was pre-med, super high pressure. Food was the only thing that gave me relief. I'd study for hours, stressed out of my mind, then I'd order two pizzas and eat them both. It felt good in the moment. After college it got better for a while, but then it came back worse when I started working. Now it's my main coping mechanism."*

*Dr. Rodriguez: "So for about 20 years, food has been your way of managing stress and difficult emotions."*

*Michael: "Yeah. And I've gained probably 80 pounds in that time. My doctor says I'm pre-diabetic now. My blood pressure is high. I can't play with my kids without getting winded. I'm embarrassed by how I look. People at work probably think I'm lazy and undisciplined. My wife tries to be supportive, but I know she's frustrated."*

*Dr. Rodriguez: "Have you tried to change this pattern?"*

*Michael: [bitter laugh] "Are you kidding? I've tried every diet. Keto, paleo, Weight Watchers, Jenny Craig, medical weight loss programs. I lose weight, feel good for a while, then something stressful happens and I'm right back to bingeing. I've probably lost and regained the same 60 pounds five times. Each time I gain it back, I feel like more of a failure."*

*Dr. Rodriguez: "That cycle of restriction and bingeing is actually very common with binge eating disorder. When you diet and deprive yourself, it sets up conditions for bingeing—both physically, because your body is hungry, and psychologically, because restriction feels like deprivation."*

*Michael: "So you're saying dieting makes it worse?"*

*Dr. Rodriguez: "Often, yes. The solution isn't another diet—it's understanding what's driving the bingeing, learning new ways to manage stress and emotions, and normalizing your relationship with food. What you're describing—eating large amounts of food, feeling out of control, eating when not hungry, eating alone due to shame, feeling intense distress afterward—these are all signs of binge eating disorder."*

*Michael: "I thought eating disorders were a teenage girl thing. I'm a middle-aged man."*

*Dr. Rodriguez: "That's a common misconception. Binge eating disorder is actually the most common eating disorder, affecting people of all genders, ages, and body sizes. Men make up a significant percentage of BED cases. It's just that cultural stereotypes prevent recognition and treatment."*

*Michael: [emotional] "I feel so ashamed. I'm an adult. I should be able to control this. My son is watching me and I'm terrified he's going to inherit my lack of self-control."*

*Dr. Rodriguez: "Michael, this isn't about willpower or self-control. Binge eating disorder is a psychological condition driven by how you're managing stress and emotions. The bingeing serves a function—it temporarily relieves stress and uncomfortable feelings. The work isn't about controlling yourself more; it's about understanding what's driving the behavior and developing healthier coping strategies."*

*Michael: "Can it really change after 20 years?"*

*Dr. Rodriguez: "Yes. With the right treatment—which involves cognitive-behavioral therapy, emotion regulation skills, addressing the underlying factors, and working with a dietitian to normalize eating—people recover from binge eating disorder. You can break this cycle and develop a healthier relationship with food. But it requires addressing not just the eating, but also the stress, the perfectionism, the self-criticism, and the emotions you've been using food to manage."*

**Clinical Note:** This vignette demonstrates:

* Loss of control during binges (eating beyond fullness, eating when not hungry)
* Emotional eating function (managing stress, creating numbness)
* Absence of compensatory behaviors (distinguishing from BN)
* Shame and secrecy
* Eating alone due to embarrassment
* Significant psychological distress
* Diet-binge cycle (restriction leading to bingeing)
* Male presentation (challenging stereotypes)
* Functional impairment (health, relationships, self-esteem)
* Long-standing pattern (20 years)
* Medical consequences (pre-diabetes, hypertension)
* Weight stigma internalization
* History of repeated failed diet attempts

**4. Avoidant/Restrictive Food Intake Disorder (ARFID): When Food Restriction Isn't About Weight**

**DSM-5-TR Diagnostic Criteria:**

**Criterion A:** An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on 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

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

**Criterion 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 one's body weight or shape is experienced

**Criterion D:** The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When occurring in the context of another condition, the severity exceeds that routinely associated with the condition

**Critical Diagnostic Distinction:**

ARFID is fundamentally different from anorexia nervosa in one crucial way: **the absence of body image disturbance and fear of weight gain.** People with ARFID restrict food, but NOT because they want to be thin or fear being fat. Understanding this distinction is essential for appropriate treatment.

**The Three ARFID Presentations:**

**Presentation 1: Sensory-Based Avoidance**

* Extreme sensitivity to food textures, tastes, temperatures, smells, or appearance
* Often begins in early childhood and persists
* Limited food repertoire (sometimes only 5-10 accepted foods)
* Avoidance of entire food groups based on sensory properties
* Physical gagging or vomiting response to non-preferred foods
* Often associated with sensory processing differences

**Common Sensory Triggers:**

* **Texture:** "Mushy," "slimy," "crunchy," "chewy" foods avoided
* **Temperature:** Only eating foods at specific temperatures
* **Mixed textures:** Avoiding foods with multiple textures (e.g., soup with vegetables)
* **Appearance:** Foods touching each other, certain colors avoided
* **Smell:** Hypersensitivity to food odors triggering nausea or disgust

**Presentation 2: Fear of Aversive Consequences**

* Intense fear of choking, vomiting, gastrointestinal pain, or allergic reaction
* Often triggered by specific traumatic experience (choking episode, severe vomiting illness, allergic reaction)
* Anxiety around eating leading to restriction
* Avoidance of foods perceived as "risky"
* May avoid solid foods entirely in severe cases
* Hypervigilance to body sensations while eating

**Common Feared Consequences:**

* Choking (particularly on meats, pills, foods requiring extensive chewing)
* Vomiting (often after illness experience like norovirus)
* Abdominal pain (if history of GI issues)
* Allergic reaction (even without true allergies)
* Food poisoning
* General feeling of illness after eating

**Presentation 3: Lack of Interest in Eating**

* Little to no appetite or interest in food
* Forgetting to eat
* Food not rewarding or pleasurable
* Eating feels like a chore
* May be related to other conditions (autism, ADHD, depression)
* Gets full quickly, finds eating effortful

**Clinical Presentation—The Complete Picture:**

**Physical Signs:**

* Low weight or failure to gain expected weight (children/adolescents)
* Nutritional deficiencies (iron, B vitamins, protein, etc.)
* Fatigue, weakness
* Poor growth (children)
* Delayed puberty (adolescents)
* Concentration difficulties
* Pale skin
* Cold intolerance
* Hair loss
* Dizziness

**Psychological/Behavioral Manifestations:**

* **Limited food variety:** Extremely narrow range of accepted foods
* **Meal rigidity:** Foods must be prepared specific ways, from specific places
* **Anxiety around meals:** Particularly new foods or social eating situations
* **Prolonged mealtimes:** Eating very slowly, small bites
* **Avoidance behaviors:** Not attending social events with food, bringing own food everywhere
* **Distress when challenged:** Anxiety or panic when encouraged to try new foods
* **Lack of body image concerns:** May actually WANT to gain weight
* **Social isolation:** Due to difficulty eating with others

**Common Comorbidities:**

* Autism spectrum disorder (high correlation)
* ADHD
* Anxiety disorders (particularly specific phobias, generalized anxiety)
* Obsessive-compulsive disorder
* Sensory processing disorder
* History of GI conditions
* Eosinophilic esophagitis

**Extended Clinical Vignette—ARFID:**

*Dr. Martinez meets with 13-year-old Tyler and his parents, Jessica and Mark, who appear exhausted and frustrated. Tyler sits quietly, looking anxious but not defiant.*

*Dr. Martinez: "Thank you for coming in. Tyler, your parents shared some concerns about eating, but I'd like to hear from you. What's your experience with food?"*

*Tyler: [quietly] "I know I don't eat much. My parents think I'm being difficult, but I'm not trying to be. Most foods just... I can't eat them."*

*Jessica: [frustrated] "He's been like this since he was a toddler. We thought he'd outgrow it, but it's gotten worse. He literally eats maybe ten foods total. That's it."*

*Dr. Martinez: "Tyler, can you tell me what foods you do eat?"*

*Tyler: "Um... plain chicken nuggets, but only from McDonald's, not other places. French fries. Plain pasta with butter. White bread. Apples, but they have to be cut up, no peel. Goldfish crackers. Milk. That's pretty much it."*

*Mark: "What happens if we try to get him to eat something else? Complete meltdown. Last week his grandmother made him a sandwich with wheat bread instead of white, and he couldn't eat it. He gagged just looking at it."*

*Dr. Martinez: "Tyler, what happens when you try to eat foods that aren't on your safe list?"*

*Tyler: [becoming emotional] "I want to eat other foods. I really do. But when I look at them, or smell them, or try to put them in my mouth, I just... can't. Like, if there's a casserole with everything mixed together, the texture makes me want to throw up. Or if I try to eat meat that's not chicken nuggets, it feels like it's going to make me choke. I've tried. It doesn't work."*

*Dr. Martinez: "It sounds really distressing for you. Is there a particular texture or taste that's hardest?"*

*Tyler: "Mushy things are the worst. Yogurt, oatmeal, mashed potatoes—I can't even look at them without feeling sick. And anything with a weird texture, like tomatoes with the seeds and jelly inside. Or meat that's chewy. I had a choking incident when I was seven—a piece of steak got stuck in my throat and I couldn't breathe. Ever since then, I can't eat meat except nuggets."*

*Jessica: "The school called us because Tyler hasn't been eating lunch. He brings his food from home, but if we pack anything he's not comfortable with, he just doesn't eat. He's lost eight pounds in two months. His pediatrician is concerned."*

*Dr. Martinez: "Tyler, how do you feel about your weight?"*

*Tyler: [emphatic] "I hate being this thin! Kids at school make comments. I want to gain weight and be stronger. I want to be able to eat pizza like everyone else at parties. But I just can't make myself do it."*

*Dr. Martinez: "That's really important information. You're telling me you want to gain weight and eat more variety, but something is getting in the way. This is very different from anorexia, where someone is afraid of gaining weight. You're not afraid of weight gain; you're afraid of the eating itself—the textures, the choking risk, the sensations."*

*Tyler: "Exactly! My parents think I'm trying to lose weight, but I'm not. I just can't eat most things."*

*Mark: "So what is this? Is it just anxiety?"*

*Dr. Martinez: "What Tyler is describing sounds like ARFID—Avoidant/Restrictive Food Intake Disorder. It's an eating disorder, but not the kind most people think of. It's not about wanting to be thin or body image. Instead, it involves food avoidance due to sensory sensitivities and fear of negative consequences like choking. Tyler's traumatic choking experience likely made things worse."*

*Jessica: "But he's so thin now. Is this dangerous?"*

*Dr. Martinez: "Yes, it can be. Tyler's restriction is causing weight loss and likely nutritional deficiencies. We need to monitor him medically while we work on gradually expanding his food repertoire. But the approach is completely different from treating anorexia. With ARFID, we don't focus on body image or weight concerns—we focus on reducing anxiety around eating, addressing sensory sensitivities, and very slowly expanding the range of safe foods."*

*Tyler: "Will I have to eat things I can't stand?"*

*Dr. Martinez: "We'll work gradually, at a pace you can handle. The goal isn't to force you to eat foods that trigger strong reactions, but to help you develop strategies to tolerate new foods slowly over time. We'll also work with an occupational therapist who specializes in sensory issues. This isn't about willpower, Tyler. Your brain is genuinely responding to these foods as dangerous or intolerable. We need to help your brain learn that they're actually safe."*

**Clinical Note:** This vignette illustrates key ARFID features:

* Sensory-based avoidance (textures, mixed foods)
* Fear of aversive consequences (choking history)
* Very limited food repertoire (approximately 10 foods)
* **Absence of weight/body image concerns** (wants to gain weight, dislikes thinness)
* Medical consequences (weight loss, nutritional deficiencies)
* Psychosocial impairment (school lunches, social events)
* Long-standing pattern (since toddlerhood)
* Physical response to non-preferred foods (gagging, nausea)
* Significant distress for both client and family
* Often misunderstood as "picky eating" or anorexia

**5. Other Specified Feeding or Eating Disorder (OSFED) and Unspecified Feeding or Eating Disorder (UFED)**

**Other Specified Feeding or Eating Disorder (OSFED)**

This category includes eating disorders causing significant distress or impairment but not meeting full criteria for another diagnosis. The clinician specifies the reason.

**Common OSFED Presentations:**

**Atypical Anorexia Nervosa**

* All criteria for AN met EXCEPT individual's weight remains in or above normal range despite significant weight loss
* Psychological features identical to AN (fear of weight gain, body image disturbance, overvaluation of weight/shape)
* Can be equally serious as low-weight AN
* Medical complications can occur at any weight
* Often more difficult to diagnose due to weight bias

**Clinical Example:** *Rebecca, 24, has lost 70 pounds through severe restriction and excessive exercise. Her BMI dropped from 32 to 22—technically "normal" weight. She meets all psychological criteria for AN (intense fear of weight gain, body image disturbance, self-evaluation based on weight), but because her BMI is above 17, she doesn't meet full AN criteria. However, her medical complications (amenorrhea, bradycardia, osteopenia) and psychological suffering are identical to someone with low-weight AN.*

**Critical Clinical Point:** The term "atypical" is highly misleading and stigmatizing. This presentation is serious and requires full eating disorder treatment. Weight does NOT determine illness severity.

**Bulimia Nervosa (of low frequency and/or limited duration)**

* Meets all criteria for BN except frequency is less than once weekly or duration less than 3 months
* Still causing significant distress and impairment

**Binge Eating Disorder (of low frequency and/or limited duration)**

* Meets all criteria for BED except frequency is less than once weekly or duration less than 3 months
* Still causing significant distress

**Purging Disorder**

* Recurrent purging behavior to influence weight or shape
* NO binge eating episodes (purging after normal amounts of food)
* Example: Someone who vomits after every meal even though meals are normal-sized

**Night Eating Syndrome**

* Recurrent episodes of night eating (eating after awakening from sleep, or excessive food consumption after evening meal)
* Awareness and recall of eating
* Causes significant distress
* Not better explained by external factors or other disorders

**Unspecified Feeding or Eating Disorder (UFED)**

Used when symptoms cause clinically significant distress/impairment but don't meet criteria for specific diagnosis AND clinician chooses not to specify why (e.g., emergency settings, insufficient information).

**Critical Understanding About OSFED/UFED:**

**OSFED is NOT less serious than "full syndrome" eating disorders:**

* Mortality rates similar to AN and BN
* Medical complications equally severe
* Psychological distress equally intense
* Functional impairment equally significant
* Requires specialized eating disorder treatment

The "Other Specified" label reflects diagnostic criteria limitations, not illness severity.

**Epidemiology: Who Develops Eating Disorders?**

**Prevalence—The True Scope**

**Lifetime Prevalence Estimates:**

**Anorexia Nervosa:**

* Women: 0.9-2.0%
* Men: 0.3%
* Note: Likely underestimated due to underdiagnosis

**Bulimia Nervosa:**

* Women: 1.5-2.5%
* Men: 0.5%

**Binge Eating Disorder:**

* Women: 2.8-3.5%
* Men: 1.0-2.0%
* Most common eating disorder diagnosis

**ARFID:**

* Children/adolescents: 1.5-3.2%
* Adults: Less studied, but occurs across lifespan

**Any Eating Disorder:**

* Women: 8-13%
* Men: 2-5%
* Overall: Approximately **9% of global population** will experience an eating disorder in their lifetime
* Translates to nearly **30 million Americans**

**The Underdiagnosis Problem:**

These numbers significantly underestimate true prevalence because:

1. **Shame prevents help-seeking:** Many suffer in silence for years
2. **Diagnostic criteria miss many:** Thresholds (frequency, duration) exclude those suffering significantly
3. **Bias in recognition:** Providers less likely to diagnose in:
   * Males
   * People of color
   * People in larger bodies
   * Older adults
   * Lower socioeconomic groups
4. **Subclinical presentations:** Many struggle with disordered eating not meeting diagnostic thresholds but still suffering

**Gender Distribution—Beyond the Stereotype**

**The Reality:**

* Eating disorders affect all genders
* Women diagnosed more frequently, but this reflects bias as much as true prevalence
* **Men represent 25-30% of eating disorder cases**
* Non-binary and transgender individuals may have higher rates

**Why Men Are Underdiagnosed:**

**Stereotypes:** "Eating disorders are a girl thing"

* Clinicians less likely to screen males
* Males less likely to self-identify symptoms
* Males face stigma seeking help for "female problem"

**Diagnostic Criteria Bias:**

* Amenorrhea criterion (removed in DSM-5 but still influences thinking)
* Focus on thinness (males may pursue muscularity)

**Different Symptom Presentation:**

* Males more likely to focus on muscularity than thinness
* "Bigorexia" or muscle dysmorphia often unrecognized
* Exercise behaviors normalized for males

**Clinical Vignette—Male Eating Disorder:**

*Kevin, 32, a personal trainer, is referred by his physician for "overtraining." He appears muscular but gaunt, with visible veins and extremely low body fat.*

*Therapist: "Your doctor is concerned about your exercise and eating. Tell me about your routine."*

*Kevin: "I train clients all day, then I train myself for three hours. I eat clean—chicken, rice, vegetables. I track every macro. I'm just dedicated to my fitness goals."*

*Therapist: "What happens if you miss a workout or eat something off your plan?"*

*Kevin: "I can't. If I miss a workout, I feel anxious all day. If I eat something not on my plan, I'll add two hours of cardio to burn it off. I weigh myself six times a day. If I'm up even a quarter pound, I cut calories further."*

*Note: Kevin's presentation mirrors anorexia (severe restriction, compulsive exercise, fear of weight gain) but pursued through a "fitness" lens. This muscle-focused variant is often missed in males.*

**Age Distribution:**

**Peak Onset:**

* **Anorexia Nervosa:** 14-18 years (adolescence)
* **Bulimia Nervosa:** Late teens to early 20s
* **Binge Eating Disorder:** Early to mid-20s
* **ARFID:** Early childhood, though can persist to adulthood

**However:** Eating disorders can develop at ANY age

* Childhood: Increasingly recognized in children as young as 5-7
* Midlife: Women in 30s-50s developing eating disorders (often triggered by life transitions, divorce, children leaving home)
* Older adults: Eating disorders in 60s-70s+ (often overlooked, attributed to aging or dementia)

**Racial and Ethnic Diversity—Dispelling Myths**

**The Myth:** Eating disorders only affect white individuals

**The Reality:** Eating disorders occur across ALL racial and ethnic groups at **similar rates**

**Research Findings:**

* Black teenagers: **50% more likely** to exhibit bulimic behaviors than white teenagers
* Hispanic/Latinx individuals: Similar or higher rates of binge eating behaviors
* Asian American college students: Higher rates of body dissatisfaction and disordered eating than white peers
* Native American populations: Elevated eating disorder risk factors

**Why People of Color Are Underdiagnosed:**

1. **Provider Bias:**
   * Stereotypes that eating disorders are "white diseases"
   * Lower rates of screening in POC
   * Symptoms interpreted differently (e.g., restriction attributed to poverty rather than eating disorder)
2. **Cultural Differences in Expression:**
   * Different cultural body ideals may mask symptoms
   * Different meanings of food in cultural contexts
   * Acculturation stress contributing but not recognized
3. **Systemic Barriers:**
   * Less access to mental health services
   * Lower likelihood of referral to eating disorder treatment
   * Fewer culturally responsive treatment options
   * Insurance and financial barriers
4. **Research Bias:**
   * Most eating disorder research conducted with white samples
   * Assessment tools not validated across cultures
   * Cultural expressions of distress not captured

**Clinical Vignette—Cultural Considerations:**

*Jasmine, a 19-year-old Black college student, presents with binge eating and purging. Her previous therapist dismissed her concerns: "You don't look like you have an eating disorder. You seem healthy." This reflects dangerous bias—eating disorders don't have a "look."*

**Socioeconomic Diversity:**

**The Myth:** Eating disorders only affect affluent individuals

**The Reality:** Eating disorders occur across ALL socioeconomic levels

* Lower-income populations may have **higher** rates of binge eating disorder
* Food insecurity creates complex relationship with food
* Weight stigma disproportionately affects lower SES individuals
* Barriers to treatment greater for lower SES, not lower prevalence

**Sexual Orientation and Gender Identity:**

**Higher Risk Populations:**

**LGBTQ+ Individuals:**

* Gay and bisexual men: Higher rates of eating disorders than heterosexual men
* Lesbian and bisexual women: Similar or higher rates than heterosexual women
* Transgender individuals: Significantly elevated risk (approximately 4 times higher than cisgender individuals)

**Factors Contributing to Elevated Risk:**

* Minority stress
* Discrimination and stigma
* Body dissatisfaction related to gender dysphoria
* Pressure to conform to gender norms
* Lack of affirming healthcare

**Mortality and Morbidity—The Serious Consequences**

**Mortality Statistics:**

**Anorexia Nervosa:**

* Highest mortality rate of any eating disorder
* **5-10% mortality rate** (some studies show higher)
* **Standardized Mortality Ratio (SMR):** 5.86 (nearly 6 times higher than general population)

**Bulimia Nervosa:**

* SMR: 1.93 (nearly twice general population)
* Lower than AN but still significantly elevated

**Binge Eating Disorder:**

* Medical complications from associated conditions
* Suicide risk elevated

**Causes of Death:**

* **Medical complications:** 50% (cardiac arrest, electrolyte imbalances, organ failure, refeeding complications)
* **Suicide:** 25-30% (highest suicide rate of any psychiatric condition)
* **Substance abuse:** 10-25%

**Morbidity—Life-Altering Consequences:**

Beyond mortality, eating disorders profoundly impair:

* **Physical health:** Chronic medical conditions, irreversible damage (bone density loss, cardiac damage)
* **Cognitive functioning:** Memory problems, concentration difficulties, decision-making impairment
* **Emotional wellbeing:** Depression, anxiety, emotional dysregulation
* **Relationships:** Family conflict, social isolation, intimacy difficulties
* **Education/Career:** School failure, inability to work, career derailment
* **Quality of life:** Years of suffering, inability to engage in normal activities

**The Treatment Gap:**

Despite severity:

* Only **10-20%** of people with eating disorders receive treatment
* Average delay from symptom onset to treatment: **2-3 years**
* For some, delay exceeds 10 years
* Many never receive any treatment

**Etiology: The Biopsychosocial Model—Understanding How Eating Disorders Develop**

Eating disorders do not have a single cause. No one factor—not genetics, not culture, not trauma, not parenting—causes an eating disorder alone. Instead, eating disorders result from a complex interaction of biological vulnerabilities, psychological factors, and sociocultural influences, often triggered by specific life events or stressors.

**The Biopsychosocial Framework:**

Think of eating disorder development as a perfect storm:

* **Biological factors** create vulnerability
* **Psychological factors** shape how distress is experienced and managed
* **Sociocultural factors** provide the context and tools (diet culture, body ideals)
* **Triggering events** activate the disorder in vulnerable individuals

**Biological Factors—The Genetic and Neurobiological Foundation**

**1. Genetic Vulnerability**

**Strong Heritability:**

* Eating disorders are **50-80% heritable**—among the most heritable psychiatric conditions
* Twin studies: If one identical twin has AN, 50-70% chance other twin will develop it
* First-degree relatives of individuals with eating disorders: **7-12 times higher risk**
* Genetic overlap with other psychiatric conditions (anxiety, depression, OCD, substance use)

**What's Inherited?** Not eating disorders themselves, but:

* Temperamental traits (perfectionism, harm avoidance, impulsivity)
* Neurotransmitter differences
* Reward system functioning
* Emotion regulation capacity
* Sensitivity to stress

**Clinical Implication:** *Therapist to client: "You didn't choose to be vulnerable to an eating disorder, any more than someone chooses to be vulnerable to diabetes. Your genetics created a susceptibility. Understanding that removes blame and helps us focus on managing the condition you have."*

**2. Neurobiology—Brain Differences**

**Brain Structure Differences:**

Research shows differences in brain regions involved in:

**Insula (Interoception):**

* Processes internal body sensations (hunger, fullness, emotions)
* Differences in AN associated with difficulty recognizing hunger/fullness
* May explain distorted interoception

**Reward Circuitry (Striatum, Dopamine System):**

* Altered response to food rewards
* In AN: Food becomes less rewarding; restriction becomes rewarding
* In BED: Enhanced reward response to food, impaired inhibitory control

**Prefrontal Cortex (Cognitive Control):**

* Involved in decision-making, impulse control, flexibility
* Differences associated with cognitive rigidity, difficulty set-shifting
* Hyperactivity in some regions (overcontrol) in AN

**Amygdala (Fear/Anxiety):**

* Heightened activation in response to food, body images
* Contributes to anxiety around eating and weight gain

**Important Note:** We can't yet determine if brain differences:

* Precede eating disorder (vulnerability factors)
* Result from malnutrition (starvation effects)
* Are both cause and consequence

**3. Neurotransmitter Systems**

**Serotonin:**

* Involved in mood, impulse control, appetite regulation
* Low serotonin: Associated with depression, impulsivity (BN, BED)
* High serotonin: Associated with anxiety, rigidity (AN)
* Starvation affects serotonin, which may reinforce restriction in AN

**Dopamine:**

* Reward and motivation system
* Differences in dopamine functioning affect food reward
* May explain why some find restriction rewarding despite negative consequences

**Other Neurotransmitters:**

* Norepinephrine (stress response)
* GABA (anxiety regulation)
* Neuropeptide Y and Leptin (appetite regulation)

**4. Temperament and Personality Traits**

Certain temperamental traits increase vulnerability:

**For Anorexia Nervosa:**

* **Perfectionism:** Impossibly high standards, fear of mistakes, self-criticism
* **Harm avoidance:** Cautious, fearful, risk-averse
* **Obsessive-compulsive traits:** Need for order, symmetry, rituals
* **Cognitive rigidity:** Difficulty with flexibility, black-and-white thinking
* **Negative emotionality:** Prone to anxiety and worry

**For Bulimia Nervosa and Binge Eating Disorder:**

* **Impulsivity:** Difficulty controlling urges, acting without thinking
* **Novelty seeking:** Sensation-seeking, risk-taking
* **Negative urgency:** Acting impulsively when distressed
* **Emotional dysregulation:** Intense emotions, difficulty modulating

**These traits aren't chosen—they're largely innate, though shaped by experience.**

**Psychological Factors—The Internal Landscape**

**1. Emotion Regulation Difficulties**

**Core Pattern:**

* Difficulty identifying emotions (alexithymia)
* Difficulty tolerating distressing emotions
* Limited adaptive coping strategies
* Eating disorder behaviors as maladaptive emotion regulation

**How It Works:**

* Experience difficult emotion (anxiety, sadness, anger, loneliness)
* Lack skills to process emotion adaptively
* Turn to eating disorder behavior
* Behavior provides temporary relief (restriction creates numbness, bingeing creates distraction, purging creates release)
* Relief reinforces behavior
* Cycle deepens

**Clinical Dialogue:** *Therapist: "What was happening before you binged last night?"*

*Client: "I had a fight with my boyfriend. He said something that really hurt me."*

*Therapist: "What did you feel?"*

*Client: "I don't know... bad. Upset."*

*Therapist: "Can you be more specific? Sad? Angry? Hurt? Scared?"*

*Client: "I... I don't know. I just felt bad and I needed to make it stop."*

*Therapist: "And bingeing stopped the feeling?"*

*Client: "For a while. While I was eating, I wasn't thinking about the fight. I wasn't feeling anything. It was just... eating."*

**2. Low Self-Esteem and Negative Self-Evaluation**

**Pattern:**

* Core belief: "I am not good enough"
* Self-worth contingent on external factors (achievement, appearance, others' approval)
* Perfectionism attempting to compensate for feeling inadequate
* Self-criticism and harsh internal dialogue

**How Eating Disorders Develop:**

* Low self-esteem creates vulnerability
* Diet culture promises: "If you're thin/fit, you'll be worthy"
* Weight/shape become proxy for self-worth
* Control over eating/weight creates temporary sense of accomplishment
* But underlying worthlessness remains

**3. Perfectionism—The Double-Edged Sword**

**Features:**

* Impossibly high standards
* Fear of mistakes
* Self-worth contingent on achievement
* All-or-nothing thinking
* Never "good enough"

**In Eating Disorders:**

* Applied to eating, weight, exercise
* "Perfect" eating (orthorexia)
* Perfect body as goal
* Inability to tolerate imperfection drives escalation
* One deviation = complete failure = intensified restriction/purging

**Clinical Example:** *"I planned to eat 1200 calories. I ate 1250. I failed. So I binged—if I already failed, might as well really fail. Then I purged and resolved to eat only 1000 tomorrow to make up for it."*

**4. Trauma History**

**Elevated Trauma Rates:**

* **30-50%** of individuals with eating disorders report trauma history
* Types: Sexual abuse, physical abuse, emotional abuse, neglect, bullying, medical trauma, discrimination

**How Trauma Contributes:**

**Direct Mechanisms:**

* Eating disorders as attempt to cope with trauma
* Restriction: Numbing emotions, controlling body
* Bingeing: Dissociating from memories
* Purging: Expressing self-disgust, punishing body

**Indirect Mechanisms:**

* Trauma causes emotion dysregulation
* Trauma causes dissociation
* Trauma damages self-worth
* Trauma creates hypervigilance and anxiety

**Important Note:** Trauma doesn't cause eating disorders (many trauma survivors don't develop eating disorders), but it's a significant risk factor in vulnerable individuals.

**5. Body Image Disturbance**

**Beyond Dissatisfaction:** True body image disturbance involves:

* **Perceptual distortion:** Literally seeing body differently than it is
* **Cognitive distortion:** Overvaluing weight/shape, negative interpretation of appearance
* **Affective component:** Intense negative feelings about body
* **Behavioral component:** Avoidance or excessive checking

**Development:**

* Biological vulnerability (brain processing differences)
* Cultural messages about ideal bodies
* Personal experiences (teasing, comparison)
* Trauma (particularly sexual abuse)

**Sociocultural Factors—The Context**

**1. The Thin Ideal and Body Image Pressure**

**Cultural Beauty Standards:**

* Western culture idealizes thinness for women
* Idealization of leanness and muscularity for men
* Standards constantly narrowing (models, celebrities increasingly thin)
* Digital alteration creating impossible standards
* Multi-billion dollar diet/beauty industry profiting from insecurity

**Impact:**

* Normalization of body dissatisfaction ("normal to hate your body")
* Constant comparison to idealized images
* Body as project requiring work
* Worth determined by appearance

**Social Media Amplification:**

* Filters and editing creating false realities
* Comparison culture on steroids
* Pro-eating disorder content
* Influencer promotion of disordered eating as "wellness"

**2. Diet Culture—The Ubiquitous Context**

**What Is Diet Culture?** A system of beliefs that:

* Worships thinness and equates it with health and moral virtue
* Promotes weight loss as means of attaining higher status
* Demonizes certain foods while elevating others
* Oppresses people who don't match the thin ideal

**Diet Culture Manifestations:**

* 45 million Americans diet each year
* $70+ billion annual diet industry
* "Wellness" and "clean eating" disguising disordered eating
* Weight loss praised regardless of method
* Moralizing food ("good" foods vs. "bad" foods)

**How Diet Culture Contributes:**

* Normalizes restriction
* Provides socially acceptable entry to eating disorder
* Restriction praised and encouraged
* Recovery resisted (society says restriction is virtuous)

**Clinical Vignette:** *"Everyone at work is doing intermittent fasting and keto. My manager praised me when I started losing weight. Friends asked 'what's your secret?' I felt proud. But now I can't stop. What started as a diet became an obsession. I can't eat outside my window. I can't eat carbs without panic. I'm trapped, but everyone still congratulates me on my discipline."*

**3. Weight Stigma and Discrimination**

**Reality:**

* Pervasive anti-fat bias in society
* Discrimination in healthcare, employment, education, media
* Weight-based teasing and bullying
* Internalized weight stigma

**Impact on Eating Disorders:**

* Weight stigma motivates dieting
* Repeated dieting predicts eating disorders
* Internalized stigma creates body shame
* People in larger bodies with eating disorders face:
  + Delayed diagnosis ("just diet")
  + Dismissal of symptoms
  + Praise for restriction
  + Inadequate treatment

**4. Gender Norms and Expectations**

**Pressures on Women:**

* Appearance as primary value
* Thinness as femininity
* Taking up less space (literally and metaphorically)
* Self-sacrifice and others-focus

**Pressures on Men:**

* Muscularity as masculinity
* "Bulk up" pressure
* Appearance concerns stigmatized as "unmanly"
* Eating disorders shameful

**LGBTQ+ Specific Pressures:**

* Hypervigilance to appearance in some gay male communities
* Gender dysphoria and body dissatisfaction in transgender individuals
* Lack of representation of diverse bodies

**5. Sport and Performance Pressures**

**High-Risk Activities:**

* Appearance sports (gymnastics, figure skating, dance, cheerleading)
* Weight-class sports (wrestling, rowing, martial arts)
* Endurance sports (long-distance running, swimming)
* Any sport emphasizing thinness or leanness

**Risk Factors:**

* Pressure from coaches
* Weight requirements
* Revealing uniforms
* Performance tied to body
* Competitive culture

**Triggering Events and Precipitants—The Spark**

In vulnerable individuals, eating disorders often emerge following specific triggers:

**Common Triggers:**

**Life Transitions:**

* Moving away from home (college)
* Relationship changes (breakup, marriage)
* Career changes
* Becoming a parent
* Children leaving home (empty nest)

**Stressful Events:**

* Academic pressure
* Family conflict
* Loss or grief
* Financial stress
* Trauma

**Comments About Body/Weight:**

* Offhand remarks from peers, family, coaches
* Being teased or bullied about weight
* Medical providers focusing on weight
* Comparisons to siblings/peers

**Dieting:**

* Intentional weight loss (even if medically recommended)
* Diet praised and reinforced
* Initial restriction feels empowering
* Then spirals out of control

**Puberty and Developmental Changes:**

* Body changes during puberty
* Increased awareness of appearance
* Peer comparison intensifies
* Identity formation

**Illness or Injury:**

* Illnesses causing weight changes
* GI illnesses triggering fear of vomiting
* Injuries requiring time off sport
* Medical procedures

**The Biopsychosocial Integration—How It All Comes Together**

**Case Example: Sarah's Anorexia Nervosa**

**Biological Vulnerability:**

* Family history: Mother had subclinical eating disorder
* Temperament: Anxious, perfectionistic from early childhood
* Genetics: Inherited predisposition to anxiety

**Psychological Factors:**

* Perfectionism (straight-A student, never satisfied)
* Difficulty with emotions (described feelings as "overwhelming")
* Low self-esteem (despite achievements, felt "not good enough")
* Need for control (organized, rigid routines)

**Sociocultural Context:**

* Elite ballet dancer since age 5
* Constant feedback on body from instructors
* Social media exposure to thin ideal
* Competitive culture among dancers

**Trigger:**

* Age 14: Instructor commented "you're getting too curvy for lead roles"
* Started "eating healthy" to improve dancing
* Received praise for weight loss from instructor and peers
* Felt sense of accomplishment and control

**Development:**

* Initial restriction felt empowering
* Weight loss praised, reinforcing behavior
* As weight dropped, brain changes from starvation (increased rigidity, anxiety, obsessiveness)
* Food restriction became compulsive, not choice
* Identity fused with thinness
* Fear of weight gain intensified
* Full anorexia nervosa developed

**Maintenance:**

* Starvation causes brain changes that maintain disorder
* Restriction reduces anxiety temporarily (negative reinforcement)
* Weight loss provides sense of achievement
* Family accommodates (reducing expectations, providing special foods)
* Disorder serves function (control, numbing, identity)

**Why Understanding Etiology Matters Clinically:**

**1. Removes Blame:**

* Not caused by parents, vanity, or weakness
* Biological, psychological, social convergence
* Reduces guilt and shame

**2. Informs Treatment:**

* Address biological factors (nutrition, medication if needed)
* Address psychological factors (emotion regulation, perfectionism, trauma)
* Address social factors (family involvement, challenging diet culture)
* Multiple intervention points

**3. Explains Complexity:**

* Why it's not "just eat more" or "just stop purging"
* Multiple maintaining factors
* Requires comprehensive treatment

**4. Guides Prevention:**

* Identifying at-risk individuals
* Addressing modifiable risk factors
* Challenging diet culture and weight stigma

**Module 1 Quiz**

**Question 1:** A 16-year-old client presents with significant weight loss, intense fear of weight gain, and body image disturbance. However, despite losing 35 pounds, their BMI remains at 21 (normal range). Their psychological symptoms, medical complications (amenorrhea, bradycardia), and functional impairment are severe. According to DSM-5-TR, the MOST accurate diagnosis would be:

a) Anorexia Nervosa, as BMI is less relevant than psychological symptoms b) Other Specified Feeding or Eating Disorder (Atypical Anorexia Nervosa) c) Unspecified Feeding or Eating Disorder d) No eating disorder diagnosis, as weight is in normal range

**Answer: b) Other Specified Feeding or Eating Disorder (Atypical Anorexia Nervosa)**

*Explanation: This case illustrates "atypical" anorexia nervosa—all psychological and behavioral criteria for AN are met (restriction, fear of weight gain, body image disturbance), and there has been significant weight loss, but the individual's weight remains in the "normal" range based on BMI. This is diagnosed as OSFED (Atypical AN) rather than full AN because the weight criterion (significantly low body weight) is not met. However, "atypical" is a misnomer—this presentation is common and can be equally serious as low-weight AN. The psychological suffering, medical complications, and functional impairment are identical. This case highlights the danger of weight-based bias in eating disorder diagnosis. Option a is incorrect because diagnostic criteria require low weight for AN diagnosis. Option c is incorrect because we have sufficient information to specify the type. Option d is dangerously incorrect—this individual clearly has a serious eating disorder requiring full treatment despite "normal" weight. This scenario emphasizes that eating disorders occur across the weight spectrum and severity is not determined by weight alone.*

**Question 2:** Which of the following BEST differentiates Avoidant/Restrictive Food Intake Disorder (ARFID) from Anorexia Nervosa?

a) ARFID involves less severe restriction than Anorexia Nervosa b) ARFID includes sensory sensitivities to food textures, tastes, or fear of aversive consequences WITHOUT body image disturbance or fear of weight gain c) ARFID only occurs in children, while Anorexia Nervosa occurs in adolescents and adults d) ARFID doesn't cause medical complications, while Anorexia Nervosa does

**Answer: b) ARFID includes sensory sensitivities to food textures, tastes, or fear of aversive consequences WITHOUT body image disturbance or fear of weight gain**

*Explanation: The key distinguishing feature between ARFID and AN is the motivation for food restriction. In AN, restriction is driven by fear of weight gain, desire for thinness, and body image disturbance. In ARFID, restriction occurs due to sensory sensitivities (textures, tastes, smells), fear of aversive consequences (choking, vomiting), or lack of interest in eating—WITHOUT weight/shape concerns. Someone with ARFID may actually WANT to gain weight but cannot because they're unable to eat most foods due to sensory or anxiety issues. This distinction is clinically crucial because treatment approaches differ substantially: AN treatment must address body image and weight concerns, while ARFID treatment focuses on gradual exposure to avoided foods, addressing anxiety, or managing sensory sensitivities. Option a is incorrect—restriction in ARFID can be equally severe. Option c is incorrect—ARFID can occur across the lifespan, though it's often identified in childhood. Option d is incorrect—ARFID can cause serious medical complications including malnutrition, weight loss, and all associated medical risks. Understanding this distinction prevents misdiagnosis and ensures appropriate treatment.*

**Question 3:** Research on eating disorder etiology demonstrates that these conditions result from:

a) Poor parenting and family dysfunction b) Cultural pressure to be thin c) A biopsychosocial interaction involving genetic vulnerability, psychological factors (emotion regulation, perfectionism, trauma), and sociocultural influences (diet culture, weight stigma) d) Lack of willpower and self-control

**Answer: c) A biopsychosocial interaction involving genetic vulnerability, psychological factors (emotion regulation, perfectionism, trauma), and sociocultural influences (diet culture, weight stigma)**

*Explanation: Current research clearly demonstrates that eating disorders result from complex interactions among biological factors (50-80% heritability, neurobiological differences, temperament), psychological factors (emotion regulation difficulties, perfectionism, low self-esteem, trauma history), and sociocultural influences (thin ideal, diet culture, weight stigma), often triggered by specific life events. No single factor causes an eating disorder—it's the convergence of multiple vulnerabilities and influences. Option a reflects outdated "refrigerator mother" theories that have been definitively disproven and caused harmful blame of families. While family dynamics can influence eating disorder maintenance, they don't cause eating disorders, and families are crucial in recovery. Option b overemphasizes one sociocultural factor while ignoring biological and psychological components—diet culture contributes but doesn't cause eating disorders in everyone exposed to it. Option d reflects stigmatizing misconceptions that minimize the serious psychiatric nature of eating disorders and ignore genetic/neurobiological factors. Understanding the multifactorial etiology is essential for: (1) reducing blame and shame in clients and families, (2) informing comprehensive treatment addressing all contributing factors, (3) identifying multiple intervention points, and (4) guiding prevention efforts by addressing modifiable risk factors.*

**Module 2: Comprehensive Assessment and Differential Diagnosis**

**Duration: 60 minutes**

**The Foundation of Effective Treatment: Thorough Assessment**

Assessment is not merely a preliminary step before "real" treatment begins—it IS treatment. The assessment process establishes the therapeutic relationship, educates clients about their condition, enhances motivation, identifies maintaining factors to target, and literally can save lives by identifying medical risk requiring immediate intervention.

**Dr. Christopher Fairburn**, developer of Enhanced Cognitive Behavioral Therapy (CBT-E), emphasizes that eating disorder assessment must be **collaborative, comprehensive, and compassionate**—gathering extensive information while building alliance and avoiding overwhelming the client.

**The Unique Challenges of Eating Disorder Assessment**

**Unlike many mental health conditions, eating disorder assessment faces specific obstacles:**

**1. Denial and Minimization**

* Ego-syntonic nature: The disorder feels like part of identity, not alien
* Ambivalence about recovery: Simultaneous desire for help and terror of change
* Genuine inability to recognize illness severity due to cognitive effects of malnutrition

**2. Shame and Secrecy**

* Profound embarrassment about behaviors (especially bingeing and purging)
* Fear of judgment
* Shame about body and eating
* Years of hiding symptoms create ingrained secrecy

**3. Cognitive Impairment from Malnutrition**

* Starvation impairs memory, concentration, insight
* Difficulty processing information or making decisions
* May require repeating information multiple times
* Assessment findings may change as nutrition improves

**4. Medical Complexity**

* Requires understanding of medical complications beyond typical mental health scope
* Therapist must recognize warning signs requiring immediate medical attention
* Determining appropriate level of care requires medical knowledge

**5. Family Dynamics**

* Family members often desperate for help but may inadvertently reinforce symptoms
* Conflicting reports between client and family
* Need to assess family functioning and resources
* Different considerations for adolescents vs. adults

**Components of Comprehensive Eating Disorder Assessment**

**1. Clinical Interview: The Foundation**

The clinical interview serves multiple functions simultaneously:

* Gathering diagnostic information
* Building therapeutic alliance
* Educating client about eating disorders
* Assessing motivation and readiness for change
* Identifying maintaining factors
* Evaluating safety and determining level of care

**Essential Interview Domains:**

**A. Current Eating Patterns and Behaviors**

**Detailed Food Intake Assessment:**

*Clinical Dialogue Example:*

*Therapist: "I'd like to understand your typical eating day. Can you walk me through yesterday from when you woke up?"*

*Client: "I woke up at 7, had coffee. That's it for breakfast."*

*Therapist: "Just coffee—how much, and did you add anything to it?"*

*Client: "Two cups, black."*

*Therapist: "And then what happened throughout the morning?"*

*Client: "I went to work. I wasn't hungry."*

*Therapist: "Not feeling hungry—is that typical for you in the mornings?"*

*Client: "I'm never hungry in the morning anymore. I used to be, but not for the past year."*

*Therapist: "Interesting. So lunch time came—what happened then?"*

*Client: "I had a salad. Just lettuce, tomatoes, cucumbers. No dressing."*

*Therapist: "How much salad—can you estimate the size?"*

*Client: "Maybe two cups?"*

*Therapist: "Anything else with it? Protein? Bread?"*

*Client: "No, just the salad."*

*Therapist: "And between lunch and dinner?"*

*Client: "Nothing. I try not to snack."*

*Therapist: "What's your thinking about snacking?"*

*Client: "If I start snacking, I'll eat all day. It's easier to just not start."*

*Therapist: "So there's a fear that eating between meals would lead to loss of control. We'll come back to that. What about dinner?"*

*Client: "Grilled chicken—maybe 3 ounces—and steamed broccoli."*

*Therapist: "Anything else? Anything after dinner?"*

*Client: "No. I don't eat after 6 PM."*

*Therapist: "What's the rule about 6 PM?"*

*Client: "Eating late makes you gain weight. Everyone knows that."*

*Therapist: "So looking at the whole day—coffee, salad, chicken and broccoli. That's roughly 400-500 calories total. What are your thoughts about that amount?"*

*Client: [defensive] "It's enough. I'm not starving. I feel fine."*

**Critical Assessment Points from this Exchange:**

* Total intake dangerously low (~400-500 calories)
* Multiple food rules (no breakfast, no snacking, no eating after 6 PM, no dressing)
* Fear of loss of control with eating
* Denial of hunger (possible starvation-induced loss of interoception)
* Cognitive distortion about eating timing and weight gain
* Defensiveness when intake questioned
* Minimization of severity

**Assessing Binge Eating:**

*Therapist: "Tell me about a time when you felt you ate more than you intended."*

*Client: "Last Tuesday. I was doing well all day—just my usual—but then I got home and everything fell apart."*

*Therapist: "Walk me through what happened, step by step."*

*Client: "I walked in the door and immediately went to the kitchen. I ate half a jar of peanut butter with a spoon. Then I made a huge bowl of cereal—like three or four servings. Then I ate leftover pasta from the fridge. Then cookies. Then ice cream."*

*Therapist: "How long did this take?"*

*Client: "Maybe an hour? I wasn't really paying attention to time."*

*Therapist: "During this hour, how did you feel?"*

*Client: "At first, relief. Like all the tension from restricting all day just... released. But then I felt out of control, like I couldn't stop even when I wanted to. I was eating past the point of fullness, past comfortable, until my stomach hurt."*

*Therapist: "And during this, did you feel like you could have stopped if someone knocked on the door?"*

*Client: "Honestly? No. Even if someone knocked, I probably would have ignored it or hidden the food and continued after they left. It's like I was in a trance."*

*Therapist: "That sense of being unable to stop—of loss of control—is really important. And you mentioned this came after restricting all day. Do you see a connection?"*

*Client: "I guess... when I restrict, I eventually break. It's like a rubber band getting tighter and tighter until it snaps."*

**Assessment Points:**

* Clear binge episode (objective binge—amount definitely larger than normal)
* Loss of control (core feature of binge eating)
* Eating past comfortable fullness
* Dissociative quality ("trance")
* Restrict-binge cycle identified
* Client developing insight into pattern

**Assessing Purging Behaviors:**

*Therapist: "After eating, do you ever do anything to try to 'undo' what you ate or prevent weight gain?"*

*Client: [ashamed] "I make myself throw up."*

*Therapist: "I appreciate your honesty. I know that's difficult to talk about. How often does this happen?"*

*Client: "After most binges. Sometimes even after normal meals if I feel too full."*

*Therapist: "So we're talking about how many times per week?"*

*Client: "Five or six times, maybe more."*

*Therapist: "Can you walk me through how you do this? I know this feels uncomfortable to discuss, but understanding the specifics helps me help you."*

*Client: "I go to the bathroom, turn on the shower so no one hears, and I stick my fingers down my throat until I throw up. I keep going until there's nothing left."*

*Therapist: "How long does this take usually?"*

*Client: "Maybe 15-20 minutes total."*

*Therapist: "And after, how do you feel?"*

*Client: "Physically terrible—my throat burns, my eyes are bloodshot, I'm exhausted. But emotionally... relieved. The panic about the food is gone. For maybe ten minutes, I feel okay. Then the shame hits."*

*Therapist: "Have you noticed any physical changes from purging? Any medical symptoms?"*

*Client: "My teeth are sensitive—my dentist asked about acid erosion. My throat hurts a lot. And I have these calluses on my knuckles that won't go away."*

**Assessment Points:**

* Self-induced vomiting confirmed
* Frequency (5-6x/week = moderate severity bulimia nervosa)
* Method described
* Reinforcing function identified (temporary relief from anxiety)
* Physical complications present (dental erosion, throat pain, Russell's sign)
* Shame interfering with help-seeking

**Assessing Compensatory Exercise:**

*Therapist: "Tell me about your exercise routine."*

*Client: "I run 10 miles every day. No matter what. Rain, snow, if I'm sick—doesn't matter."*

*Therapist: "What happens if something prevents you from running?"*

*Client: [anxious] "That can't happen. It just can't."*

*Therapist: "But hypothetically, if you were injured and couldn't run?"*

*Client: "I'd do something else—bike, swim, weights. The point is I have to burn a certain number of calories every day."*

*Therapist: "What number are you aiming for?"*

*Client: "At least 1,000 calories burned through exercise."*

*Therapist: "And if you eat more than planned, does that change?"*

*Client: "Then I have to exercise more. If I ate an extra 300 calories, I need to burn an extra 300 calories."*

*Therapist: "So exercise is directly tied to food intake—it's compensating for eating."*

*Client: "I guess when you put it that way, yes."*

**Assessment Points:**

* Compulsive exercise (rigid, non-negotiable daily pattern)
* Excessive duration/intensity (10 miles daily)
* Compensatory function (burning calories to offset food)
* Inability to rest even when sick/injured
* Mathematical precision in compensation
* Anxiety when unable to exercise
* Exercise eclipsing other activities

**B. Weight and Shape Concerns**

**Assessing Body Image:**

*Therapist: "How much do you weigh? When did you last weigh yourself?"*

*Client: "This morning. 118 pounds. I weigh myself every morning."*

*Therapist: "Just once in the morning, or multiple times per day?"*

*Client: [hesitant] "Multiple times. Morning, after work, before bed, sometimes more."*

*Therapist: "What's your height?"*

*Client: "5'6".*

*Therapist: "So your BMI is about 19, which is in the normal range. What's your reaction to hearing that?"*

*Client: "It doesn't feel normal. I feel huge. When I look in the mirror, I see fat—on my stomach, my thighs, my arms."*

*Therapist: "So there's a disconnect between the objective data—BMI of 19—and how your body feels to you. You see 'fat' where the numbers say 'normal weight.' Tell me more about what you see in the mirror."*

*Client: "I see someone who's out of control. Someone who's let themselves go. I can see areas that are bigger than they should be."*

*Therapist: "When you say 'should be'—what's the ideal you're comparing yourself to?"*

*Client: "I don't know exactly. Just... smaller. When I was 110 pounds, I felt closer to acceptable. But even then, it wasn't enough."*

*Therapist: "So 110 wasn't enough. What weight would be enough?"*

*Client: [pause] "I don't think there is a weight that would feel enough. That's scary to realize."*

**Assessment Points:**

* Body image distortion (seeing "fat" at normal BMI)
* Overvaluation of weight/shape (weight determines self-worth)
* Frequent weighing (compulsive body checking)
* Moving target ("even at 110 it wasn't enough")
* Insight developing (realizing no weight would satisfy)

**Assessing Fear of Weight Gain:**

*Therapist: "What would happen if you gained 5 pounds?"*

*Client: [immediate anxiety] "I can't. I can't gain weight."*

*Therapist: "What specifically scares you about gaining weight?"*

*Client: "Everything would fall apart. I'd lose all control. People would see that I'm weak and disgusting. I'd become one of those people who just lets themselves go."*

*Therapist: "So weight gain represents loss of control, weakness, being disgusting, 'letting yourself go.' Those are powerful associations. Where do you think those connections come from?"*

*Client: "Society? Media? I don't know. I just know that being thin means being disciplined, in control, successful. And gaining weight means the opposite."*

**Assessment Points:**

* Intense fear of weight gain (core AN feature)
* Weight/control equation
* Moral judgment of weight ("weak," "disgusting")
* Internalized cultural messages
* All-or-nothing thinking (thin=good, weight gain=complete failure)

**C. Psychological Factors and Comorbidities**

**Assessing Emotion Regulation:**

*Therapist: "When you're feeling upset or stressed, what do you typically do?"*

*Client: "I don't know. I guess I restrict more. Or if it's really bad, I binge."*

*Therapist: "So restricting and bingeing serve emotional functions—they're ways of managing difficult feelings. Can you give me an example?"*

*Client: "Last week I had a huge presentation at work. I was terrified. The night before, I barely slept, and I couldn't eat at all that day. The thought of food made me nauseous. After the presentation—which actually went fine—I felt this overwhelming need to binge. I think it was releasing all that tension."*

*Therapist: "So restricting helped manage anticipatory anxiety, and bingeing released the tension afterward. What other ways do you have of managing stress or difficult emotions?"*

*Client: [long pause] "I can't think of any, really. Food is how I deal with everything."*

**Assessment Points:**

* Limited emotion regulation strategies
* Eating disorder behaviors serving emotional functions
* Alexithymia possible (difficulty identifying/describing emotions)
* Need to develop alternative coping skills

**Screening for Trauma:**

*Therapist: "Have you experienced any traumatic events—things like abuse, assault, accidents, or other events that felt overwhelming?"*

*Client: [tense] "Why does that matter for an eating disorder?"*

*Therapist: "Trauma and eating disorders often co-occur. Sometimes eating disorder behaviors develop as ways of managing trauma-related feelings or as attempts to gain control after experiencing powerlessness. Not everyone with an eating disorder has trauma history, but it's important to know if it's part of your experience."*

*Client: "I was sexually assaulted in college. I've never really dealt with it."*

*Therapist: "I'm sorry that happened to you. Do you notice any connection between the assault and your eating disorder?"*

*Client: "I started restricting right after. At the time, I told myself I was just trying to 'get healthy' after freshman year weight gain. But looking back... I think I was trying to disappear. To make my body less noticeable, less female, less... there."*

**Assessment Points:**

* Trauma history identified (sexual assault)
* Connection between trauma and eating disorder onset
* Eating disorder as trauma response (attempting to change/control body)
* Will need trauma-informed treatment approach
* May need integrated ED + trauma treatment

**Assessing Suicidality:**

*Therapist: "Have you had thoughts of harming yourself or ending your life?"*

*Client: "Sometimes I think it would be easier if I just... wasn't here anymore. But I wouldn't actually do anything."*

*Therapist: "Tell me more about those thoughts. When do they come up?"*

*Client: "When I've binged and purged multiple times in a day. When I feel completely out of control. When I hate myself so much I can't stand being in my own skin."*

*Therapist: "Have you ever made a plan or taken steps toward acting on those thoughts?"*

*Client: "No. They're just thoughts."*

*Therapist: "Have you ever attempted suicide in the past?"*

*Client: "Once, in high school. I took pills. I ended up in the hospital."*

**Assessment Points:**

* Current suicidal ideation (passive)
* Ideation linked to eating disorder behaviors (post-binge/purge)
* Previous suicide attempt (significant risk factor)
* Requires ongoing suicide risk monitoring
* May need higher level of care if risk increases

**D. Medical Status**

**Medical History and Current Symptoms:**

*Therapist: "Tell me about your overall health. Any medical conditions or concerns?"*

*Client: "My doctor says I'm healthy. My labs were mostly fine last time."*

*Therapist: "When was that?"*

*Client: "Maybe six months ago?"*

*Therapist: "And what did the doctor say about your weight?"*

*Client: "She said I should try to gain a few pounds. But she doesn't understand."*

*Therapist: "Have you noticed any physical symptoms? Dizziness, fainting, heart racing or slowing, digestive issues?"*

*Client: "I get dizzy when I stand up sometimes. And I'm cold all the time—I wear sweaters even in summer. My period stopped about four months ago."*

*Therapist: "Those are all concerning symptoms that suggest your body is struggling. The dizziness when standing is called orthostatic hypotension—it means your blood pressure drops when you change positions. Feeling cold constantly and loss of menstruation are both signs that your weight is too low for your body to function normally. Have you told your doctor about these symptoms?"*

*Client: "Not really. I didn't think they were a big deal."*

*Therapist: "They are a big deal. These symptoms tell us your body is in conservation mode—shutting down non-essential functions to preserve energy. You need medical monitoring. I'd like to coordinate with your physician to ensure you're medically safe while we work on the eating disorder."*

**Assessment Points:**

* Medical symptoms present (orthostatic changes, hypothermia, amenorrhea)
* Last medical assessment 6 months ago (too long)
* Client minimizing medical symptoms
* Need for immediate medical referral
* Coordination with physician essential

**E. Social and Functional Assessment**

*Therapist: "How is the eating disorder affecting your life? Your relationships, work, activities?"*

*Client: "I don't really see friends anymore. They want to go out to eat or get drinks, and I always make excuses. It's easier to just be alone."*

*Therapist: "So social isolation is happening. What about work?"*

*Client: "I can still function at work, but it's hard. I'm thinking about food and calories all day. Sometimes I can't concentrate in meetings because I'm calculating what I ate."*

*Therapist: "And activities you used to enjoy?"*

*Client: "I used to paint. I haven't touched my art supplies in over a year. The eating disorder takes up all my mental space. There's no room for anything else."*

**Assessment Points:**

* Significant social impairment (isolation)
* Occupational impairment (concentration difficulties)
* Loss of previously valued activities
* Preoccupation dominating mental life
* Quality of life severely diminished

**F. Motivation and Readiness for Change**

**Using Motivational Interviewing Principles:**

*Therapist: "What brings you to treatment now? What made you decide to seek help?"*

*Client: "My family is worried. My mom is threatening to make me go to residential treatment if I don't get help."*

*Therapist: "So part of what brought you here is family pressure. Is there any part of you that wants help for yourself?"*

*Client: [pause] "I'm tired. I'm tired of thinking about food every minute. I'm tired of lying to people about why I can't eat with them. I'm tired of feeling like crap all the time. But I'm also terrified of gaining weight."*

*Therapist: "So there are two parts—a part that's exhausted by the eating disorder and wants relief, and a part that's terrified of change, particularly weight gain. Both parts are real and valid. This ambivalence is completely normal. Most people feel this way."*

*Client: "Really? I thought I was supposed to want recovery fully before I could start treatment."*

*Therapist: "Not at all. We can work with ambivalence. In fact, understanding both sides—what the eating disorder costs you and what you fear about letting it go—is essential. Can you tell me more about what you'd lose if the eating disorder was completely gone?"*

*Client: "I'd lose... control. The eating disorder is the one thing I'm good at. Without it, I don't know who I'd be."*

*Therapist: "So the eating disorder provides identity and a sense of competence. Those are powerful functions. And what would you gain if it was gone?"*

*Client: "My life back, I guess. Friends. Energy. Being able to think about things other than food. Not being afraid all the time."*

**Assessment Points:**

* External motivation initially (family pressure)
* Ambivalence present (wants relief but fears change)
* Eating disorder serving functions (control, identity, competence)
* Client able to identify costs of disorder
* Normalizing ambivalence reduces shame
* Working with ambivalence rather than demanding full commitment

**2. Standardized Assessment Measures**

**Essential Instruments:**

**Eating Disorder Examination Questionnaire (EDE-Q)**

* 28-item self-report measure
* Assesses eating disorder psychopathology over past 28 days
* Four subscales: Restraint, Eating Concern, Shape Concern, Weight Concern
* Global score provides overall severity
* Free, widely used, well-validated
* Excellent for tracking treatment progress

**Sample Items:**

* "Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?"
* "Has thinking about food, eating, or calories made it very difficult to concentrate on things you are interested in?"
* "Have you had a definite fear of losing control over eating?"

**Interpretation:**

* Higher scores indicate greater eating disorder psychopathology
* Can compare subscale scores to identify primary concerns
* Repeat monthly to track progress
* Scores typically decrease with successful treatment

**Eating Attitudes Test (EAT-26)**

* Brief screening tool for eating disorder risk
* 26 items assessing dieting, bulimia/food preoccupation, oral control
* Score ≥20 indicates need for further evaluation
* Free, takes 5-10 minutes
* Useful in medical settings, colleges, community screening

**Sample Items:**

* "Am terrified about being overweight"
* "Avoid eating when I am hungry"
* "Find myself preoccupied with food"

**Body Shape Questionnaire (BSQ)**

* 34 items assessing body dissatisfaction and preoccupation
* Focus on concerns about body shape over past 4 weeks
* Particularly useful for tracking body image changes during treatment
* Higher scores indicate greater body dissatisfaction

**Comorbidity Screening:**

* **PHQ-9:** Depression screening (9 items)
* **GAD-7:** Anxiety screening (7 items)
* **PCL-5:** PTSD screening (20 items)
* **AUDIT:** Alcohol use screening
* **DAST:** Drug use screening

**Clinical Implementation:**

*Therapist: "I'd like you to complete this questionnaire—the EDE-Q. It asks about eating, weight, and shape concerns over the past month. There are no right or wrong answers. I'm looking for an honest picture of your experience. After you complete it, we'll review it together and it will help guide our conversation."*

[After client completes]

*Therapist: "I notice on item 12, you indicated you've felt fat 'every day' over the past month. Can you tell me more about that experience?"*

*Client: "I wake up feeling fat. I feel fat all day, no matter what I'm doing. It's like a constant background noise."*

*Therapist: "That sounds exhausting—having that thought loop running constantly. And on the subscales, your Shape Concern score is significantly elevated compared to your other scores. This suggests that concerns about body shape are particularly central for you right now. Does that match your experience?"*

*Client: "Yes. I think about my body shape constantly—how my clothes fit, how I look compared to others, whether certain poses make me look bigger."*

**3. Medical Assessment Coordination**

**While therapists don't conduct medical exams, ensuring medical assessment occurs is essential:**

**Initial Medical Evaluation Should Include:**

**Vital Signs:**

* Heart rate (resting)
* Blood pressure (sitting and standing for orthostatic assessment)
* Temperature
* Respiratory rate
* Weight and height (calculate BMI)

**Physical Examination:**

* Overall appearance and nutritional status
* Cardiovascular exam (heart sounds, peripheral pulses)
* Signs of purging (parotid enlargement, Russell's sign, dental erosion)
* Signs of malnutrition (lanugo, hair loss, dry skin, edema)
* Neurological exam (if indicated)

**Laboratory Studies:**

* Complete blood count (CBC)
* Comprehensive metabolic panel (electrolytes, kidney function, liver function, glucose)
* Thyroid function tests (TSH, T3, T4)
* Urinalysis
* Electrocardiogram (ECG)
* Bone density scan (if amenorrhea >6 months or other risk factors)

**Red Flags Requiring Immediate Medical Attention:**

**Vital Signs:**

* Heart rate <50 bpm (adults) or <45 bpm (adolescents)
* Blood pressure <90/60 mmHg
* Orthostatic increase in HR >20 bpm or decrease in BP >10-20 mmHg
* Temperature <96°F (35.5°C)
* Rapid weight loss (>2 lbs/week)

**Symptoms:**

* Syncope (fainting)
* Chest pain or palpitations
* Difficulty breathing
* Severe weakness
* Altered mental status
* Acute food refusal
* Uncontrolled purging

**Labs:**

* Potassium <3.0 mEq/L
* Phosphorus <3.0 mg/dL
* Prolonged QTc on ECG (>450 msec males, >470 msec females)
* Severe anemia

**Clinical Action When Red Flags Identified:**

*Therapist: "I'm very concerned about what you've told me. Your heart rate is 45 beats per minute, you've been fainting, and you're having chest pain. These symptoms indicate your body is in medical crisis. I need you to go to the emergency department today—either I can call an ambulance, or your parents can drive you, but this needs to happen now. I know this is scary and not what you want, but your life is at risk. What would feel most comfortable—ambulance or having your parents take you?"*

**4. Differential Diagnosis**

**Distinguishing Eating Disorders from Other Conditions:**

**Medical Conditions That Can Mimic Eating Disorders:**

**Hyperthyroidism:**

* Weight loss despite normal/increased appetite
* Differentiation: Labs show elevated thyroid hormones; no body image disturbance; no intentional restriction

**Inflammatory Bowel Disease (IBD - Crohn's, Ulcerative Colitis):**

* Weight loss, food avoidance due to GI symptoms
* Differentiation: Documented GI pathology on endoscopy; pain-driven food avoidance; no weight/shape concerns

**Celiac Disease:**

* Weight loss, food avoidance, malnutrition
* Differentiation: Positive celiac antibodies/biopsy; symptoms improve with gluten-free diet; no psychological eating disorder features

**Diabetes (Type 1):**

* Weight loss, altered eating patterns
* Differentiation: Elevated blood glucose; insulin manipulation (diabulimia) can co-occur with eating disorder

**Superior Mesenteric Artery Syndrome:**

* Vomiting after eating, food avoidance
* Differentiation: Anatomical finding on imaging; postprandial pain; develops secondary to weight loss, not primary cause

**Psychiatric Conditions:**

**Major Depression:**

* Appetite changes (increased or decreased), weight changes
* Differentiation: No body image disturbance; no fear of weight gain; eating changes are symptoms of depression, not driven by weight/shape concerns

**Obsessive-Compulsive Disorder (OCD):**

* Food rituals, contamination fears, symmetry needs
* Differentiation: Food rituals not driven by weight/shape concerns; part of broader OCD symptom pattern

**Psychotic Disorders:**

* Delusions about food (poisoned, contaminated), food refusal
* Differentiation: Delusional quality different from eating disorder beliefs; presence of other psychotic symptoms; food refusal based on delusional content

**Autism Spectrum Disorder:**

* Food restriction based on sensory sensitivities, rigidity
* Differentiation: Similar to ARFID (sensory-based), but ASD has broader social communication difficulties; no weight/shape concerns
* Note: ASD and eating disorders can co-occur

**Substance Use Disorders:**

* Weight loss, altered eating
* Differentiation: Weight loss secondary to substance use effects; eating normalizes with abstinence; no primary body image disturbance

**Overlapping/Comorbid Conditions:**

**Eating Disorder + Depression:**

* Very common (50-75% of individuals with eating disorders)
* Both require treatment
* Often depression improves with eating disorder treatment and weight restoration
* Sometimes requires additional antidepressant medication

**Eating Disorder + Anxiety:**

* Extremely common (60-70%)
* Social anxiety, generalized anxiety, OCD particularly common
* Anxiety often predates eating disorder
* May persist after eating disorder recovery, requiring continued treatment

**Eating Disorder + PTSD/Trauma:**

* 30-50% report trauma history
* Eating disorder may serve trauma-coping function
* Requires integrated or sequential treatment
* Trauma processing often deferred until weight/medical stability achieved

**Eating Disorder + Substance Use:**

* 30-50%, particularly in BN and BED
* Shared mechanisms (impulsivity, emotion dysregulation, reward sensitivity)
* Integrated treatment ideal
* Address both conditions simultaneously when possible

**Eating Disorder + Personality Disorders:**

* Particularly borderline, avoidant, obsessive-compulsive personality disorders
* Complicates treatment (affects alliance, impulse control, emotional regulation)
* May require adapted treatment approach (e.g., DBT for ED + BPD)

**5. Level of Care Determination**

**Matching Client to Appropriate Treatment Setting:**

**American Psychiatric Association (APA) Criteria:**

**Level 5: Inpatient Hospitalization**

* Medical instability requiring 24-hour medical monitoring
* Acute suicidal ideation with plan/intent
* Severe psychiatric comorbidity requiring hospitalization

**Medical Criteria:**

* HR <40 bpm
* BP <90/60 or orthostatic instability
* Temperature <96°F
* Rapid weight loss
* Severe electrolyte abnormalities
* ECG abnormalities
* Syncope
* Organ compromise

**Level 4: Residential Treatment**

* Medical stability insufficient for lower level
* Need for 24-hour structured supervision
* Inability to interrupt eating disorder behaviors in less restrictive setting
* Lack of safe living environment
* Insufficient response to lower level of care

**Typical Stay:** 30-90 days

**Level 3: Partial Hospitalization (PHP)**

* Medically stable but requires structured meal support
* Can manage overnight without 24-hour supervision
* Motivated to participate in intensive treatment
* Has adequate support at home

**Structure:** 6-8 hours/day, 5-7 days/week

**Level 2: Intensive Outpatient (IOP)**

* Medically stable
* Able to interrupt behaviors with support
* Needs more than weekly therapy
* Has adequate support system

**Structure:** 9-12 hours/week, typically 3-4 days

**Level 1: Outpatient**

* Medically stable
* Motivated for treatment
* Can manage meals and behaviors with weekly support
* Adequate support system

**Structure:** Individual therapy 1x/week, may include dietitian, psychiatrist

**Decision-Making Clinical Dialogue:**

*Therapist: "Based on our assessment—your BMI of 15.8, heart rate of 48, dizziness, and continued rapid weight loss despite outpatient treatment for three months—I'm recommending a higher level of care. Your medical symptoms indicate your body is struggling, and you've told me you can't interrupt the restricting even though you're trying. Have you heard of partial hospitalization or residential treatment?"*

*Client: "I can't do that. I have work. I have a life."*

*Therapist: "I understand this feels overwhelming. And right now, the eating disorder is preventing you from fully engaging in work and life anyway. You mentioned you can't concentrate at work, you're calling in sick frequently, and you've withdrawn from everything outside of work. Intensive treatment is actually the pathway back to those things, not away from them. Let's talk about what each level of care would look like."*

*Client: "How long would I have to be there?"*

*Therapist: "For PHP, you'd be there during the day—maybe 8 AM to 4 PM—and go home at night. This way you could potentially maintain some work commitments or arrange short-term medical leave. For residential, you'd be there 24/7, typically for 4-8 weeks. Which feels more feasible for you?"*

*Client: "Neither feels feasible. But if I had to choose... maybe PHP? At least I could sleep at home."*

*Therapist: "PHP is a good starting point. If you stabilize there, you'd step down to IOP, then back to outpatient. If you need more support, residential is an option. The goal is getting you the intensity of treatment you need right now. I'll help you research programs and figure out insurance coverage. Does that sound okay?"*

**Module 2 Quiz**

**Question 1:** During an eating disorder assessment, a client reports eating approximately 600 calories daily, but appears defensive and irritated when the therapist expresses concern about the inadequacy of this intake. The MOST therapeutically effective response would be:

a) Firmly tell the client they must eat more or they will need hospitalization b) Explore what's coming up for the client emotionally when their intake is questioned, while gently providing psychoeducation about nutritional needs c) Avoid mentioning the low intake to preserve the therapeutic relationship d) Immediately refer to a dietitian to handle all nutrition discussions

**Answer: b) Explore what's coming up for the client emotionally when their intake is questioned, while gently providing psychoeducation about nutritional needs**

*Explanation: This response balances necessary clinical information (the intake is medically concerning) with therapeutic sensitivity to the client's emotional response. When clients become defensive about eating, it often signals fear, shame, or the eating disorder's protective function being threatened. By exploring the emotional reaction ("I notice you're feeling uncomfortable when I ask about this—what's coming up for you?") while still providing factual information ("This amount isn't adequate to support your body's basic functions"), the therapist maintains alliance while not colluding with minimization. Option a is confrontational and likely to damage rapport without addressing underlying issues. Option c colludes with denial and fails in the therapist's responsibility to address medical risk. Option d inappropriately delegates assessment responsibility—while dietitians are essential team members, therapists must understand and assess eating patterns. The most effective approach validates the emotional experience while providing necessary reality testing and education.*

**Question 2:** A client's EDE-Q results show significantly elevated Shape Concern and Weight Concern subscales, while Restraint and Eating Concern subscales are in the normal range. This pattern MOST likely suggests:

a) The client is not experiencing a significant eating disorder b) The client is in recovery and symptoms are resolving c) Body image disturbance and weight preoccupation are present, but overt restriction may not yet be occurring, or the client may have binge eating disorder d) The assessment tool was completed incorrectly

**Answer: c) Body image disturbance and weight preoccupation are present, but overt restriction may not yet be occurring, or the client may have binge eating disorder**

*Explanation: The EDE-Q subscale pattern provides valuable clinical information about the focus of eating disorder psychopathology. Elevated Shape and Weight Concern with normal Restraint and Eating Concern suggests the client has significant body image disturbance and weight preoccupation without current high levels of dietary restriction or eating concern. This pattern can occur in several scenarios: (1) Early eating disorder development where body image issues precede behavioral symptoms, (2) Binge Eating Disorder where shape/weight concerns drive distress but restriction isn't the primary behavior, (3) Recovery from restrictive eating disorder where behavioral symptoms have improved but body image concerns persist, or (4) Atypical presentations. This pattern warrants further clinical exploration to understand the full picture. Option a is incorrect—significant body image disturbance alone can cause clinical impairment and may predict eating disorder development. Option b is possible but not the most likely explanation given no treatment context provided. Option d assumes error without clinical justification—this is a meaningful pattern requiring exploration.*

**Question 3:** When determining appropriate level of care for a client with anorexia nervosa, which combination of factors would MOST clearly indicate need for residential treatment rather than outpatient therapy?

a) BMI of 17.5, motivated for treatment, strong family support, no previous treatment b) BMI of 16, heart rate 52 bpm, failed two previous outpatient attempts, lives alone c) BMI of 18, moderate restriction, high anxiety, supportive roommate d) BMI of 15, motivated for recovery, lives with parents who can supervise meals

**Answer: b) BMI of 16, heart rate 52 bpm, failed two previous outpatient attempts, lives alone**

*Explanation: Level of care determination requires considering multiple factors: medical stability, psychiatric risk, motivation/treatment response, environmental supports, and previous treatment response. Option b presents the strongest case for residential treatment: (1) BMI of 16 indicates moderate malnutrition severity, (2) heart rate of 52 shows cardiovascular compromise requiring close monitoring, (3) failed outpatient attempts suggest intensity of outpatient care insufficient, and (4) living alone means no supervision or support for meal implementation. This combination indicates need for 24-hour structured environment with medical monitoring and meal support. Option a, despite lower BMI, shows positive prognostic factors (motivation, family support, no previous treatment failures) suggesting outpatient or PHP could be attempted first. Option c shows mild medical severity with adequate support. Option d shows more severe medical status but strong motivation and parental support that might allow for PHP with close medical monitoring. Level of care decisions require clinical judgment weighing all factors—medical status alone doesn't determine placement, but the combination in option b most clearly indicates residential need.*

**Module 3: Medical Complications and Multidisciplinary Collaboration**

**Duration: 60 minutes**

**Understanding the Medical Seriousness: Every System Affected**

Eating disorders are among the deadliest psychiatric conditions not because of psychiatric symptom severity alone, but because they profoundly affect every organ system in the body. Dr. Philip Mehler, an eating disorders medicine specialist, emphasizes: "Eating disorders are medical emergencies masquerading as psychiatric conditions."

**The Starvation Cascade:**

When the body doesn't receive adequate nutrition, it enters survival mode—a cascade of physiological adaptations aimed at preserving life but ultimately causing devastating damage:

1. **Metabolic rate slows** → Fatigue, cold intolerance, cognitive slowing
2. **Non-essential functions shut down** → Amenorrhea, decreased libido, growth stunting
3. **Fat stores depleted** → Body breaks down muscle for energy
4. **Muscle wasting** → Includes cardiac muscle (weakened heart)
5. **Organ systems compromise** → Multi-system failure in severe cases

**The Minnesota Starvation Experiment (1944-1945):**

Ancel Keys and colleagues studied semi-starvation in healthy male volunteers, providing crucial insights into starvation's psychological and physical effects:

**Findings:**

* Participants became obsessed with food (reading cookbooks, hoarding, constant food thoughts)
* Mood deteriorated (depression, irritability, anxiety, social withdrawal)
* Cognitive function declined (concentration problems, decision-making impairment)
* Bizarre eating rituals developed (diluting food, mixing strange combinations)
* Physical effects (edema, hair loss, sensitivity to cold, weakness)
* Effects persisted months after refeeding

**Clinical Implication:** Many "eating disorder symptoms" are actually starvation effects. This means:

* Food obsession is biological, not just psychological
* Cognitive rigidity improves with refeeding
* Mood symptoms may resolve with weight restoration alone
* Refeeding is therapeutic for psychological symptoms, not just physical health

**Cardiovascular Complications: The Leading Cause of Death**

**Bradycardia (Slow Heart Rate)**

**Mechanism:**

* Metabolic adaptation to conserve energy
* Decreased cardiac output
* Vagal tone changes

**Clinical Presentation:**

* Resting heart rate <60 bpm (adults), <50 bpm concerning
* May be asymptomatic or cause fatigue, dizziness, syncope
* Can progress to dangerous arrhythmias

**Assessment:** *Therapist checking in: "Have you noticed your heart beating more slowly? Any dizziness or fainting?"*

*Client: "My Apple Watch keeps alerting me that my heart rate is low—like 45 beats per minute. It happens even when I'm just sitting."*

*Therapist: "That's an important sign your body is struggling. Heart rate that low means your heart is working in slow motion to conserve energy. Have you shared this with your doctor?"*

**Hypotension (Low Blood Pressure)**

**Mechanism:**

* Reduced blood volume from dehydration
* Decreased cardiac output
* Vascular changes

**Clinical Presentation:**

* Blood pressure <90/60 mmHg
* Symptoms: Lightheadedness, dizziness, blurred vision, fatigue

**Orthostatic Hypotension**

**Definition:** Significant drop in BP or rise in HR upon standing

**Criteria:**

* HR increase >20 bpm, OR
* Systolic BP decrease >20 mmHg, OR
* Diastolic BP decrease >10 mmHg

**Clinical Significance:**

* More sensitive indicator of cardiovascular compromise than absolute vital signs
* Indicates inability of cardiovascular system to adjust to position changes
* High risk for falls, syncope

**Assessment Protocol:**

1. Measure BP and HR lying down (after 5 minutes rest)
2. Have client stand
3. Immediately measure BP and HR standing
4. Repeat at 1 minute and 3 minutes standing

*Therapist observing client stand up during session and sway:*

*Therapist: "I noticed you got dizzy standing just now. That happens a lot?"*

*Client: "Every time I stand up. I have to hold onto something for a minute until it passes."*

*Therapist: "That's orthostatic hypotension—your blood pressure drops when you stand because your body doesn't have enough reserves to adjust quickly. This is medically serious. When's your next doctor appointment?"*

**ECG Abnormalities**

**QTc Prolongation**

**Definition:** QTc interval >450 msec (males) or >470 msec (females)

**Mechanism:**

* Electrolyte abnormalities (low potassium, magnesium, calcium)
* Malnutrition effects on cardiac muscle
* Certain medications (many psych meds prolong QTc)

**Clinical Significance:**

* Risk for Torsades de Pointes (life-threatening arrhythmia)
* Sudden cardiac death
* Can occur even with normal electrolytes in severe malnutrition

**Arrhythmias**

**Types:**

* Premature ventricular contractions (PVCs)
* Atrial fibrillation
* Ventricular tachycardia
* Bradyarrhythmias

**Warning Signs:**

* Palpitations ("heart racing or skipping")
* Chest pain
* Shortness of breath
* Syncope

**Clinical Emergency Response:**

*Client during session: "My heart feels weird—like it's skipping beats and then racing."*

*Therapist: "I need you to go to the emergency room right now. Heart rhythm problems can be dangerous. I'm going to call your emergency contact to drive you, or would you prefer I call an ambulance?"*

*Client: "It's probably nothing—"*

*Therapist: "I understand you don't want to go to the ER, but irregular heartbeat in someone with an eating disorder is a medical emergency. This isn't optional. Your safety is the priority. Who can I call to take you?"*

**Gastrointestinal Complications**

**Gastroparesis (Delayed Gastric Emptying)**

**Mechanism:**

* Malnutrition causes stomach muscles to weaken
* Stomach empties very slowly
* Worsens during refeeding initially

**Symptoms:**

* Feeling full after small amounts
* Bloating, distension
* Nausea
* Upper abdominal discomfort

**Clinical Impact:**

* Makes refeeding difficult
* Client feels genuinely uncomfortable eating
* Can trigger restriction or purging
* Creates physiological reinforcement for eating disorder

**Management:**

* Smaller, more frequent meals
* Lower fat initially (fat slows emptying further)
* Adequate hydration
* Sometimes prokinetic medications
* Reassurance that symptoms improve with consistent nutrition

**Therapeutic Response:**

*Client: "I can't eat more. When I try, I feel like the food just sits in my stomach like a rock. I feel nauseous and bloated for hours."*

*Therapist: "What you're describing is real—it's called gastroparesis. When you've been restricting, your stomach muscles weaken and digestion slows way down. So you genuinely do feel uncomfortable when you eat. The paradox is that the only way to improve it is to keep eating consistently—your digestive system has to relearn how to function normally."*

*Client: "So it gets worse before it gets better?"*

*Therapist: "In some ways, yes. Early in refeeding, discomfort often increases. But typically within a few weeks of consistent eating, your digestive system adapts and the discomfort decreases significantly. It's temporary, even though it doesn't feel that way right now."*

**Superior Mesenteric Artery (SMA) Syndrome**

**Mechanism:**

* Fat pad between SMA and duodenum depletes with severe weight loss
* SMA compresses duodenum
* Partial bowel obstruction

**Symptoms:**

* Severe postprandial pain and vomiting
* Unable to tolerate eating
* Weight loss worsens (can't eat → lose more weight → syndrome worsens)

**Diagnosis:** Upper GI series or CT scan showing compression

**Management:**

* Nutritional support (may require NG tube or IV nutrition)
* Weight restoration usually resolves
* Surgery rarely needed

**Refeeding Syndrome: A Life-Threatening Complication**

**Definition:** Metabolic disturbances occurring when nutrition reintroduced after prolonged starvation

**Mechanism:**

1. During starvation, electrolytes shift from intracellular to extracellular spaces
2. Feeding triggers insulin release
3. Insulin drives glucose AND electrolytes (phosphate, potassium, magnesium) into cells
4. Serum electrolyte levels drop dangerously
5. Cellular processes dependent on these electrolytes fail

**Clinical Consequences:**

* **Hypophosphatemia** → Cardiac dysfunction, respiratory failure, rhabdomyolysis, neurological symptoms, death
* **Hypokalemia** → Cardiac arrhythmias, muscle weakness
* **Hypomagnesemia** → Seizures, arrhythmias

**Risk Factors:**

* BMI <16 kg/m²
* Minimal intake for >10 days
* History of alcohol abuse
* Rapid weight loss
* Baseline electrolyte abnormalities

**Prevention:**

* "Start low, go slow" with refeeding
* Begin at 30-40% of calculated needs, increase gradually
* Aggressive electrolyte supplementation (phosphate, potassium, magnesium)
* Close monitoring (daily labs initially)
* Thiamine supplementation

**Clinical Monitoring:**

*Medical provider to team: "We're starting refeeding at 1200 calories daily—about 40% of her needs. We'll increase by 200 calories every 3-4 days. We're supplementing phosphate, potassium, and magnesium preventively. Daily labs for the first week. Watch for edema, shortness of breath, confusion—any of these, call me immediately."*

**Purging-Related Complications**

**Electrolyte Imbalances from Self-Induced Vomiting**

**Hypokalemia (Low Potassium)**

**Mechanism:**

* Vomiting causes loss of stomach contents including hydrochloric acid and potassium
* Kidney compensation worsens potassium loss
* Metabolic alkalosis develops

**Clinical Consequences:**

* Cardiac arrhythmias (life-threatening)
* Muscle weakness, cramps
* Constipation
* In severe cases: paralysis, respiratory failure, cardiac arrest

**Critical Values:**

* Normal: 3.5-5.0 mEq/L
* Mild: 3.0-3.5 mEq/L
* Moderate: 2.5-3.0 mEq/L
* Severe: <2.5 mEq/L (medical emergency)

**Hyponatremia (Low Sodium)**

**Mechanism:**

* Water loading (drinking excessive water before/after purging)
* Free water retention

**Clinical Consequences:**

* Confusion, headache
* Seizures
* Cerebral edema
* Death in severe cases

**Esophageal Damage**

**Mallory-Weiss Tears:**

* Linear tears in esophageal mucosa from forceful vomiting
* Can cause bleeding (hematemesis)
* Usually heal with cessation of vomiting

**Boerhaave Syndrome:**

* Complete esophageal rupture
* SURGICAL EMERGENCY
* Presents with severe chest pain, fever, shock
* High mortality if not treated emergently

**Dental Erosion**

**Mechanism:**

* Stomach acid (pH 1-2) erodes tooth enamel
* Enamel doesn't regenerate

**Progression:**

* Early: Sensitivity to hot/cold/sweet
* Moderate: Yellow dentin visible through thinned enamel
* Advanced: Severe decay, tooth fractures, tooth loss

**Prevention:**

* Rinsing mouth with water (not brushing) after vomiting
* Fluoride treatments
* Cessation of purging

**Clinical Dialogue:**

*Dentist report to therapist: "Severe enamel erosion on lingual surfaces of upper front teeth. Pattern consistent with acid exposure from vomiting. Multiple cavities requiring treatment. Long-term prognosis poor if vomiting continues."*

*Therapist to client: "Your dentist shared concerns about acid erosion on your teeth from purging. This damage is permanent—enamel doesn't grow back. Right now it's causing sensitivity and cavities, but if purging continues, you could lose teeth. I know stopping feels impossible, but this is one of many reasons we're working on it."*

**Laxative Abuse Complications**

**"Cathartic Colon"**

* Chronic laxative use damages colon nerves and muscles
* Colon loses ability to function normally
* Severe, intractable constipation
* May become permanent even after laxative cessation

**Rebound Edema**

* When laxatives stopped, body retains fluid
* Can gain several pounds of water weight in days
* Terrifying for clients → triggers resumption of laxative use
* Temporary (usually resolves in 1-2 weeks)

**Management Dialogue:**

*Therapist: "We need to talk about stopping laxatives. I know that's scary—"*

*Client: "I can't. If I stop, I'll gain so much weight."*

*Therapist: "You'll gain water weight temporarily—usually 3-7 pounds that represents fluid retention, not fat. It's uncomfortable and scary, but it's temporary. Within 1-2 weeks, your body adjusts and the water weight comes off. But if you continue laxatives, you're damaging your colon in ways that might be permanent."*

*Client: "How do I deal with the constipation without them?"*

*Therapist: "We'll work with your dietitian on adequate fluids, fiber, and maybe stool softeners temporarily. Your doctor might prescribe something to help. But we need to taper off the laxatives rather than stopping abruptly. What's your current laxative use?"*

**Metabolic and Endocrine Complications**

**Amenorrhea (Loss of Menstruation)**

**Mechanism:**

* Hypothalamic suppression from energy deficit
* Decreased estrogen production
* Can occur at any weight with severe restriction

**Clinical Significance:**

* Marker of hormonal disruption
* Associated with bone density loss
* Can affect fertility

**Bone Density Loss**

**Mechanism:**

* Estrogen deficiency (from amenorrhea)
* Elevated cortisol from starvation stress
* Inadequate calcium and vitamin D intake
* Low body weight (reduced mechanical load on bones)

**Timeline:**

* Bone density loss can begin within 6 months of amenorrhea
* May be partially irreversible even with recovery
* Critical period: adolescence (peak bone mass development)

**Clinical Consequences:**

* Osteopenia (low bone density)
* Osteoporosis (very low bone density)
* Stress fractures
* Increased fracture risk throughout life

**Screening:**

* DEXA scan if amenorrhea >6 months or other risk factors
* Repeat annually if ongoing amenorrhea

**Treatment:**

* Weight restoration (most important)
* Adequate calcium (1200-1500 mg/day) and vitamin D
* Weight-bearing exercise (NOT excessive)
* **Oral contraceptives do NOT prevent bone loss** (common misconception)

**Clinical Explanation:**

*Client: "My period stopped six months ago, but my gynecologist put me on birth control pills to 'protect my bones.' So I'm fine, right?"*

*Therapist: "Unfortunately, that's a common misunderstanding. Birth control pills cause withdrawal bleeding that looks like a period, but they don't restore your actual hormone cycle or protect your bones. The only thing that protects bones is weight restoration and return of natural menstruation. The birth control is giving you a false sense of security."*

*Client: "So my bones are still at risk?"*

*Therapist: "Yes. Every month without your natural period is time your bones aren't getting the estrogen they need. In adolescence and young adulthood, you're supposed to be building peak bone mass—the bone density you'll have for life. We can't get that time back. This is one reason early treatment and weight restoration are so critical."*

**Neurological and Cognitive Complications**

**Brain Changes from Malnutrition**

**Structural Changes:**

* Brain volume loss (gray and white matter)
* Ventricular enlargement (brain shrinks, fluid-filled spaces expand)
* Visible on MRI

**Functional Consequences:**

* Cognitive impairment (memory, attention, processing speed, executive function)
* Emotional dysregulation
* Decision-making difficulties

**Reversibility:**

* Some recovery with weight restoration
* May not be complete, especially with prolonged illness
* Adolescent brains particularly vulnerable

**Clinical Implications:**

*Therapist: "I notice you're having trouble concentrating in session and remembering what we discussed last week. This is actually a neurological symptom of malnutrition—your brain isn't getting adequate fuel to function optimally. As you restore weight, cognitive function improves. This isn't something you can just try harder at—it's a biological consequence of inadequate nutrition."*

**Peripheral Neuropathy**

**Mechanism:**

* Vitamin deficiencies (particularly B vitamins)
* Direct malnutrition effects on nerves

**Symptoms:**

* Numbness, tingling in hands/feet
* Weakness
* Pain

**Reversibility:**

* May improve with nutrition and supplementation
* Can be permanent if prolonged

**Multidisciplinary Team Collaboration**

**The Essential Team Members:**

**1. Primary Care Physician or Eating Disorders Medicine Specialist**

**Role:**

* Medical monitoring (vital signs, labs, ECG)
* Managing medical complications
* Determining medical stability for level of care
* Medication management for medical issues
* Coordinating with all team members

**Communication frequency:**

* Weekly for high-risk clients
* Bi-weekly to monthly for stable clients
* Immediate communication for concerning changes

**2. Therapist (You)**

**Role:**

* Psychotherapy addressing psychological maintaining factors
* Motivational work
* Cognitive-behavioral interventions
* Trauma processing (when appropriate)
* Family therapy (when indicated)
* Coordinating overall treatment team

**3. Registered Dietitian (Specialized in Eating Disorders)**

**Role:**

* Nutritional assessment
* Meal planning
* Nutrition education
* Challenging food rules and diet mentality
* Supporting normalization of eating
* Food exposures

**What Dietitians Do NOT Do:**

* Tell clients exactly what to eat (unless in higher level of care with structured meal plans)
* Focus primarily on weight gain (focus on normalizing relationship with food)
* Promote "healthy eating" in ways that reinforce restriction

**Collaborative Example:**

*Dietitian to therapist: "Sarah is making progress with eating regular meals, but she's still avoiding all dairy and grains. She's intellectualized it as 'I'm lactose intolerant' and 'gluten sensitive' even though testing was negative. Can you address the anxiety underlying these rules?"*

*Therapist: "Absolutely. I'll explore the food rules in our next session and work on cognitive restructuring. Can you create some gentle exposure hierarchy for reintroducing these foods once she's psychologically ready?"*

**4. Psychiatrist**

**Role:**

* Evaluating for and treating comorbid psychiatric conditions
* Prescribing psychotropic medications when indicated
* Managing medication interactions
* Monitoring for medication effects on QTc, weight

**Medications in Eating Disorders:**

**Anorexia Nervosa:**

* No FDA-approved medications
* SSRIs may help with anxiety/depression/OCD, especially after weight restoration
* Atypical antipsychotics (olanzapine) sometimes used for severe anxiety, not first-line
* Avoid medications affecting appetite (bupropion contraindicated—lowers seizure threshold)

**Bulimia Nervosa:**

* Fluoxetine (Prozac) FDA-approved (60 mg dose)
* Other SSRIs may help
* Topiramate sometimes used off-label (reduces binge/purge frequency)

**Binge Eating Disorder:**

* Lisdexamfetamine (Vyvanse) FDA-approved
* SSRIs may help with comorbid depression/anxiety
* Topiramate off-label

**Important:** Medication is adjunctive, not primary treatment. Therapy is essential.

**5. Family (for adolescents and when appropriate for adults)**

**Role:**

* Providing support and supervision at home
* Implementing meal support
* Monitoring behaviors
* Participating in family therapy
* Creating recovery-supportive environment

**Effective Team Communication:**

**Team Meeting Structure:**

* Regular scheduled meetings (weekly for complex cases)
* Clear agenda
* Each discipline reports
* Collaborative treatment planning
* Unified message to client

**Sample Team Meeting:**

*Physician: "Sarah's vital signs are improving—heart rate up to 58, no orthostatic changes this week. Weight increased 1.2 pounds. Labs stable. Medically, she can continue at current level of care with weekly monitoring."*

*Dietitian: "She's following meal plan about 70% of the time. Still struggling with evening snack—says she's 'too full' but I think it's anxiety. Made progress reintroducing bread. Still avoiding all fats."*

*Therapist: "In session, she's starting to acknowledge the eating disorder's negative impact, which is progress. Still significant ambivalence. We're working on emotion regulation skills—she identified that evening snack resistance is about anxiety about 'losing control overnight.' I'll continue addressing that. Also starting to touch on perfectionistic thinking."*

*Psychiatrist: "No medication changes. Anxiety improving somewhat. Depression still moderate. Will reassess need for SSRI in two weeks if mood doesn't continue improving with nutrition."*

*Mom: "At home, she's more engaged with family. Mealtimes are still hard—she needs a lot of support and reassurance. She asked if she could eat lunch with her friends at school this week instead of coming home, which feels like progress."*

*Team: "That is progress. Let's support that—with safety plan if she struggles. Dietitian will review strategies with Sarah. Therapist will process in session."*

**Crisis Planning:**

**Team establishes criteria for immediate communication:**

* Vital signs meeting hospitalization criteria
* Suicidal ideation with plan/intent
* Significant medical symptom changes
* Complete food refusal
* Uncontrollable binge/purge cycle
* Any medical emergency

**After-hours protocol:**

* Emergency contacts for each team member
* Client/family has crisis numbers
* Protocol for ED vs. psychiatric emergency

**When to Refer to Higher Level of Care**

**Clinical Decision-Making:**

*Therapist internal deliberation: "Emma's been in outpatient for 12 weeks. Initial progress, but the last month she's lost 4 pounds instead of gaining, heart rate dropped to 48, she's restricting more, and she's isolating more. Outpatient isn't working. Time to discuss higher level of care."*

**Presenting to Client:**

*Therapist: "Emma, I need to talk with you about your progress. When we started 12 weeks ago, you were engaging well and we saw some positive changes. But over the past month, things have shifted—you've lost weight despite our work together, your heart rate is concerning, and you've told me the eating disorder voice is louder than ever. This tells me outpatient treatment isn't providing enough support right now. I'm recommending we consider partial hospitalization."*

*Emma: "No. I can do this. I'll try harder."*

*Therapist: "I know you're trying. This isn't about effort—it's about the intensity of support you need. Your eating disorder has strengthened while we've been meeting weekly. You need more structure, more frequent support, and daily medical monitoring. PHP would provide that. It doesn't mean you failed—it means you need a different level of care right now."*

*Emma: "Will I have to gain weight there?"*

*Therapist: "The goal is medical stabilization and interrupting the restriction. Yes, weight restoration will be part of treatment. I know that's frightening. And I also know that continuing as we are isn't working and is putting your health at serious risk. Let me explain what PHP looks like..."*

**Module 3 Quiz**

**Question 1:** A client with bulimia nervosa reports purging 5-7 times daily through self-induced vomiting. Lab results show potassium level of 2.8 mEq/L. The MOST immediate clinical action should be:

a) Continue outpatient therapy and recheck labs in two weeks b) Increase therapy sessions to twice weekly to address purging c) Refer for immediate medical evaluation as this represents a medical emergency d) Recommend the client drink electrolyte beverages

**Answer: c) Refer for immediate medical evaluation as this represents a medical emergency**

*Explanation: Potassium level of 2.8 mEq/L is significantly below normal range (3.5-5.0 mEq/L) and represents moderate to severe hypokalemia, which is a medical emergency. Hypokalemia from purging can cause life-threatening cardiac arrhythmias, muscle weakness, and in severe cases, respiratory failure or cardiac arrest. A potassium level below 3.0 mEq/L requires immediate medical intervention—typically hospitalization for IV potassium replacement and cardiac monitoring. The client cannot continue outpatient care safely with this level; attempting to manage this in outpatient therapy (option a or b) puts the client at risk for sudden death. While electrolyte beverages (option d) might be part of ongoing management, they're insufficient for this level of depletion, which requires medical treatment. The therapist's responsibility is to recognize this as a medical emergency and facilitate immediate medical care—calling the client's physician, sending to emergency department, or calling emergency services depending on circumstances. This scenario illustrates why therapists working with eating disorders must understand medical complications and know when psychiatric treatment must pause for medical stabilization.*

**Question 2:** Refeeding syndrome is MOST likely to occur in which scenario?

a) A client with binge eating disorder begins a structured meal plan with adequate calories b) A severely malnourished client with anorexia nervosa (BMI 14) rapidly increases caloric intake from 400 to 2500 calories daily c) A client in recovery from bulimia nervosa eliminates purging behaviors d) A client with ARFID gradually expands food variety with adequate total calories

**Answer: b) A severely malnourished client with anorexia nervosa (BMI 14) rapidly increases caloric intake from 400 to 2500 calories daily**

*Explanation: Refeeding syndrome occurs when nutrition is reintroduced too quickly after prolonged starvation, causing dangerous shifts in electrolytes (particularly phosphate, potassium, and magnesium). The scenario described in option b has multiple high-risk factors: (1) severe malnutrition (BMI 14), (2) prolonged inadequate intake (400 calories), and (3) rapid increase in calories (400 to 2500—a 525% increase). This rapid refeeding triggers insulin release that drives electrolytes into cells, creating potentially life-threatening serum deficiencies that can cause cardiac dysfunction, respiratory failure, seizures, and death. Safe refeeding requires "start low, go slow"—beginning at 30-40% of estimated needs and increasing gradually with aggressive electrolyte monitoring and supplementation. Option a involves adequate baseline calories without starvation. Option c involves behavioral change without nutritional deprivation. Option d describes gradual change with adequate nutrition throughout. Understanding refeeding syndrome is critical because well-meaning aggressive refeeding can be fatal; medical supervision during nutritional rehabilitation in severe malnutrition is essential.*

**Question 3:** In a multidisciplinary eating disorders treatment team, the PRIMARY role of the therapist is to:

a) Determine all meal plans and monitor nutritional intake b) Prescribe medications for comorbid psychiatric conditions c) Address psychological maintaining factors through psychotherapy while coordinating the overall treatment team d) Provide medical monitoring including vital signs and lab interpretation

**Answer: c) Address psychological maintaining factors through psychotherapy while coordinating the overall treatment team**

*Explanation: In multidisciplinary eating disorder treatment, each team member has a distinct but complementary role. The therapist's primary responsibilities include: (1) providing psychotherapy addressing psychological factors maintaining the eating disorder (emotion regulation, perfectionism, body image, trauma, etc.), (2) motivational work to address ambivalence about recovery, (3) implementing evidence-based interventions (CBT-E, DBT, etc.), (4) when indicated, family therapy, and (5) often serving as the coordinator who facilitates communication among team members and ensures integrated care. Option a describes the dietitian's role—determining meal plans, nutritional counseling, and monitoring nutritional adequacy; therapists should NOT prescribe specific meal plans as this is outside scope of practice. Option b describes the psychiatrist's role—psychiatric medication management. Option d describes the physician's role—medical monitoring, vital signs, lab work. While therapists should understand medical and nutritional aspects to recognize concerning changes and facilitate appropriate referrals, direct provision of medical or nutritional services is outside therapy scope. Effective multidisciplinary treatment requires each team member staying within their scope while maintaining clear communication and collaborative treatment planning.*

**Module 4: Evidence-Based Treatment Approaches**

**Duration: 90 minutes**

**The Foundation: What Works in Eating Disorder Treatment**

Unlike many areas of mental health where multiple theoretical approaches show similar efficacy, eating disorders research has identified specific interventions with strong empirical support. Dr. Christopher Fairburn emphasizes: "Not all psychotherapy is equally effective for eating disorders. Using evidence-based treatments significantly improves outcomes."

**Established Evidence-Based Treatments:**

1. **Cognitive Behavioral Therapy—Enhanced (CBT-E)**: Most robust evidence, particularly for bulimia nervosa and binge eating disorder; transdiagnostic approach
2. **Family-Based Treatment (FBT)**: Gold standard for adolescent anorexia nervosa
3. **Dialectical Behavior Therapy (DBT)**: Strong evidence for bulimia nervosa and binge eating disorder, especially with emotion dysregulation
4. **Interpersonal Psychotherapy (IPT)**: Effective for bulimia nervosa and binge eating disorder
5. **Enhanced Cognitive Behavioral Therapy with Appetite Awareness**: Specific to binge eating disorder

**Less Established but Promising:**

* Acceptance and Commitment Therapy (ACT)
* Cognitive Remediation Therapy (CRT)
* Radically Open DBT (RO-DBT) for anorexia nervosa

**Enhanced Cognitive-Behavioral Therapy (CBT-E)**

**Developed by:** Christopher Fairburn and colleagues at Oxford

**Theoretical Foundation:**

CBT-E is based on a cognitive-behavioral model proposing that eating disorders are maintained by:

1. **Overvaluation of weight and shape** → Core psychopathology driving other symptoms
2. **Dietary restraint** → Paradoxically increases binge eating risk
3. **Binge eating** → Maintains overvaluation and restraint through shame cycle
4. **Purging/Compensatory behaviors** → Reinforces binge eating and overvaluation
5. **Mood intolerance** → Events and moods trigger eating disorder behaviors
6. **Perfectionism** (in some)
7. **Low self-esteem** (in some)
8. **Interpersonal difficulties** (in some)

**Core Principle:** Address mechanisms maintaining the disorder, not just symptoms.

**Transdiagnostic Approach:**

CBT-E uses the same treatment protocol across eating disorder diagnoses (AN, BN, BED, OSFED) because:

* Maintaining mechanisms are similar
* Diagnostic migration is common (patients move between diagnoses)
* Core psychopathology (overvaluation of weight/shape) is shared

**Two Versions:**

**Focused CBT-E:**

* Addresses core eating disorder maintaining mechanisms only
* 20 sessions over 20 weeks (underweight patients: 40 sessions over 40 weeks)
* For patients where eating disorder is primary problem

**Broad CBT-E:**

* Addresses core mechanisms PLUS perfectionism, low self-esteem, or interpersonal difficulties
* Same duration, additional modules
* For patients where these factors significantly maintain eating disorder

**Treatment Structure:**

**Four Stages:**

**Stage 1: Starting Well (Sessions 1-8)**

* Twice-weekly sessions
* Engagement and psychoeducation
* Establishing regular eating
* Self-monitoring

**Goals:**

* Develop formulation (personalized maintaining mechanisms)
* Establish collaborative therapeutic relationship
* Psychoeducation about eating disorders and CBT-E
* Implement weekly weighing (therapist weighs, discusses reaction)
* Introduce regular eating pattern (3 meals + 2-3 snacks, no more than 3-4 hour gaps)
* Self-monitoring (food intake, context, thoughts, feelings)

**Clinical Dialogue—Session 1:**

*Therapist: "CBT-E is a specialized treatment for eating disorders. It's different from general therapy. We'll meet 20 times over 20 weeks—twice weekly for the first few weeks, then weekly. The focus is on the mechanisms keeping your eating disorder going, not on your past or your childhood, unless those directly relate to maintaining the eating disorder now. Does that make sense?"*

*Client: "So we won't talk about my family or my trauma?"*

*Therapist: "We'll talk about anything that's maintaining your eating disorder now. If family relationships or past trauma are currently driving eating disorder behaviors, we'll address that. But we won't do extensive trauma processing—that's better done after eating disorder recovery. The evidence shows that addressing maintaining mechanisms directly is most effective. Are you willing to try this approach?"*

*Client: "I guess. What do I have to do?"*

*Therapist: "You'll need to come to every session, complete regular self-monitoring—writing down everything you eat, when, where, and what you're thinking and feeling. You'll work on changing your eating patterns, starting with establishing regular eating. And you'll be weighed weekly here in session, which I know might be anxiety-provoking, but it's an important part of treatment."*

**Self-Monitoring Example:**

| **Time** | **Food/Drink** | **Location** | **V/L\*** | **Context (thoughts, feelings, events)** |
| --- | --- | --- | --- | --- |
| 8:00 AM | Black coffee | Kitchen |  | Anxious about work presentation. Not hungry. |
| 12:30 PM | Salad (lettuce, tomato, cucumber, no dressing) | Desk at work |  | Everyone else eating pizza. Feel superior that I didn't. |
| 3:00 PM | Apple | Desk |  | Starving. Debated eating chips but proud I chose apple. |
| 6:30 PM | Chicken breast (3oz), broccoli | Home alone |  | Measured everything. Feel safe. |
| 9:00 PM |  |  |  | Feel weak and dizzy. Hungry but it's too late to eat. |

\*V = Vomiting, L = Laxative use

*Therapist reviewing monitoring: "I notice several patterns here. You're eating only about 700 calories total—far below what your body needs. There are no carbohydrates—no bread, rice, pasta, grains. And there are gaps of 6+ hours between eating. These patterns maintain the eating disorder. One of our first goals will be establishing a regular eating pattern with adequate nutrition."*

**Stage 2: Taking Stock (Sessions 9-10)**

* Review progress
* Refine formulation
* Plan for Stage 3

**Joint Review:**

*Therapist: "Let's look at what's changed so far. You're eating three meals and two snacks most days—that's excellent progress. Your binge eating has decreased from daily to twice weekly. And you're able to eat with others without panic, which is huge. What do you notice?"*

*Client: "I do feel less obsessed with food. But I still can't eat carbs without freaking out. And I'm terrified about the weight I've gained."*

*Therapist: "Those are the exact areas we need to focus on in Stage 3—addressing the rules about carbs and working on your reaction to weight changes. You've built the foundation with regular eating. Now we tackle the harder parts."*

**Stage 3: Addressing Key Mechanisms (Sessions 11-17)**

**Core Interventions:**

**1. Addressing Dietary Restraint and Food Avoidance**

**Goal:** Eliminate rigid food rules; expand food variety

**Method:**

* Create hierarchy of feared/avoided foods
* Systematic exposure to feared foods
* Challenging food rules through behavioral experiments

**Clinical Dialogue:**

*Therapist: "Let's identify your food rules. What foods are completely off-limits?"*

*Client: "Bread, pasta, rice, potatoes, desserts, fried foods, cheese... pretty much everything."*

*Therapist: "And what's your belief about what would happen if you ate bread?"*

*Client: "I'd gain weight immediately. And once I started eating it, I wouldn't be able to stop. I'd eat the whole loaf."*

*Therapist: "Those are predictions we can test. Let's design an experiment. This week, I'd like you to include one serving of bread with a meal—maybe half a sandwich or a slice of toast with eggs. Then we'll monitor what actually happens. My prediction is different from yours. I predict you'll eat the planned amount, you won't gain weight from one serving, and you won't lose control. What do you think?"*

*Client: [anxious] "I don't think I can."*

*Therapist: "I understand you're scared. The eating disorder is screaming that this is dangerous. But think about this: you've been avoiding bread for three years based on fear, not evidence. We need data. If your predictions are correct, we'll know. If mine are correct, you'll have challenged a rule that's been controlling your life. Either way, we learn. Are you willing to try as an experiment?"*

**2. Addressing Overvaluation of Weight and Shape**

**Goal:** Reduce influence of weight/shape on self-evaluation

**Methods:**

* Identifying other domains of self-evaluation (relationships, work, values, etc.)
* Expanding self-worth beyond appearance
* Body checking reduction
* Addressing body avoidance
* Cognitive restructuring of appearance-based thoughts

**Body Checking Reduction:**

*Therapist: "You mentioned checking your body in the mirror multiple times daily, pinching your stomach, measuring your thighs. These checking behaviors seem like they'd reduce anxiety, but actually they maintain it. Each time you check, you're reinforcing the message that your body is the most important thing to monitor. This week, I'd like you to limit body checking to once daily for no more than 2 minutes—just enough to get dressed—and notice what happens to your anxiety."*

**Addressing Overvaluation:**

*Therapist: "If I asked 10 people who know you to describe you, what would they say?"*

*Client: "I don't know... maybe that I'm smart, reliable, a good friend?"*

*Therapist: "Would anyone mention your weight or body?"*

*Client: "Probably not."*

*Therapist: "So the people who know you best don't evaluate you based on your body. Yet you evaluate yourself almost entirely on weight and shape. What would it be like to evaluate yourself the way others see you—based on kindness, intelligence, reliability, being a good friend?"*

*Client: "It sounds nice, but I can't imagine it."*

*Therapist: "We'll work on it gradually. This week, I want you to notice when you judge yourself based on appearance, and practice instead identifying one non-appearance quality you brought to that situation."*

**3. Addressing Mood Intolerance**

**Goal:** Develop alternative strategies for managing difficult emotions

**Methods:**

* Identifying events and moods triggering eating disorder behaviors
* Developing emotion regulation skills
* Problem-solving skills
* Delaying use of eating disorder behaviors
* Alternative coping strategies

**Functional Analysis:**

*Therapist: "Let's map out what happened before last night's binge. What was the trigger?"*

*Client: "I got feedback from my boss that my project needed major revisions. I felt like a complete failure."*

*Therapist: "What emotion did you feel?"*

*Client: "Ashamed. Embarrassed. Worthless."*

*Therapist: "And then what happened?"*

*Client: "I came home, tried to distract myself, but I couldn't stop thinking about it. The feeling kept getting bigger. Finally I just went to the kitchen and started eating. And once I started, I couldn't stop."*

*Therapist: "So the binge served a function—it interrupted the shame and self-criticism. While you were eating, you weren't thinking about the feedback."*

*Client: "Exactly. For like 30 minutes, I didn't feel anything."*

*Therapist: "The binge makes sense as an emotion regulation strategy. The problem is it's a short-term solution with long-term costs. We need to develop alternative ways of managing shame and self-criticism that don't involve bingeing. What else might have helped in that moment?"*

**Alternative Coping Development:**

*Therapist: "Let's create a coping card for moments when you feel overwhelming shame or self-criticism. What are some things that might help?"*

*Client: "Maybe calling a friend? Or going for a walk?"*

*Therapist: "Good. What else? What about self-compassion—talking to yourself the way you'd talk to a friend who made a mistake at work?"*

*Client: "I've never thought of that."*

*Therapist: "Let's practice. If your friend told you her boss wanted revisions on her project, what would you say?"*

*Client: "I'd say that's normal, it doesn't mean she's a failure, revisions are part of the process."*

*Therapist: "Perfect. Can you say that to yourself? We're going to write out specific self-compassion statements you can use when the shame spiral starts."*

**4. Addressing Perfectionism (Broad CBT-E)**

When perfectionism maintains the eating disorder:

**Methods:**

* Identifying perfectionist standards
* Examining costs/benefits of perfectionism
* Behavioral experiments with non-perfect performance
* Developing more flexible standards

*Therapist: "Your perfectionism extends beyond food. You mentioned working 12-hour days, redoing projects multiple times, exercising 2 hours daily no matter what. What would happen if you allowed yourself to be 'good enough' instead of perfect?"*

*Client: "I'd be mediocre. Average. Nothing special."*

*Therapist: "That's the belief perfectionism creates—it's either perfect or worthless, nothing in between. But is that actually true? Can we test it?"*

**5. Addressing Low Self-Esteem (Broad CBT-E)**

**Methods:**

* Identifying core beliefs ("I'm unlovable," "I'm defective")
* Examining evidence for/against beliefs
* Behavioral experiments
* Developing self-acceptance

**Stage 4: Ending Well (Sessions 18-20)**

**Goals:**

* Consolidate progress
* Develop relapse prevention plan
* Prepare for ending therapy

**Relapse Prevention Planning:**

*Therapist: "Let's identify situations that might trigger setbacks after treatment ends. What are your high-risk situations?"*

*Client: "Stress at work. Relationship problems. Seeing triggering content on social media."*

*Therapist: "Good awareness. For each of these, what's your plan? When work stress increases, what will you do instead of restricting?"*

*Client: "Use the emotion regulation skills we practiced. Reach out to my support person. Make sure I'm still eating regularly even when stressed."*

*Therapist: "Exactly. And if you notice early warning signs—like wanting to weigh yourself more frequently or starting to skip snacks—what will you do?"*

*Client: "Come back for a booster session."*

*Therapist: "Yes. Recovery isn't linear. If you need support after we end, reaching out early is key."*

**CBT-E Outcomes:**

**Research findings:**

* **Bulimia Nervosa:** 50-60% recovery rate
* **Binge Eating Disorder:** 60-70% recovery (higher than BN)
* **Anorexia Nervosa:** 40-50% recovery (lower than other EDs but still substantial)
* Improvements maintained at long-term follow-up
* Transdiagnostic approach equally effective across diagnoses

**Family-Based Treatment (FBT) for Adolescent Anorexia Nervosa**

**Also called:** Maudsley Method

**Developed by:** Christopher Dare, Ivan Eisler, and colleagues; expanded by James Lock and Daniel Le Grange

**Key Principle:** Parents as resource, not cause

**Revolutionary shift from:** Blaming parents → Empowering parents as agents of recovery

**Theoretical Foundation:**

* Eating disorder is external to the adolescent (like a cancer or infection)
* Parents best positioned to help adolescent recover
* Adolescent's decision-making compromised by starvation
* Family reorganization around refeeding necessary
* As weight restores, adolescent can resume normal development

**Appropriate for:**

* Adolescents (typically 12-18 years)
* Anorexia nervosa or atypical AN
* Living with family
* Less than 3 years illness duration (though can adapt for longer)
* Family able to manage meal support

**Not appropriate for:**

* Severe family conflict or abuse
* Parent with active eating disorder or severe psychiatric condition preventing participation
* Adolescent with severe suicidality or psychosis

**Treatment Structure:**

**Three Phases (15-20 sessions over 6-12 months)**

**Phase 1: Parental Control of Refeeding (Sessions 1-10)**

**Goals:**

* Transfer control of eating from adolescent to parents
* Weight restoration begins
* Parents united in recovery efforts

**Key Intervention: Family Meal Session (Session 2)**

**Structure:**

* Family brings meal to session
* Therapist observes family interaction around eating
* Parents attempt to get adolescent to eat more than planned
* Therapist coaches parents in real-time

**Clinical Example—Family Meal Session:**

*Therapist: "Thank you for bringing lunch today. I'd like you to eat together as you would at home while I observe. Parents, I'd like you to see if you can get Sarah to eat a bit more than she planned."*

*[Sarah has brought a small container of plain salad. Parents have brought a sandwich and chips for her.]*

*Sarah: "I'm not eating that. I brought my food."*

*Mother: [to therapist] "See? This is what happens every meal. We can't make her eat."*

*Therapist: "I can see this is really hard. Sarah, the eating disorder is telling you this food is dangerous. Parents, your job is to help Sarah fight this. You need to work together to get her to eat the sandwich. Sarah needs you to be stronger than the eating disorder right now."*

*Father: [to Sarah] "Honey, you need to eat. Your body needs more than lettuce. Please, just take one bite of the sandwich."*

*Sarah: "No! Why are you doing this to me?"*

*Therapist: [to parents] "I know this feels terrible. She's saying you're hurting her, and you love her desperately. But the eating disorder has convinced her brain that food is dangerous. You're not hurting her—you're saving her life. Keep going. Work together."*

*Mother: "Sarah, we're not leaving until you eat half this sandwich. Your dad and I agree. We love you too much to let this eating disorder win."*

*[After 45 minutes of negotiation, support, and united parental front, Sarah eats half the sandwich.]*

*Therapist: "That was incredibly hard, and you did it. This is what needs to happen at every meal until Sarah's weight is restored and the eating disorder's voice quiets. Parents, you just proved you can do this. Sarah, I know that was excruciating, but your parents are fighting for you."*

**Phase 1 Core Strategies:**

**Parental Supervision of All Eating:**

* Parents determine what, when, how much adolescent eats
* Parents present united front
* Parents supervise all meals and snacks
* Initially, no unsupervised eating

**Externalizing the Eating Disorder:**

*Therapist: "It's not Sarah vs. you. It's all of you vs. the eating disorder. Sarah is trapped by this illness. When she says 'I'm not hungry' or 'I already ate,' that's the eating disorder talking, not Sarah. Your job is to help Sarah fight it."*

**Removing Blame:**

*Therapist: "Parents don't cause eating disorders. You didn't do anything wrong. And you're the ones best positioned to help Sarah recover. You know her, you love her, you can supervise meals. We need your strength."*

**Phase 2: Returning Control to Adolescent (Sessions 11-16)**

**Timing:** When weight is near target and eating less chaotic

**Goals:**

* Gradually return age-appropriate autonomy over eating
* Maintain weight
* Address other adolescent developmental issues

**Process:**

*Therapist: "Sarah's weight is now 95% of expected weight for her height and age. The chaos around meals has decreased significantly. It's time to start giving Sarah back some control. This doesn't mean no supervision—it means you're coaching from the sidelines instead of being on the field."*

*Parents: "What does that look like?"*

*Therapist: "Sarah might choose what to have for breakfast—with your guidance and within parameters. She eats unsupervised at school lunch but you check in. You're transitioning from directing every bite to helping her direct herself."*

**Phase 3: Establishing Healthy Adolescent Identity (Sessions 17-20)**

**Timing:** When weight maintained at healthy level and eating normalized

**Goals:**

* Address normal adolescent developmental issues
* Establish autonomous identity separate from eating disorder
* Terminate treatment

**Dialogue:**

*Therapist: "Sarah, you've achieved weight restoration and your eating is normalized. Now we focus on you being a 16-year-old, not an eating disorder patient. What are your interests? What do you want for your future? Who is Sarah when the eating disorder isn't in the way?"*

**FBT Outcomes:**

**Research findings:**

* **40-50% full remission** at end of treatment
* **60-75% full remission** at long-term follow-up (as adolescents continue recovery)
* Most effective when: illness duration <3 years, family able to participate, adolescent age
* Superior to individual therapy for adolescent AN

**Critical FBT Principles:**

1. **Agnostic about cause**: Don't waste time seeking cause; focus on solution
2. **Parents as resource**: Leverage parents' love and knowledge
3. **Non-authoritarian**: Therapist is consultant, not expert telling family what to do
4. **Externalization**: Eating disorder is the enemy, adolescent is the victim
5. **Behavioral focus**: Change behavior (eating) first; psychological insight follows

**Dialectical Behavior Therapy (DBT) for Eating Disorders**

**Adapted from:** Marsha Linehan's DBT for borderline personality disorder

**Key Developers for ED:** Debra Safer, Christy Telch, Eunice Chen

**Theoretical Foundation:**

Eating disorders (particularly BN and BED) involve emotion dysregulation:

* Difficulty identifying emotions
* Difficulty tolerating distressing emotions
* Intense, volatile emotions
* Limited effective coping strategies
* Eating disorder behaviors as attempts to regulate emotions

**DBT provides skills for emotion regulation without using eating disorder behaviors.**

**Appropriate for:**

* Bulimia nervosa
* Binge eating disorder
* Eating disorders with significant emotion dysregulation
* Eating disorders comorbid with borderline personality disorder
* Individuals with impulsive behaviors

**Less appropriate for:**

* Severe restriction/low weight (need weight restoration first)
* Anorexia nervosa restricting type (unless also significant emotion dysregulation)

**Treatment Structure:**

**Components:**

1. **Individual therapy** (weekly)
2. **Skills group** (weekly, 2-2.5 hours)
3. **Phone coaching** (between sessions for skill practice)
4. **Therapist consultation team** (for therapist support)

**Duration:** Typically 20 weeks (can extend to 40)

**Four Skill Modules:**

**1. Mindfulness**

**Goal:** Awareness and focus on present moment without judgment

**Skills:**

* **Observe:** Notice without words
* **Describe:** Put words to experience without judgment
* **Participate:** Fully engage in present activity
* **Non-judgmental stance:** Separate facts from opinions/judgments
* **One-mindfully:** Focus on one thing at a time
* **Effectively:** Do what works in the situation

**Application to Eating Disorders:**

*Teaching mindful eating:*

*Therapist: "Before eating, pause. Notice the food—appearance, smell. Take one bite. Chew slowly, noticing texture, taste, temperature. Swallow. Notice sensations in your body. This is eating mindfully—being present rather than automatic or numb."*

*Client: "When I binge, I'm totally checked out. I'm not even tasting the food."*

*Therapist: "Exactly. Bingeing is the opposite of mindful—it's dissociative eating. Practicing mindfulness with meals helps you stay present, notice fullness cues, and reduce automatic eating."*

**2. Distress Tolerance**

**Goal:** Survive crisis without making it worse; accept reality as it is

**Skills:**

* **STOP:** Stop, Take a step back, Observe, Proceed mindfully
* **Distract:** With activities, contributing, comparisons, emotions, pushing away, thoughts, sensations (ACCEPTS)
* **Self-soothe:** Using five senses
* **Improve the moment**
* **Radical acceptance:** Accepting reality as it is, even when painful

**Application to Eating Disorders:**

*Crisis survival when urge to binge:*

*Therapist: "When the urge to binge hits, you don't have to act on it immediately. Use STOP: Stop—freeze, don't move toward food. Take a step back—physically and mentally. Observe—what's happening? What triggered this? What am I feeling? Proceed mindfully—make a choice based on values, not impulse."*

*Client: "But the urge is so strong."*

*Therapist: "I know. That's why we pair STOP with distraction. ACCEPTS skills: Activities—go for a walk, call a friend, play a game. Emotions—watch a sad movie if feeling numb, a comedy if feeling sad. Sensations—hold ice, take a hot shower. These create distance from the urge. Urges peak and then decrease. If you can ride it out without acting, it will pass."*

**Radical Acceptance:**

*Client: "I hate my body. I can't accept looking like this."*

*Therapist: "Radical acceptance doesn't mean liking your body or thinking it's perfect. It means accepting the reality that this is your body right now, rather than fighting reality with 'should' statements. Fighting reality creates suffering. Accepting reality allows you to work with what is."*

**3. Emotion Regulation**

**Goal:** Understand and change unwanted emotions

**Skills:**

* **Identify and label emotions**
* **Understand function of emotions**
* **Reduce vulnerability to negative emotions** (PLEASE skills: treat PhysicaL illness, balanced Eating, avoid mood-Altering drugs, balanced Sleep, Exercise)
* **Increase positive emotions**
* **Opposite action:** Act opposite to emotion urge when emotion not justified
* **Check the facts**

**Application to Eating Disorders:**

*Identifying emotions:*

*Therapist: "When you binged yesterday, what emotion were you feeling right before?"*

*Client: "I don't know. Bad?"*

*Therapist: "Bad is vague. Was it sad, angry, lonely, anxious, ashamed, frustrated? Emotion identification is a skill. Let's get specific."*

*Client: [thinking] "Lonely, I guess. My friends went out without inviting me."*

*Therapist: "Good. Loneliness was the emotion. What did loneliness make you want to do?"*

*Client: "Isolate. Eat."*

*Therapist: "So the loneliness urge was to isolate and eat, which would make loneliness worse. What's the opposite action?"*

*Client: "Reaching out? But that feels impossible."*

*Therapist: "That's the opposite action—when lonely, connect. It feels hard because loneliness makes you want to hide. But the way through loneliness is connection, not isolation. Even texting one friend counts."*

**PLEASE Skills for Emotion Regulation:**

*Therapist: "Notice that when you're not eating adequately, sleeping poorly, and not treating your diabetes, your emotions are more intense and harder to regulate. PLEASE skills are about reducing vulnerability to emotion dysregulation. When your basic needs are met—you're eating balanced meals, sleeping 7-8 hours, taking medications, exercising moderately—emotions are more manageable."*

**4. Interpersonal Effectiveness**

**Goal:** Ask for what you need, say no effectively, maintain relationships and self-respect

**Skills:**

* **DEAR MAN:** Describe, Express, Assert, Reinforce, Mindful, Appear confident, Negotiate (for getting what you want)
* **GIVE:** Gentle, Interested, Validate, Easy manner (for maintaining relationships)
* **FAST:** Fair, Apologies (no excessive), Stick to values, Truthful (for maintaining self-respect)

**Application to Eating Disorders:**

*Navigating social eating situations:*

*Client: "My friends want to go out for dinner, but I can't deal with restaurant eating."*

*Therapist: "This is an interpersonal effectiveness challenge. You want to maintain friendships (GIVE), but also advocate for your needs (DEAR MAN), while respecting your recovery (FAST). What would using these skills look like?"*

*Client: "I guess... I could Describe the situation: 'I'm working on recovery from an eating disorder and restaurants are challenging right now.' Express how I feel: 'I want to see you all.' Assert what I need: 'Could we do something else, or maybe I could meet you after dinner for coffee?'"*

*Therapist: "Perfect. You're being truthful about your situation, advocating for what you need, while still showing you want connection. That's FAST and DEAR MAN together."*

**DBT Chain Analysis:**

**Core DBT Tool for Understanding and Preventing Eating Disorder Behaviors:**

**Structure:**

1. **Prompting Event:** What happened right before the behavior?
2. **Vulnerability Factors:** What made you more vulnerable? (sleep, hunger, stress, etc.)
3. **Links in the Chain:** Thoughts, feelings, actions between event and behavior
4. **Behavior:** Specific eating disorder behavior
5. **Consequences:** What happened after?

**Clinical Example:**

*Therapist: "Let's do a chain analysis of yesterday's binge. What was the prompting event?"*

*Client: "I got an email from my ex."*

*Therapist: "What were your vulnerability factors—what made you more vulnerable to this event triggering a binge?"*

*Client: "I'd only eaten an apple all day. I was exhausted because I didn't sleep well. And I was already stressed about work."*

*Therapist: "So multiple vulnerabilities. What happened after you got the email—walk me through the chain."*

*Client: "I read it and felt this wave of sadness and rejection. I thought 'I'm not good enough. I'll always be alone.' I tried to work but couldn't concentrate. The feelings got bigger. I thought 'I need to make this stop.' I went to the kitchen and started eating."*

*Therapist: "During the binge, what happened to the sad and rejected feelings?"*

*Client: "They went away temporarily. I was numb."*

*Therapist: "And after?"*

*Client: "Shame. Physical discomfort. More loneliness."*

*Therapist: "So the binge worked short-term—it made the feelings stop—but long-term it made things worse. Let's identify solutions at each link in the chain. What could have been different?"*

**Solutions Generated:**

* **Reduce vulnerability:** Regular eating, adequate sleep (PLEASE skills)
* **Different thinking:** Challenge "I'm not good enough" (check the facts)
* **Different action:** Use distress tolerance when feelings intensified (distraction, self-soothe)
* **Alternative to binge:** Call friend, journal, use opposite action (connect instead of isolate)

**DBT Outcomes:**

**Research findings:**

* **Bulimia Nervosa:** Significant reduction in binge/purge frequency
* **Binge Eating Disorder:** High abstinence rates (40-60% binge-free at end of treatment)
* Particularly effective for individuals with emotion dysregulation
* Skills maintained at follow-up
* Improvements in comorbid symptoms (depression, anxiety)

**Other Evidence-Based Approaches**

**Interpersonal Psychotherapy (IPT)**

**Foundation:** Eating disorders develop and are maintained in interpersonal context

**Focus:** Four interpersonal problem areas:

1. **Grief/loss**
2. **Role disputes** (conflicts with significant others)
3. **Role transitions** (life changes—college, career, marriage, parenthood, divorce)
4. **Interpersonal deficits** (social isolation, difficulty forming relationships)

**Structure:** 15-20 sessions, addressing one primary interpersonal area

**Mechanism:** Improving interpersonal functioning → Reduced need for eating disorder as coping → Symptom improvement

**Appropriate for:** BN and BED; particularly when interpersonal issues clearly maintain ED

**Acceptance and Commitment Therapy (ACT)**

**Core Principles:**

* Psychological flexibility
* Acceptance of internal experiences rather than avoidance
* Values-based action
* Defusion from unhelpful thoughts
* Present-moment awareness

**Application to EDs:**

* Accept uncomfortable thoughts/feelings about body rather than trying to control through restriction
* Defuse from ED thoughts (observe them as mental events, not facts)
* Identify values and take action aligned with values rather than ED

**Cognitive Remediation Therapy (CRT)**

**Target:** Cognitive inflexibility in anorexia nervosa

**Method:** Exercises to improve cognitive flexibility, set-shifting

**Rationale:** AN associated with rigid thinking; improving flexibility may support recovery

**Evidence:** Promising adjunct, particularly for severe/enduring AN

**Adapting Treatment to Individual Needs**

**Factors Influencing Treatment Selection:**

**Diagnosis:**

* **AN adolescent:** FBT first-line
* **AN adult:** CBT-E, may need weight restoration focus
* **BN/BED:** CBT-E or DBT (DBT if significant emotion dysregulation)
* **ARFID:** Exposure-based treatment, may involve OT for sensory issues

**Age:**

* **Adolescents:** FBT preferred when living with family
* **Adults:** Individual therapy approaches

**Comorbidities:**

* **BPD:** DBT
* **Trauma:** May need trauma-focused work (after stabilization)
* **Significant depression/anxiety:** May need concurrent medication

**Client Factors:**

* **Cognitive/intellectual functioning:** Adapt complexity
* **Motivation:** MI techniques to build
* **Cultural background:** Culturally adapt interventions

**Severity:**

* **Severe medical instability:** Stabilize medically before outpatient therapy
* **Severe psychiatric risk:** May need hospitalization before psychotherapy

**Common Therapeutic Errors to Avoid**

**1. Focusing Only on Food/Weight**

**Error:** "Just eat more" / "Just stop purging"

**Why it fails:** Doesn't address maintaining mechanisms

**Correct approach:** Address psychological factors maintaining behaviors

**2. Colluding with ED**

**Error:** Agreeing to "just focus on anxiety, not the eating disorder"

**Why it fails:** Avoids core issue, allows ED to continue

**Correct approach:** "The anxiety and eating disorder are connected. We address both."

**3. Power Struggles**

**Error:** Arguing with ED logic or forcing change

**Why it fails:** Strengthens resistance

**Correct approach:** Motivational interviewing, exploring ambivalence

**4. Weight as Primary Outcome**

**Error:** Emphasizing weight as goal

**Why it fails:** Reinforces weight overvaluation

**Correct approach:** Weight as one health indicator; emphasize functioning, quality of life, freedom from ED thoughts

**5. Insufficient Medical Monitoring**

**Error:** Providing therapy without ensuring medical oversight

**Why it fails:** Medical complications can be fatal

**Correct approach:** Require medical monitoring, coordinate with physician

**Module 4 Quiz**

**Question 1:** In Enhanced Cognitive-Behavioral Therapy (CBT-E) for eating disorders, the core maintaining mechanism considered central to all eating disorders is:

a) Family dysfunction and poor attachment b) Trauma history and PTSD symptoms c) Overvaluation of weight and shape (self-worth based primarily on weight/shape and control over eating) d) Genetic predisposition and neurotransmitter imbalances

**Answer: c) Overvaluation of weight and shape (self-worth based primarily on weight/shape and control over eating)**

*Explanation: CBT-E's transdiagnostic model identifies overvaluation of weight and shape as the core psychopathology maintaining all eating disorders. This means the person's self-evaluation is determined largely or exclusively by their weight, shape, and ability to control eating. This overvaluation drives dietary restraint, which paradoxically increases binge eating risk, which leads to compensatory behaviors, maintaining the cycle. While trauma (option b) and genetics (option d) may contribute to eating disorder development, they're not identified as the core maintaining mechanism in the CBT-E model—treatment focuses on current maintaining factors rather than historical causes. Family dysfunction (option a) is not considered causal or primary maintaining factor in CBT-E (distinguishing it from older family systems models). Understanding this core mechanism is essential because CBT-E interventions directly target overvaluation: expanding self-evaluation beyond appearance, addressing body image disturbance, challenging weight/shape-based thinking. The model's strength is identifying this shared mechanism across diagnoses (AN, BN, BED, OSFED), allowing a transdiagnostic treatment protocol. Treatment success involves reducing the influence of weight/shape on self-worth, not just changing eating behaviors.*

**Question 2:** Family-Based Treatment (FBT) for adolescent anorexia nervosa differs from traditional family therapy approaches by:

a) Blaming parents for causing the eating disorder through dysfunctional family dynamics b) Empowering parents as primary agents of recovery and externalizing the eating disorder as separate from the adolescent c) Excluding parents from treatment to allow the adolescent autonomy d) Focusing primarily on resolving past family conflicts and communication patterns

**Answer: b) Empowering parents as primary agents of recovery and externalizing the eating disorder as separate from the adolescent**

*Explanation: FBT represents a revolutionary shift from older family therapy models. Rather than viewing parents as pathological or causal (option a—explicitly rejected in FBT), FBT positions parents as the most important resource for recovery. Core FBT principles include: (1) Agnostic about cause—doesn't blame parents or seek to identify family pathology, (2) Parents empowered to take control of refeeding, (3) Eating disorder externalized as external enemy ("Sarah vs. anorexia" not "Sarah has anorexia"), (4) Treatment is behavioral and present-focused, not insight-oriented or historical. The famous "family meal" session exemplifies this—therapist coaches parents in real-time to work together getting their child to eat, positioning them as competent and necessary. This differs dramatically from option c (FBT intensively involves parents, especially in Phase 1) and option d (FBT doesn't focus on past conflicts or communication patterns unless directly maintaining eating disorder). The theoretical foundation is that: (1) eating disorder is like a cancer requiring aggressive parental intervention, (2) adolescent's decision-making is compromised by starvation, (3) parents know their child best and are best positioned to help. Research shows FBT superior to individual therapy for adolescent AN, with 40-50% full remission at treatment end and 60-75% at long-term follow-up.*

**Question 3:** In Dialectical Behavior Therapy (DBT) for eating disorders, a client experiencing an intense urge to binge would FIRST be taught to use which skill category?

a) Mindfulness skills to observe the urge without judgment b) Distress tolerance skills to survive the crisis without making it worse through bingeing c) Emotion regulation skills to reduce vulnerability to future urges d) Interpersonal effectiveness skills to improve relationships

**Answer: b) Distress tolerance skills to survive the crisis without making it worse through bingeing**

*Explanation: DBT skills are strategically deployed based on the situation. When a client is experiencing an acute urge to binge (crisis situation), the immediate priority is crisis survival—getting through the urge without engaging in the behavior. This is the function of distress tolerance skills. Specific skills include: STOP (Stop, Take step back, Observe, Proceed mindfully), ACCEPTS distraction skills (Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, Sensations), Self-soothe using five senses, and Improve the moment. These skills help ride out the urge (which will peak and decrease) without acting on it. While mindfulness (option a) is important and may be part of the response (the "Observe" in STOP), mindfulness alone doesn't provide the crisis survival tools needed. Emotion regulation skills (option c) are crucial but are about reducing future vulnerability and changing emotions over time—not managing acute crisis. Interpersonal effectiveness (option d) addresses relationship and communication issues, not relevant to immediate urge management. The DBT model teaches skills in this priority order: crisis survival first (distress tolerance), then building life worth living (emotion regulation, interpersonal effectiveness, mindfulness). In the moment of crisis, dialectical behavior therapy emphasizes "survive the crisis without making it worse"—don't add bingeing to whatever difficulty triggered the urge.*

**Module 5: Special Populations, Comorbidities, and Complex Cases**

**Duration: 60 minutes**

**Working with Diverse Populations**

**Males with Eating Disorders**

**The Underrecognition Crisis:**

Males comprise 25-30% of eating disorder cases yet face significant diagnostic and treatment barriers:

* Average 3x longer to receive diagnosis than females
* Less likely to be screened by healthcare providers
* Less likely to self-identify symptoms
* Face greater stigma ("eating disorders are a girl thing")
* Higher mortality when untreated (later diagnosis = more severe at presentation)

**Gender-Specific Presentations:**

**Muscle Dysmorphia (Bigorexia):**

* Preoccupation with being insufficiently muscular
* Excessive weightlifting, supplement use, steroid use
* Rigid dietary patterns (extreme protein focus, carb avoidance)
* Body checking focused on muscularity rather than thinness
* Distress when unable to exercise

**Clinical Example:**

*Kyle, 24, presents with "obsession with fitness." He lifts weights 3 hours daily, follows extremely rigid macronutrient targets, uses multiple supplements, and experiences panic when unable to exercise. He sees himself as "small and weak" despite being visibly muscular. Traditional eating disorder screening misses him because he's not pursuing thinness.*

*Therapist: "You mentioned you feel small and weak. When you look in the mirror, what do you see?"*

*Kyle: "I see someone who's not big enough. My arms are too small, my shoulders aren't wide enough. I look like I don't even lift."*

*Therapist: "But you're visibly very muscular. That disconnect—between what the mirror shows others and what you see—is similar to body image disturbance in anorexia nervosa, just focused on muscularity instead of thinness."*

**Different Symptom Expression:**

* May focus on "getting ripped" or "lean" rather than "thin"
* Exercise addiction more common
* Protein supplement use normalized
* Steroid use risk

**Assessment Adaptations:**

**Standard EDE-Q question:** "Have you wanted your stomach to be flat?"

**Adapted for males:** "Have you wanted to be more muscular/lean/ripped? Have you felt your body wasn't muscular enough?"

**Treatment Considerations:**

* Address masculinity pressures and "ideal male body" standards
* Recognize muscle-focused body dysmorphia as valid presentation
* Challenge "fitness culture" that disguises eating disorder
* Involve partners/family in understanding this isn't "just being healthy"

**LGBTQ+ Individuals**

**Elevated Risk Factors:**

**Statistics:**

* Gay/bisexual men: 4x higher risk than heterosexual men
* Transgender individuals: 4x higher risk than cisgender individuals
* Lesbian/bisexual women: similar or higher risk than heterosexual women

**Contributing Factors:**

**Minority Stress:**

* Discrimination and prejudice
* Internalized homophobia/transphobia
* Concealing identity
* Violence or harassment
* Family rejection

**Body Image Pressures:**

* In some gay male communities: Hypervigilance to appearance, muscular ideal
* In transgender individuals: Body dysphoria related to gender identity
* Pressure to conform to gender norms

**Clinical Vignette—Transgender Client:**

*Alex, 19, assigned female at birth, identifies as non-binary/transmasculine, presents with restrictive eating and compulsive exercise. Assessment reveals restriction aimed at suppressing female secondary sex characteristics (breast tissue, hip fat) and achieving more androgynous/masculine appearance.*

*Therapist: "Help me understand the connection between your eating and your gender identity."*

*Alex: "I hate my body—not because I want to be thin, but because it's too feminine. When I restrict and my period stops and my chest gets smaller, I feel more like myself. The eating disorder serves my dysphoria."*

*Therapist: "So the restriction is about gender, not weight per se. That's really important to understand. And—here's the hard part—the restriction is also medically dangerous and won't solve the dysphoria long-term. What would actually address the dysphoria?"*

*Alex: "Hormone therapy. Top surgery eventually. But my parents won't support that."*

*Therapist: "So in the absence of gender-affirming medical care, you're using restriction as a way to modify your body toward your gender identity. That makes sense as a coping strategy, and it's also harmful. We need to work on two fronts: addressing the eating disorder's medical dangers, and advocating for appropriate gender-affirming care."*

**Treatment Adaptations:**

* Use affirming language and pronouns
* Understand eating disorder may serve gender dysphoria management
* Connect to gender-affirming medical care when appropriate
* Address minority stress as contributing factor
* Avoid assumptions about body ideal (may not be thin-ideal)

**People in Larger Bodies**

**Critical Understanding: Eating Disorders at Every Size**

**Dangerous Myths to Dispel:**

* "You have to be thin to have an eating disorder"
* "People in larger bodies are just overeating, not eating disordered"
* "Eating disorders in higher-weight people are less serious"

**Reality:**

* All eating disorder diagnoses occur across weight spectrum
* **Atypical anorexia nervosa** often unrecognized because individual doesn't "look anorexic"
* Medical complications can occur at any weight
* Psychological suffering is independent of body size

**Weight Stigma in Healthcare:**

**Common experiences:**

* Symptoms attributed to weight rather than eating disorder
* Restriction praised as "finally taking health seriously"
* Delayed diagnosis and treatment
* Providers missing clear eating disorder symptoms

**Clinical Example:**

*Rebecca, BMI 28, has lost 65 pounds in 6 months through severe restriction (800 calories daily), compulsive exercise, and extreme anxiety about food. She experiences bradycardia, amenorrhea, and orthostatic changes. Her physician says "Great job losing weight! Keep it up!" Missing that this is anorexia nervosa.*

**Assessment Considerations:**

* **Always ask about weight history:** Significant weight loss from any starting weight requires eating disorder evaluation
* **Don't assume based on current weight:** Client at BMI 30 who was BMI 40 and lost through restriction has eating disorder
* **Assess psychological symptoms:** Body image disturbance, fear of weight gain, overvaluation of weight/shape occur at any size

**Treatment Considerations:**

* Address weight stigma client has internalized and experienced
* Challenge diet culture messages client receives
* Medical monitoring still essential (complications can occur at any weight)
* Weight restoration may or may not be goal depending on situation
* Focus on normalizing eating and psychological recovery

**Therapeutic Dialogue:**

*Therapist: "I know you came to therapy wanting to lose weight, but what you've described—eating 600 calories daily, exercising 3 hours daily, weighing yourself constantly, intense fear of food—this is an eating disorder."*

*Client: "But I'm not thin. How can I have an eating disorder?"*

*Therapist: "Eating disorders happen at every size. Your BMI doesn't determine whether you have an eating disorder—your behaviors and thoughts do. You meet criteria for atypical anorexia nervosa. The 'atypical' just means your weight isn't in the underweight range—it doesn't mean your eating disorder is any less serious."*

*Client: "But shouldn't I lose weight? My doctor says I need to for my health."*

*Therapist: "There's a difference between medically supervised, gradual, health-focused behavior change and what you're doing, which is dangerous restriction causing medical complications. You're not eating enough to support your body. That's not healthy at any size."*

**Athletes**

**Sport-Specific Risk:**

**High-Risk Sports:**

* **Aesthetic sports:** Gymnastics, figure skating, dance, diving, cheerleading
* **Weight-class sports:** Wrestling, rowing, lightweight crew, martial arts, boxing
* **Endurance sports:** Distance running, swimming, cycling, triathlons

**Risk Factors:**

* Pressure from coaches regarding weight/body
* Revealing uniforms increasing body consciousness
* Performance-weight link (real or perceived)
* Competitive culture
* Early sport specialization

**RED-S (Relative Energy Deficiency in Sport):**

**Definition:** Inadequate energy intake relative to exercise expenditure

**Consequences:**

* Menstrual dysfunction
* Low bone density → stress fractures
* Decreased performance (paradoxically, despite eating disorder goal of performance improvement)
* Impaired immune function
* Cardiovascular complications
* Psychological effects

**Female Athlete Triad:**

1. Low energy availability (with or without disordered eating)
2. Menstrual dysfunction
3. Low bone density

**Clinical Presentation:**

*Emma, 16, elite cross-country runner, referred by coach for "overtraining." She runs 70+ miles/week, restricts "for performance optimization," lost 15 pounds, periods stopped, suffered two stress fractures this season. She believes lighter = faster.*

*Therapist: "Your coach is concerned because your performance has declined, not improved, with the weight loss."*

*Emma: "I just need to get lighter. The best runners are really thin."*

*Therapist: "Actually, research shows that relative energy deficiency—not eating enough for the amount you're training—decreases performance. Your body doesn't have enough fuel to train hard and recover. Your stress fractures are a sign your bones are suffering. Your lost period means your hormones are disrupted. These are all making you a slower runner, not a faster one."*

**Treatment Considerations:**

**Working with coaches:**

* Educate coaches about eating disorders and RED-S
* Encourage weight-neutral coaching
* Establish return-to-play criteria (medical clearance, adequate nutrition, absence of behaviors)

**Balancing sport and recovery:**

* May need exercise restriction initially (extremely difficult for athletes)
* Graduated return to sport with medical clearance
* Monitoring to ensure nutrition adequate for training volume

**Addressing identity:**

* Athlete identity often central
* Eating disorder may feel like competitive advantage
* Fear that recovery = weight gain = performance loss = loss of identity

**Challenge:** *"I know it feels like restricting gives you a competitive edge. And the reality is it's causing stress fractures, hormonal disruption, and declining performance. Recovery actually makes you a better athlete—stronger bones, better endurance, faster recovery between workouts, sharper mental focus. But I know it doesn't feel that way right now."*

**Comorbid Conditions and Integrated Treatment**

**Depression and Eating Disorders**

**Prevalence:** 50-75% of individuals with eating disorders have comorbid depression

**Relationship:**

* Depression may predate eating disorder
* Depression may develop secondary to malnutrition
* Depression and eating disorder may share vulnerability factors
* Often bidirectional relationship

**Assessment Question:** *"Were you depressed before the eating disorder started, or did depression develop after?"*

**Treatment Implications:**

**If depression secondary to malnutrition:**

* Often improves with weight restoration alone
* May not need separate depression treatment
* Monitor; if persists post-weight restoration, add depression-specific treatment

**If depression primary or persisting:**

* May need concurrent depression treatment
* SSRIs can be helpful (after medical stabilization)
* Cognitive therapy for depression integrated with ED treatment

**Clinical Consideration:**

*Therapist: "Your depression symptoms—low mood, anhedonia, hopelessness, poor concentration—are they better or worse when you're eating more regularly?"*

*Client: "Actually... better. I hadn't noticed, but on days I eat breakfast and lunch, I feel less depressed."*

*Therapist: "That suggests your depression is at least partly related to malnutrition. Your brain needs fuel to produce neurotransmitters that regulate mood. As we continue nutritional rehabilitation, we may see mood continue improving. We'll monitor and add depression-specific treatment if needed."*

**Anxiety Disorders and Eating Disorders**

**Prevalence:** 60-70%, particularly social anxiety, GAD, OCD

**Common patterns:**

* Anxiety often predates eating disorder
* Eating disorder may be attempt to manage anxiety
* Anxiety about food/body overlaps with general anxiety
* Social anxiety exacerbated by eating concerns

**OCD and Eating Disorders:**

* High comorbidity
* Shared features: Obsessions (intrusive thoughts), compulsions (ritualized behaviors), need for control
* Can be difficult to differentiate OCD about food from eating disorder
* May need concurrent OCD treatment (ERP)

**Clinical Example:**

*Daniel has both OCD and bulimia nervosa. His OCD involves contamination fears and checking rituals. His eating disorder involves food rituals, binge eating, and purging.*

*Therapist: "We need to address both conditions. Some of your food rituals might be OCD-related (contamination fear, need for food to be 'pure'), while others are eating disorder-related (eating in specific order to minimize calories). We'll use exposure and response prevention for both—exposing you to contamination fears without washing compulsions, and exposing you to feared foods without purging."*

**PTSD/Trauma and Eating Disorders**

**Prevalence:** 30-50% report trauma history

**Types of trauma:**

* Sexual abuse (particularly strong association)
* Physical abuse
* Emotional abuse/neglect
* Bullying
* Medical trauma
* Witnessing violence

**Eating Disorder as Trauma Response:**

**Restriction:**

* Numbing emotions
* Controlling body after loss of bodily autonomy
* Making body smaller/less noticeable
* Stopping sexual development (amenorrhea)

**Bingeing/Purging:**

* Dissociation from trauma memories
* Self-harm through purging
* Expressing self-disgust
* Punishing body

**Treatment Considerations:**

**Stabilization first:**

* Address acute eating disorder symptoms before trauma processing
* Ensure client medically stable
* Develop emotion regulation skills
* Create safety

**Trauma processing:**

* After eating disorder symptoms improved
* Use evidence-based trauma treatments (EMDR, CPT, PE)
* Continue eating disorder support during trauma work
* Monitor for eating disorder symptom return with trauma activation

**Clinical Dialogue:**

*Therapist: "I know the sexual abuse history is significant and painful. We will address it—but not right now. Here's why: Trauma processing is emotionally intense. Right now, you're using bingeing and purging to manage overwhelming emotions. If we dive into trauma before you have other coping skills, the eating disorder will likely intensify. We need to first stabilize your eating, develop emotion regulation skills, and get you medically stable. Then we'll address the trauma when you have tools to manage it without turning to eating disorder behaviors."*

*Client: "But isn't the trauma causing the eating disorder?"*

*Therapist: "The trauma contributed to vulnerability, but what's maintaining the eating disorder now is the restrict-binge-purge cycle and the function these behaviors serve. We address current maintaining factors first, build skills, then process trauma. This sequencing gives you the best chance of recovery from both."*

**Substance Use Disorders and Eating Disorders**

**Prevalence:** 30-50%, particularly in BN and BED

**Shared mechanisms:**

* Impulsivity
* Reward sensitivity
* Emotion dysregulation
* Addictive-like features

**Assessment:** *"Do you use alcohol, marijuana, or other substances? How often? Do you use them before or after eating disorder behaviors?"*

**Patterns:**

* Alcohol use before bingeing (lowering inhibitions)
* Stimulant use for appetite suppression
* Substance use to cope with negative emotions (like ED behaviors)
* "Drunkorexia" (restricting food to "save calories" for alcohol)

**Treatment:**

**Integrated treatment preferred:**

* Address both conditions simultaneously
* Shared emotion regulation skills
* Recognize substances and ED serve similar functions
* DBT particularly effective (designed for multi-problem patients)

**Sequencing consideration:**

* If severe substance use requiring detox, may need substance treatment first
* If severe medical instability from ED, may need ED stabilization first
* Ideal: Concurrent treatment with team coordination

**Personality Disorders and Eating Disorders**

**Borderline Personality Disorder (BPD) + ED:**

**High comorbidity:** Particularly with BN and BED

**Shared features:**

* Emotion dysregulation
* Impulsivity
* Unstable relationships
* Identity disturbance
* Self-harm (ED behaviors can be form of self-harm)

**Treatment:** DBT ideal (designed for BPD, adapted for ED)

**Avoidant Personality Disorder + ED:**

**Common in:** AN restricting type

**Shared features:**

* Social anxiety and withdrawal
* Fear of rejection
* Low self-worth
* Restriction as avoidance of social eating

**Treatment:** Gradually increase social exposure alongside ED treatment

**Obsessive-Compulsive Personality Disorder + ED:**

**Common in:** AN

**Shared features:**

* Perfectionism
* Rigidity
* Need for control
* Detail orientation

**Treatment:** Address perfectionism directly (CBT-E broad version)

**Complex Cases Requiring Specialized Approaches**

**Severe and Enduring Eating Disorders (SEED)**

**Definition:** Eating disorder lasting >7 years despite treatment

**Challenges:**

* Multiple treatment failures
* Medical complications
* Psychological chronicity
* Despair and hopelessness
* Identity fused with ED

**Shift in approach:**

**From:** Aggressive pursuit of full recovery **To:** Harm reduction, quality of life improvement

**Harm reduction strategies:**

* Reducing medical risk without demanding full recovery
* Improving quality of life within eating disorder
* Maintaining life-sustaining nutrition even if not full recovery
* Supporting functioning and relationships

**Palliative care considerations:**

For very severe cases where recovery not achieved despite extensive treatment:

* Focus on comfort and quality of life
* Reduce suffering
* Maintain dignity
* Support family
* Difficult ethical territory requiring consultation

**Autism Spectrum Disorder + Eating Disorders**

**High comorbidity:** Particularly with ARFID and AN

**Shared features:**

* Rigidity and need for sameness
* Sensory sensitivities
* Social difficulties
* Attention to detail
* Restricted interests

**Assessment considerations:**

* Differentiate ASD rigidity from ED rigidity
* Assess sensory issues vs. weight-driven food avoidance
* ASD may predate ED; ED develops on foundation of ASD traits

**Treatment adaptations:**

* Concrete, structured approach
* Visual supports
* Predictability and routine
* Sensory accommodations
* Social skills training for navigating social eating
* Parent/caregiver involvement

**Pregnancy and Eating Disorders**

**Risks:**

* Miscarriage
* Preterm birth
* Low birth weight
* Developmental delays
* Maternal medical complications

**Assessment:** *"How has pregnancy affected your eating disorder? Are you restricting? Purging? Bingeing?"*

**Treatment approach:**

* Motivational: Baby's health as motivation
* Close obstetric monitoring
* Nutritional counseling specific to pregnancy needs
* Address body image changes during pregnancy
* Plan for postpartum (high-risk period for relapse)

**Dialogue:**

*Therapist: "I know your body changing during pregnancy is triggering all your eating disorder fears. And right now, your baby needs you to eat adequately. Your baby's brain is developing, and that requires specific nutrients. Can we use your love for your baby as motivation to fight the eating disorder, even when it's hard?"*

**Cultural Competence in Eating Disorder Treatment**

**Recognizing Cultural Factors:**

**Food meanings vary across cultures:**

* Meals as family bonding
* Food as love expression
* Cultural celebrations centered on food
* Religious food practices

**Body ideals vary:**

* Not all cultures idealize thinness
* Some cultures value larger bodies as health/prosperity
* Acculturation stress when navigating multiple beauty standards

**Expression of distress varies:**

* Somatic complaints vs. psychological language
* Stigma around mental health treatment
* Role of family in treatment decisions

**Treatment adaptations:**

*Working with Latina adolescent and family:*

*Therapist: "I understand that in your family, refusing food your mother prepared can feel disrespectful. Let's talk about how to honor your cultural values around family meals while also addressing the eating disorder. What if we worked with your mother to modify recipes so you feel safe eating them, while still participating in family meals?"*

**Addressing barriers:**

* Language barriers (bilingual providers, interpreters)
* Culturally adapted materials
* Understanding immigration-related stress
* Addressing discrimination experiences
* Including family in culturally appropriate ways

**Module 5 Quiz**

**Question 1:** A 22-year-old gay male client reports extreme anxiety about his body, excessive exercise (4 hours daily weightlifting), rigid high-protein diet, and steroid use to "get bigger." He sees himself as "too small" despite being visibly very muscular. Traditional eating disorder screening questions about wanting to be thin don't resonate with him. This presentation MOST likely represents:

a) Body dysmorphic disorder unrelated to eating disorders b) Muscle dysmorphia, a variant of eating disorder common in males focusing on muscularity rather than thinness c) Obsessive-compulsive disorder with exercise compulsions d) Normal behavior for someone interested in fitness

**Answer: b) Muscle dysmorphia, a variant of eating disorder common in males focusing on muscularity rather than thinness**

*Explanation: This case illustrates muscle dysmorphia (sometimes called "bigorexia"), an eating disorder presentation particularly common in males that involves body image disturbance focused on being insufficiently muscular rather than too large/fat. Like anorexia nervosa involves seeing oneself as fat despite being thin, muscle dysmorphia involves seeing oneself as small/weak despite being muscular. Key features include: (1) body image distortion (seeing self as small when muscular), (2) preoccupation with muscularity, (3) excessive exercise (compulsive weightlifting), (4) rigid dietary patterns (extreme protein focus), (5) supplement/steroid use, (6) significant distress and functional impairment. This is an eating disorder, not just BDD (option a)—though overlap exists. It's more than OCD (option c) because of the specific body image component and eating/exercise patterns. It's definitely not "normal fitness interest" (option d)—the rigidity, distortion, and impairment distinguish this from healthy fitness pursuit. Traditional eating disorder assessments asking about wanting to be thin miss these presentations, which is one reason males are underdiagnosed. Culturally, "fitness culture" can disguise eating disorders in males. Treatment involves addressing body image distortion, challenging "ideal male body" pressures, reducing compulsive exercise, and addressing underlying psychological factors using adapted eating disorder interventions.*

**Question 2:** A client with anorexia nervosa also reports significant trauma history (childhood sexual abuse). The MOST appropriate treatment approach would be:

a) Begin intensive trauma processing immediately, as trauma is causing the eating disorder b) First stabilize eating disorder symptoms and develop emotion regulation skills, then address trauma when client is medically stable and has coping resources c) Ignore trauma history and focus only on eating disorder treatment d) Refer immediately to trauma specialist and discontinue eating disorder treatment

**Answer: b) First stabilize eating disorder symptoms and develop emotion regulation skills, then address trauma when client is medically stable and has coping resources**

*Explanation: When eating disorders and trauma co-occur (30-50% prevalence), treatment sequencing is crucial. The recommended approach is: (1) First stabilize acute eating disorder symptoms—ensure medical safety, establish regular eating, reduce dangerous behaviors (purging, severe restriction), develop basic emotion regulation skills, (2) Then address trauma when client has stabilized—client is medically stable, has coping skills beyond eating disorder behaviors, can tolerate emotional intensity of trauma processing. Rationale: Trauma processing is emotionally intense and often temporarily increases distress. If a client's primary coping mechanism is eating disorder behaviors (restricting to numb, bingeing/purging to dissociate), intensive trauma work will likely trigger intensification of eating disorder symptoms, potentially creating medical crisis. Building emotion regulation skills first provides alternatives to eating disorder behaviors when trauma material is activated. Option a (immediate trauma processing) is dangerous—can destabilize eating disorder and worsen medical status. Option c (ignoring trauma) misses important maintaining factor and prevents full recovery. Option d (referring away) abandons integrated care—ideally the same provider or coordinated team addresses both, sequenced appropriately. The client may need to be informed about this sequencing to understand why trauma isn't addressed immediately despite being important.*

**Question 3:** A client with BMI of 32 reports losing 75 pounds in 8 months through eating 700 calories daily, compulsive exercise, intense fear of weight gain, and body image disturbance. Despite current BMI in "overweight" range, the client is experiencing amenorrhea, bradycardia, and orthostatic hypotension. The MOST accurate diagnosis would be:

a) No eating disorder, as BMI indicates overweight status b) Binge Eating Disorder, as client is in larger body c) Other Specified Feeding or Eating Disorder (Atypical

**Question 3:** A client with BMI of 32 reports losing 75 pounds in 8 months through eating 700 calories daily, compulsive exercise, intense fear of weight gain, and body image disturbance. Despite current BMI in "overweight" range, the client is experiencing amenorrhea, bradycardia, and orthostatic hypotension. The MOST accurate diagnosis would be:

a) No eating disorder, as BMI indicates overweight status b) Binge Eating Disorder, as client is in larger body c) Other Specified Feeding or Eating Disorder (Atypical Anorexia Nervosa) d) Anorexia Nervosa, as psychological symptoms override BMI criteria

**Answer: c) Other Specified Feeding or Eating Disorder (Atypical Anorexia Nervosa)**

*Explanation: This case powerfully illustrates why eating disorders occur at every size and why weight-based assumptions are dangerous. The client meets ALL psychological and behavioral criteria for anorexia nervosa: (1) severe restriction (700 calories—significantly inadequate), (2) intense fear of weight gain (Criterion B), (3) body image disturbance (Criterion C), (4) significant weight loss (75 pounds in 8 months is rapid and substantial), AND is experiencing serious medical complications identical to low-weight AN (amenorrhea, bradycardia, orthostatic hypotension). The ONLY criterion not met is "significantly low body weight" (Criterion A)—current BMI is 32, which is above the underweight threshold. Therefore, the diagnosis is OSFED—Atypical Anorexia Nervosa. This is NOT "no eating disorder" (option a)—this is a severe, medically dangerous eating disorder requiring full eating disorder treatment. The term "atypical" is misleading and stigmatizing—there's nothing atypical about the severity or the need for treatment. Option b is incorrect—BED involves binge eating without compensation; this client is restricting. Option d is technically incorrect per DSM-5-TR criteria (low weight required for AN diagnosis), though the psychological presentation is identical. This case highlights critical clinical points: (1) Never assume based on current weight—always assess weight history, (2) Significant weight loss from ANY starting weight requires eating disorder evaluation, (3) Medical complications occur at any weight when restriction is severe, (4) Weight stigma in healthcare causes dangerous delays in diagnosis—providers often praise weight loss in higher-weight individuals without assessing methods, (5) Atypical AN can be equally or more medically serious than low-weight AN. Treatment approach is identical to AN treatment: medical monitoring, nutritional rehabilitation, CBT-E or other evidence-based therapy, multidisciplinary team.*

**Module 6: Recovery, Relapse Prevention, and Family Involvement**

**Duration: 30 minutes**

**Understanding Recovery: What Does It Mean?**

Recovery from eating disorders is not simply the absence of symptoms—it's the restoration of physical health, psychological wellbeing, and full engagement in life. Dr. Angela Guarda, eating disorders expert, emphasizes: "Recovery means more than weight restoration or stopping behaviors. It means reclaiming your life from the eating disorder."

**Dimensions of Recovery:**

**1. Physical Recovery**

* Weight restoration to healthy range (if underweight)
* Return of menstruation (if amenorrheic)
* Normalization of vital signs and lab values
* Resolution of medical complications
* Adequate nutritional intake
* Appropriate, not compulsive, exercise

**2. Behavioral Recovery**

* Regular, flexible eating patterns (3 meals + snacks)
* Eating variety of foods without rigid rules
* Absence of binge eating
* Absence of purging (vomiting, laxative use)
* Absence of compulsive exercise
* Ability to eat socially without anxiety

**3. Psychological Recovery**

* Reduced overvaluation of weight and shape
* Improved body image (realistic perception, reduced distress)
* Self-worth based on multiple domains, not just appearance
* Effective emotion regulation strategies
* Reduced eating disorder thoughts
* Improved self-esteem
* Motivation for continued health

**4. Social Recovery**

* Re-engagement with relationships
* Ability to participate in social activities involving food
* Reduced isolation
* Pursuit of interests beyond eating disorder
* Return to school/work functioning
* Authentic connections with others

**The Spectrum of Recovery:**

Recovery isn't binary (sick vs. recovered)—it's a spectrum:

**Full Recovery:**

* All physical, behavioral, psychological symptoms resolved
* No eating disorder thoughts or behaviors
* Full quality of life restoration
* Maintained over time (typically defined as 1+ year symptom-free)

**Partial Recovery:**

* Significant improvement in symptoms
* Some residual behaviors or thoughts
* Generally functioning well
* May have occasional slips

**Minimal Recovery:**

* Some symptom reduction
* Still significantly impaired
* Eating disorder still dominating life

**The Reality: Recovery Takes Time**

**Timeline Expectations:**

**Bulimia Nervosa/Binge Eating Disorder:**

* Behavioral symptoms (binge/purge cessation): 3-6 months with intensive treatment
* Psychological symptoms (body image, overvaluation): 6-12 months
* Full recovery: 1-2 years on average
* Some individuals recover more quickly; others take longer

**Anorexia Nervosa:**

* Weight restoration: 6-12 months (depending on severity and treatment intensity)
* Behavioral normalization: 1-2 years
* Psychological recovery: 2-5 years
* Full recovery: Often 5-7 years, though substantial improvement much sooner

**Important:** These are averages. Some recover more quickly with early intervention and appropriate treatment. Others take longer, especially with:

* Longer duration of illness before treatment
* Severe malnutrition
* Multiple comorbidities
* Limited support systems
* Inadequate or interrupted treatment

**What Recovery Feels Like: Managing Expectations**

**Clinical Dialogue—Early Recovery:**

*Client (3 months into treatment): "I'm doing everything you're telling me to do. I'm eating the meal plan, I haven't purged in two weeks, I'm coming to therapy. But I don't feel recovered. I still think about food constantly. I still hate my body. I'm still anxious all the time. When will I feel better?"*

*Therapist: "What you're experiencing is completely normal. You're in early recovery—you're changing behaviors, which is huge and incredibly difficult. But the psychological recovery—the thoughts quieting, body image improving, anxiety decreasing—that takes longer. Think of it this way: The eating disorder was your brain's solution to managing distress. You're removing that solution, but you haven't fully built new neural pathways yet. Your brain is still defaulting to old patterns: 'Feel anxious → think about food.' With time and practice with new coping strategies, those pathways strengthen and the eating disorder thoughts fade."*

*Client: "How long?"*

*Therapist: "For most people, behavioral recovery—stopping the bingeing and purging—stabilizes within a few months of consistent treatment. The psychological piece—the thoughts quieting, body image improving—typically takes 6 months to a year, sometimes longer. But improvement is gradual and progressive. You won't wake up one day 'recovered.' You'll notice one day that you went several hours without thinking about food. Then a day. Then you'll realize your body image is slightly less distressing. Recovery is cumulative."*

**Recovery Is Not Linear:**

**Clinical Vignette:**

*Sarah, recovering from anorexia nervosa, has been doing well for 4 months—eating regularly, weight restored, engaged in life. Then she has a difficult week: argument with boyfriend, stressful exam, triggering comment from classmate. She skips two meals and increases exercise.*

*Sarah: [in session, crying] "I failed. I'm not in recovery. I'm right back where I started."*

*Therapist: "Let's look at what actually happened. You had a challenging week with multiple stressors. You had two brief lapses—skipping meals and over-exercising. But you recognized it, you came to session, and you're talking about it. You didn't restrict for weeks. You didn't lose significant weight. You caught yourself and course-corrected. That's not failure—that's recovery in action."*

*Sarah: "But I thought I was done with this."*

*Therapist: "Recovery isn't a straight line from sick to well. It's more like this [draws wavy line trending upward]. There are ups and downs, good weeks and hard weeks. What matters is the overall trajectory—are you generally moving forward? Yes. Do setbacks mean you're back at the beginning? No. They mean you're human, you're still learning, and you're practicing recovery skills."*

**Building a Life Worth Living: Recovery as More Than Symptom Absence**

**The Challenge:**

For many, eating disorder becomes identity. Recovery requires answering: "Who am I without the eating disorder?"

**Therapeutic Exploration:**

*Therapist: "You've told me the eating disorder has taken up 5 years of your life—ages 15 to 20. You missed high school social events, struggled through college, lost friendships. If the eating disorder wasn't filling your life, what would be?"*

*Client: "I don't know. I honestly don't know who I am without it."*

*Therapist: "Let's explore. Before the eating disorder, what did you enjoy? What were you curious about? What did you care about?"*

*Client: "I loved art. I was taking a painting class when the eating disorder started, and I just... stopped. It felt frivolous compared to obsessing about food and exercise."*

*Therapist: "Art wasn't frivolous—it was part of your identity that got lost. Recovery involves reclaiming that. What would it be like to take a painting class again?"*

*Client: "Terrifying. I don't even know if I'd be good at it anymore."*

*Therapist: "That's the perfectionism talking—the same perfectionism that fuels the eating disorder. What if you took a class just for enjoyment, not to be 'good'? What if recovery meant permission to be imperfect and still engage in life?"*

**Values Clarification Exercise:**

*Therapist: "Let's identify your core values—what matters most to you beyond weight and appearance. If you look back on your life at 80 years old, what do you want to have valued? What do you want to have spent your time and energy on?"*

*Client: "Relationships... family... making a difference... creativity... maybe travel?"*

*Therapist: "None of those are about being thin or controlling food. Yet the eating disorder has you spending all your time and energy on weight and control. What if you redirected that energy toward your actual values? What would your life look like?"*

**Relapse Prevention: Preparing for Challenges**

**Understanding Relapse vs. Lapse:**

**Lapse:** Brief return to symptom (skipping one meal, one binge, one purge)

* Normal part of recovery
* Doesn't mean treatment failed
* Opportunity to practice recovery skills

**Relapse:** Return to regular pattern of eating disorder behaviors

* Multiple symptoms over time
* Functional impairment returns
* May require return to higher level of care

**Goal: Prevent lapses from becoming relapses**

**Early Warning Signs:**

**Behavioral:**

* Increasing food rules or restriction
* Weighing more frequently
* Increasing exercise
* Avoiding social eating
* Skipping meals/snacks
* Return of body checking
* Isolating from support

**Cognitive:**

* Increasing eating disorder thoughts
* More frequent body image distress
* "Fat talk" increasing
* Black-and-white thinking about food
* Overvaluation of weight/shape increasing

**Emotional:**

* Increasing anxiety, especially around food
* Depression worsening
* Irritability
* Emotional numbing

**Relapse Prevention Plan Components:**

**1. Identify High-Risk Situations**

*Therapist: "Let's map out situations that might trigger eating disorder urges. What circumstances put you at risk?"*

*Client: "Stress—like finals week. Relationship conflicts. Holidays with family. Seeing triggering stuff on social media. Being around people who diet or talk about weight."*

*Therapist: "Good awareness. Now, for each of these, what's your plan? When finals week stress hits, what will you do instead of restricting?"*

*Client: "Keep eating regularly even when stressed—don't skip meals just because I'm busy. Use the emotion regulation skills we practiced. Reach out to my support person. Maybe reduce social media during high-stress times."*

**2. Develop Specific Coping Strategies**

**Coping Card Example:**

**My Relapse Prevention Plan**

**Warning Signs to Watch For:**

* Skipping breakfast
* Weighing myself more than weekly
* Avoiding eating with friends
* Increasing gym time
* "I feel fat" thoughts multiple times daily

**High-Risk Situations:**

* Final exams
* Family holidays
* Relationship stress
* Diet talk from friends
* Before big events (weddings, reunions)

**My Coping Strategies:**

1. **Regular Eating:** No matter how busy or stressed, eat 3 meals + 2 snacks
2. **Support Contact:** Call sponsor/friend/family when urges are strong
3. **Distraction:** Go for walk, journal, call friend, watch show
4. **Self-Compassion:** Talk to myself like I'd talk to a friend struggling
5. **Professional Support:** Schedule session with therapist if warning signs emerge

**Emergency Contacts:**

* Therapist: [Phone]
* Support Person: [Phone]
* Crisis Line: 988
* Dietitian: [Phone]

**Reminders:**

* Recovery isn't perfect
* Lapses don't equal failure
* I've gotten through hard times before
* The eating disorder lies to me
* My values are relationships, school, future—not weight

**3. Maintain Treatment Gains**

**Continued Support After Intensive Treatment:**

* Booster sessions with therapist (monthly or as needed)
* Continued dietitian check-ins
* Support group participation
* Medical monitoring (if history of medical complications)

**4. Address Life Transitions**

**Common Transition Points Requiring Extra Support:**

* Graduating treatment programs
* Returning to college after medical leave
* Starting new job
* Moving to new city
* Relationship changes (new relationship, breakup, marriage)
* Pregnancy and postpartum
* Other major life changes

*Therapist: "You're graduating college and moving to a new city for your first job—huge transition. Transitions are high-risk times because they involve stress, loss of structure, and loss of support systems. Let's plan ahead. How will you maintain recovery supports in your new city?"*

*Client: "I'll need to find a new therapist and dietitian there. Maybe find a support group. Build new social connections."*

*Therapist: "Yes. Let's identify resources before you move so you're not starting from scratch. And let's plan weekly check-ins with me by phone for the first month of transition until you're settled."*

**5. Manage Social Media and Triggering Content**

**Strategies:**

* Unfollow accounts promoting disordered eating or unrealistic body standards
* Follow body-positive, recovery-focused accounts
* Limit time on appearance-focused platforms
* Curate feed to support recovery
* Take social media breaks when needed

*Client: "Instagram is so triggering. Everyone's posting their perfect bodies and their restrictive eating."*

*Therapist: "What would it be like to take a break from Instagram? Or to radically curate your feed—unfollow anyone whose content triggers comparison or eating disorder urges, and follow recovery accounts, accounts about your actual interests like art and travel, accounts showing diverse bodies?"*

**Family Involvement in Recovery and Relapse Prevention**

**For Adolescents: Family as Essential Recovery Partner**

**Family's Role:**

* Providing meal support and supervision (especially early recovery)
* Creating recovery-supportive home environment
* Monitoring for warning signs
* Attending family therapy sessions
* Managing their own anxiety about the eating disorder
* Balancing support with appropriate autonomy

**Clinical Guidance for Families:**

**What Helps:**

**1. United Front** *"Parents, you need to present a united message: 'We're supporting your recovery. We love you. We're stronger than the eating disorder.' If one parent is lenient and one is strict, the eating disorder finds the gap."*

**2. Meal Support Without Power Struggles** *"Make the expectation clear, then stay calm. 'Dinner is at 6. We expect you to eat your full meal. We'll sit with you as long as it takes.' Then stay calm even when your child is distressed. The eating disorder wants you to engage in battle. Don't."*

**3. Externalization** *"Remember you're fighting the eating disorder, not fighting your child. 'The anorexia is telling you this food is dangerous. We know that's not true. We're going to help you fight that voice.'"*

**4. Focus on Behaviors, Not Thoughts** *"You can't control what your child thinks about their body or food. You CAN ensure they eat adequately. Focus your energy on supervising eating and supporting behaviors."*

**5. Separate Identity from Eating Disorder** *"Continue to see your child as a whole person—student, friend, artist, athlete—not just 'eating disorder patient.' Engage them in conversations about their interests, not just food and weight."*

**What Doesn't Help:**

**1. Accommodating the Eating Disorder** *"Making special 'safe' foods, allowing meal skipping, accepting eating disorder rules—these seem kind but actually reinforce the disorder. Compassionate firmness is needed."*

**2. Food as Battleground** *"Yelling, threatening, begging, crying during meals escalates anxiety. Stay as calm and matter-of-fact as possible. 'This is what we're eating. I know it's hard. We'll get through it together.'"*

**3. Commenting on Appearance** *"Don't comment on weight—up or down. Don't say 'You look healthier' (heard as 'You look fatter'). Don't say 'You're still so thin.' Focus on functioning: 'I noticed you have more energy' or 'I'm glad you joined us for the movie.'"*

**4. Policing Outside Meal Times** *"If you're supervising every bite and asking 'Did you eat that?' constantly, it maintains food as central focus and prevents autonomy development. Supervision is necessary early recovery, but should fade as recovery progresses."*

**For Adults: Involving Partners and Family When Appropriate**

**Considerations:**

* Adult autonomy and privacy
* Family/partner dynamics
* Cultural factors
* Client preference

**When Family/Partner Involvement Helpful:**

* Client living with family/partner
* Family/partner able to provide meal support
* Relationship dynamics not actively harmful
* Client consents to involvement

**Partner Psychoeducation:**

*Therapist meeting with client's spouse:*

*Therapist: "Your wife's bulimia affects you too—you witness her distress, you're impacted by behaviors, you want to help but don't know how. Let me explain what's most helpful. First, understand this isn't about food or vanity—it's a serious mental illness serving complex functions. Second, you can't fix it or love it away, but you can support her treatment. Third, the most helpful thing is creating a judgment-free environment. Don't comment on what she eats. Don't monitor her bathroom use. Do remind her of her coping strategies when she's struggling. Do engage in non-food activities together. Do take care of yourself—this is stressful for you too."*

**Family as Support System:**

*Client: "My parents want to help but they don't understand. They keep trying to 'fix' things or minimize it."*

*Therapist: "Would it be helpful to bring them to a session so I can help educate them about eating disorders and what's most supportive?"*

*Client: "Maybe. I'm just worried they'll make it worse."*

*Therapist: "We can set ground rules for the session. The goal isn't for them to take over your recovery, but to understand how to support you in ways that are actually helpful. You're in control of how much they're involved."*

**Support Groups and Peer Support**

**Benefits of Support Groups:**

* Connection with others who understand
* Reduction of isolation
* Learning from others' experiences
* Mutual encouragement
* Normalizing struggles

**Types:**

* **Recovery-focused groups:** Emphasize recovery principles, hope
* **Diagnosis-specific groups:** AN, BN, BED separate groups
* **Online groups:** Accessibility, but requires careful selection (avoid pro-ED sites)
* **12-step adapted models:** Some eating disorder 12-step groups

**Concerns to Address:**

* Competition (comparing severity)
* Triggering content
* Pro-eating disorder messaging (avoid these groups entirely)
* Substituting group for professional treatment

**Clinical Guidance:**

*Therapist: "I think a support group could be helpful for you—connecting with others who get it. But I want to be clear about red flags. If the group focuses on 'tips' for hiding behaviors, compares who's sicker, or reinforces eating disorder thinking, leave immediately. The group should be recovery-focused, hopeful, and supportive of getting better, not staying sick."*

**Maintaining Motivation for Recovery**

**Motivation Fluctuates:**

*Client: "I was so motivated when I started treatment. Now I'm tired. I'm tired of thinking about food all the time in recovery the same way I was in the eating disorder. I'm tired of fighting. Sometimes I just want to give up."*

*Therapist: "Motivation isn't constant—it ebbs and flows. That's normal. When motivation is low, we use commitment and structure to carry you through. You made a commitment to recovery when motivation was high. Now we honor that commitment even when motivation is low."*

**Pros and Cons Revisited:**

When motivation wanes, revisit the decisional balance:

*Therapist: "Let's make two lists. First: What does the eating disorder give you? What would you lose in recovery?"*

*Client: "Control. A sense of accomplishment. Distraction from difficult feelings. Identity—I don't know who I am without it."*

*Therapist: "Those are real losses, and it's okay to acknowledge them. Now: What does the eating disorder cost you? What would you gain in recovery?"*

*Client: "It costs me relationships, energy, health, my future, my education, time. I'd gain freedom from constant food thoughts, ability to enjoy meals, energy for things I care about, authentic connections, my goals and dreams."*

*Therapist: "When you look at both lists, what do you notice?"*

*Client: "That what I'd gain is bigger than what I'd lose. But it doesn't always feel that way in the moment."*

*Therapist: "That's why we write it down—so when motivation is low, you can look at this and remind yourself why you started this journey."*

**Life After Recovery: Sustaining Wellness**

**Recovery Maintenance:**

**Regular Self-Monitoring:**

* Weekly check-ins with self: Am I eating regularly? Any warning signs?
* Don't need daily monitoring, but regular awareness

**Continued Health Behaviors:**

* Regular, flexible eating
* Joyful movement (not compulsive exercise)
* Adequate sleep
* Stress management
* Social connection

**Managing Life Stress Without Eating Disorder:**

*Client (2 years into recovery): "I lost my job. This is exactly the kind of thing that would have sent me into relapse before. But I'm eating regularly, I'm reaching out to friends, I'm using my coping skills. The thought crossed my mind to restrict, but I reminded myself it wouldn't actually help the job situation and would make everything harder."*

*Therapist: "That's profound recovery—experiencing major stress and choosing adaptive coping over eating disorder behaviors. The thought crossed your mind—that's normal, the eating disorder was your brain's go-to solution for years. But you didn't act on it. You chose differently. That's sustainable recovery."*

**Giving Back:**

Many in sustained recovery find meaning in helping others:

* Sharing recovery story (when appropriate and stable)
* Peer support roles
* Advocacy work
* Raising awareness

*Client: "My college invited me to speak to incoming students about my eating disorder and recovery. Part of me wants to—to help others avoid what I went through. Part of me worries about being defined by it forever."*

*Therapist: "That's a thoughtful concern. Questions to consider: Are you stable in recovery? Can you share your story without it triggering you? Do you have boundaries around what you'll share? Is this serving your values or the eating disorder's need for identity? If you can answer those well, sharing your story can be meaningful. But you're not obligated to. Recovery is yours, and you get to decide what to do with it."*

**Module 6 Quiz**

**Question 1:** A client in recovery from bulimia nervosa had been symptom-free for 4 months but binged and purged once after a stressful event. The client states, "I've completely failed. I'm back at square one." The MOST therapeutic response would be:

a) "You're right to be concerned. This means treatment isn't working and we need to change our approach." b) "One episode doesn't define your recovery. This is a lapse, not a relapse. What matters is what you do next—can you use your coping skills to prevent this from becoming a pattern?" c) "Don't worry about it. Everyone slips sometimes. Just forget it happened and move on." d) "You need to go back to residential treatment immediately."

**Answer: b) "One episode doesn't a lapse, not a relapse. What matters is what you do next—can you use your coping skills to prevent this from becoming a pattern?"**

*Explanation: This response appropriately distinguishes between a lapse (single episode) and relapse (return to regular pattern), normalizes that recovery isn't linear, validates the client's distress while reframing catastrophic thinking, and redirects focus to using recovery skills to prevent escalation. Option a reinforces the client's catastrophizing and black-and-white thinking ("one mistake = complete failure"), potentially demoralizing them and ironically increasing relapse risk. Option c minimizes the event in a way that doesn't acknowledge the client's very real distress and misses the opportunity to process what happened and strengthen relapse prevention. Option d is extreme overreaction—residential treatment isn't indicated for a single lapse in otherwise stable recovery; this would reinforce the idea that any slip is catastrophic. The therapeutic goal when lapses occur is to: (1) Normalize them as part of recovery process, (2) Prevent the "abstinence violation effect" (one lapse leading to "I've failed completely" leading to full relapse), (3) Use the lapse as learning opportunity—what triggered it? What can be done differently next time?, (4) Reinforce coping skills and return to recovery behaviors immediately. The therapist's response should convey: "This is disappointing but manageable. You haven't lost your progress. Let's understand what happened and practice recovery skills." Research shows that how clinicians respond to lapses significantly influences whether they become relapses—validating, normalizing, and problem-solving responses support continued recovery.*

**Question 2:** When working with the parents of an adolescent in recovery from anorexia nervosa using Family-Based Treatment principles, the therapist should emphasize:

a) That parents caused the eating disorder through their parenting mistakes b) That parents should take control of refeeding while presenting a united front and viewing the eating disorder as external to their child c) That parents should step back completely and let the adolescent manage their own eating d) That parents should focus primarily on their child's emotional state rather than ensuring adequate nutrition

**Answer: b) That parents should take control of refeeding while presenting a united front and viewing the eating disorder as external to their child**

*Explanation: This reflects core Family-Based Treatment (FBT) principles. In Phase 1 of FBT, parents take charge of refeeding because the adolescent's decision-making is compromised by starvation. Key elements include: (1) Parents present united front (if one parent is lenient, one strict, eating disorder exploits the gap), (2) Externalization—eating disorder viewed as external enemy ("Sarah vs. anorexia" not "Sarah has anorexia"), positioning all family members as allied against the disorder, (3) Parents responsible for ensuring adequate nutrition during active illness, with control gradually returned as recovery progresses. Option a reflects outdated, harmful "refrigerator mother" theories that blamed parents for causing eating disorders—FBT explicitly rejects this, positioning parents as solution, not cause. Option c is dangerous during acute AN—adolescent's judgment is impaired by malnutrition; stepping back allows disorder to continue. In FBT, autonomy is gradually returned in Phase 2 after weight approaching restoration, not during acute phase. Option d reverses appropriate priorities—during acute AN, ensuring adequate nutrition IS supporting emotional state (malnutrition causes mood deterioration, anxiety, cognitive impairment). Focus must be behavioral first (getting child to eat), with emotional processing happening alongside and improving with nutrition. FBT's strength is empowering parents as experts on their child who are best positioned to save their child's life, removing blame, and providing specific behavioral guidance for meal support.*

**Question 3:** Which of the following is considered an early warning sign that might indicate increased risk for relapse in someone recovering from an eating disorder?

a) Occasionally feeling dissatisfied with body image but using coping skills b) Eating a larger meal than planned without compensating and experiencing temporary discomfort c) Increasing frequency of weighing self, skipping meals "because too busy," and isolating from support system d) Talking openly about difficulties in recovery during therapy sessions

**Answer: c) Increasing frequency of weighing self, skipping meals "because too busy," and isolating from support system**

*Explanation: This option describes multiple behavioral warning signs indicating possible relapse trajectory: (1) Increasing body checking (more frequent weighing) suggests increasing preoccupation with weight, (2) Skipping meals regardless of rationalization ("too busy") represents return to restriction, (3) Isolating from support system removes protective factors. When multiple warning signs cluster, relapse risk increases significantly and requires intervention—therapist should explore what's happening, reinforce relapse prevention plan, possibly increase session frequency, involve treatment team. Option a describes normal recovery experience—body image fluctuates, but person is using coping skills appropriately (this is recovery in action, not relapse). Option b also describes normal occurrence—occasionally eating more than comfortable (perhaps at celebration or social event) and experiencing physical discomfort is different from bingeing; not compensating shows recovery skills being used. Option c represents eating disorder escalation. Option d is actually positive—openly discussing difficulties in therapy shows engagement, willingness to be vulnerable, and appropriate use of support (opposite of relapse, which typically involves secrecy and withdrawal). Other warning signs include: returning to rigid food rules, increasing exercise, avoiding social eating, "fat talk" increasing, black-and-white thinking about food, mood deteriorating, eating disorder thoughts becoming louder. The relapse prevention plan should identify personalized warning signs and specify what actions to take when they emerge (e.g., contact therapist, increase support group attendance, reach out to recovery friend, review coping strategies).*

**Final Comprehensive Examination**

**Instructions:** This 10-question examination covers all modules. You must score 80% or higher (8/10 correct) to receive continuing education credit. Take your time and select the BEST answer for each question.

**Question 1:** According to DSM-5-TR diagnostic criteria, which of the following is TRUE regarding the diagnosis of Bulimia Nervosa?

a) Compensatory behaviors must occur daily for at least one month b) The individual must be at low body weight c) Binge eating and compensatory behaviors must occur at least once weekly for 3 months, with self-evaluation unduly influenced by body shape and weight d) Binge eating episodes must involve at least 2000 calories to be considered objective binges

**Answer: c) Binge eating and compensatory behaviors must occur at least once weekly for 3 months, with self-evaluation unduly influenced by body shape and weight**

*Explanation: DSM-5-TR criteria for Bulimia Nervosa specify: (A) Recurrent binge eating episodes, (B) Recurrent compensatory behaviors (vomiting, laxatives, fasting, excessive exercise), (C) Occurring on average AT LEAST ONCE WEEKLY FOR 3 MONTHS, (D) Self-evaluation unduly influenced by shape/weight, (E) Not occurring exclusively during anorexia nervosa. Option a is incorrect—frequency is weekly, not daily, and duration is 3 months. Option b is incorrect—BN typically occurs at normal or above-normal weight; if at low weight, AN diagnosis takes precedence. Option d is incorrect—while binges typically involve larger than normal amounts, no specific calorie threshold exists in diagnostic criteria; the defining feature is eating more than most people would in similar circumstances combined with loss of control. Understanding accurate diagnostic criteria prevents under- or over-diagnosis and ensures appropriate treatment.*

**Question 2:** The Minnesota Starvation Experiment demonstrated that many psychological symptoms of eating disorders (food preoccupation, rituals, mood changes, cognitive impairment) are:

a) Primarily caused by underlying personality disorders b) Direct effects of semi-starvation that occur even in previously healthy individuals and often improve with refeeding c) Unrelated to nutritional status and require separate psychiatric treatment d) Permanent changes that persist even after weight restoration

**Answer: b) Direct effects of semi-starvation that occur even in previously healthy individuals and often improve with refeeding**

*Explanation: The Minnesota Starvation Experiment (1944-45) studied healthy male volunteers subjected to semi-starvation, demonstrating that: previously psychologically healthy individuals developed food obsession, bizarre eating rituals, mood deterioration, social withdrawal, cognitive impairment, and other "eating disorder" symptoms purely from starvation itself. These symptoms improved with refeeding, though some persisted months afterward. Clinical implications are profound: (1) Many ED symptoms are starvation effects, not just psychological pathology, (2) Weight restoration itself is therapeutic for psychological symptoms, (3) Psychological interventions are more effective after nutritional rehabilitation (can't do meaningful cognitive work with a starved brain), (4) Food preoccupation in AN is biological response to starvation, not just psychological obsession. This doesn't mean EDs are "just starvation"—psychological factors cause and maintain restriction—but it means starvation creates a vicious cycle maintaining symptoms. This knowledge removes blame ("you're not crazy—you're starved"), provides hope ("these symptoms can improve with nutrition"), and guides treatment sequencing (nutritional rehabilitation is essential, not optional).*

**Question 3:** When assessing a client presenting with restrictive eating, which finding would MOST clearly differentiate Avoidant/Restrictive Food Intake Disorder (ARFID) from Anorexia Nervosa?

a) The client is at low body weight b) The client reports sensory sensitivity to food textures and fear of choking, but NO body image disturbance or fear of weight gain and actually WANTS to gain weight c) The client restricts caloric intake significantly d) The client has amenorrhea and medical complications

**Answer: b) The client reports sensory sensitivity to food textures and fear of choking, but NO body image disturbance or fear of weight gain and actually WANTS to gain weight**

*Explanation: The KEY distinguishing feature between ARFID and AN is the MOTIVATION for restriction. In AN, restriction is driven by fear of weight gain, desire for thinness, and body image disturbance. In ARFID, restriction occurs due to: (1) Sensory sensitivities (textures, tastes, smells), (2) Fear of aversive consequences (choking, vomiting, pain), or (3) Lack of interest in eating—WITHOUT weight/shape concerns. Someone with ARFID may actively WANT to gain weight but be unable to eat due to sensory or anxiety barriers. Options a, c, and d can all occur in BOTH ARFID and AN—low weight, significant restriction, amenorrhea, and medical complications are possible in both disorders. What differs is the psychological motivation. This distinction is clinically crucial because treatment approaches differ substantially: AN treatment must address body image and fear of weight gain through cognitive restructuring, whereas ARFID treatment focuses on exposure to avoided foods, managing anxiety, addressing sensory issues (possibly with occupational therapy), without needing to address weight/shape concerns. Misdiagnosis leads to inappropriate treatment and poor outcomes.*

**Question 4:** A therapist conducts an assessment on a new client who reports binge eating 3-4 times weekly, intense shame about eating behaviors, eating when not physically hungry, and eating alone due to embarrassment. The client does NOT engage in compensatory behaviors (no purging, fasting, or excessive exercise). Based on this information, the MOST likely diagnosis would be:

a) Bulimia Nervosa b) Binge Eating Disorder c) Other Specified Feeding or Eating Disorder d) Anorexia Nervosa, binge-eating/purging type

**Answer: b) Binge Eating Disorder**

*Explanation: This presentation meets DSM-5-TR criteria for Binge Eating Disorder: (A) Recurrent binge eating with loss of control, (B) Episodes associated with 3+ markers (eating when not hungry, eating alone due to embarrassment, feeling disgusted/guilty—client shows these), (C) Marked distress (shame indicates this), (D) Occurring at least weekly for 3 months (3-4x/week meets this), (E) NOT associated with compensatory behaviors (key distinction from BN), and not occurring during AN or BN. Option a (BN) is incorrect because BN REQUIRES regular compensatory behaviors—the absence of compensation is what differentiates BED from BN. Option c might be considered if frequency or duration criteria weren't met, but this case meets full BED criteria. Option d is incorrect because there's no evidence of restriction or low weight. BED is the MOST COMMON eating disorder but often under-recognized. Critical points: (1) BED diagnosis doesn't depend on body weight (occurs across spectrum), (2) The absence of compensation distinguishes it from BN, (3) BED involves significant psychological distress and impairment, (4) Evidence-based treatments (CBT-E, DBT) are effective. Treatment focuses on normalizing eating patterns, addressing emotional triggers for bingeing, developing alternative coping strategies, and reducing shame.*

**Question 5:** In the context of eating disorder medical complications, which vital sign finding would require IMMEDIATE medical evaluation and possible hospitalization?

a) Heart rate of 62 bpm in an adult client b) Blood pressure of 100/65 mmHg while sitting c) Heart rate of 42 bpm with orthostatic blood pressure drop of 25 mmHg upon standing d) Temperature of 97.5°F

**Answer: c) Heart rate of 42 bpm with orthostatic blood pressure drop of 25 mmHg upon standing**

*Explanation: This combination represents severe cardiovascular compromise requiring immediate medical evaluation and likely hospitalization. Heart rate <45 bpm in adults (or <50 in adolescents) indicates significant bradycardia suggesting cardiac muscle dysfunction from malnutrition. Orthostatic BP drop of 25 mmHg (or >20 mmHg systolic, >10 mmHg diastolic) indicates orthostatic hypotension—inability of cardiovascular system to compensate for position changes due to depleted blood volume, dehydration, and cardiac weakness. Together these indicate the body is in medical crisis with high risk for syncope, arrhythmias, and sudden cardiac death. Hospitalization criteria include: HR <50 (adults) or <45 (adolescents), orthostatic instability, BP <90/60, temperature <96°F, rapid weight loss, severe electrolyte abnormalities, ECG abnormalities. Option a (HR 62) is mildly low but not emergent. Option b (BP 100/65) is on lower end of normal but not critical. Option d (temp 97.5°F) is slightly low but not severely hypothermic (<96°F is concerning). Therapists must know these criteria to recognize medical emergencies and facilitate immediate referral—continuing outpatient therapy with these vital signs is dangerous.*

**Question 6:** Enhanced Cognitive-Behavioral Therapy (CBT-E) identifies which mechanism as the CORE maintaining factor across all eating disorders?

a) Childhood trauma and insecure attachment patterns b) Overvaluation of weight and shape, where self-worth is determined primarily by weight, shape, and control over eating c) Family dysfunction and enmeshed boundaries d) Neurochemical imbalances in serotonin and dopamine systems

**Answer: b) Overvaluation of weight and shape, where self-worth is determined primarily by weight, shape, and control over eating**

*Explanation: CBT-E's transdiagnostic model identifies overvaluation of weight/shape as the central psychopathology maintaining ALL eating disorders (AN, BN, BED, OSFED). This means the person judges their self-worth primarily or exclusively by their weight, shape, and ability to control eating. This core mechanism drives: (1) Dietary restraint (attempting to control weight/shape), (2) Which paradoxically increases binge eating risk (physiologically and psychologically), (3) Which triggers compensatory behaviors, (4) Which reinforces overvaluation and the cycle continues. While trauma (option a), family factors (option c), and neurobiology (option d) may contribute to eating disorder DEVELOPMENT or vulnerability, they're not identified as the primary MAINTAINING mechanism in CBT-E. Treatment directly targets overvaluation through: addressing dietary restraint and food rules, reducing body checking/avoidance, expanding self-evaluation beyond appearance, challenging weight/shape-based thinking, and developing alternative sources of self-worth. The model's strength is identifying this shared mechanism allowing a unified treatment protocol across diagnoses rather than requiring different treatments for each ED. Success is measured not just by behavioral change but by reduced influence of weight/shape on self-evaluation.*

**Question 7:** Family-Based Treatment (FBT) for adolescent anorexia nervosa differs from older family therapy models primarily by:

a) Exploring past family conflicts and communication patterns to identify the cause of the eating disorder b) Empowering parents to take control of refeeding, externalizing the eating disorder as separate from the adolescent, and explicitly NOT blaming parents c) Focusing exclusively on the identified patient without involving family members d) Recommending parents take a hands-off approach, allowing the adolescent complete autonomy over eating

**Answer: b) Empowering parents to take control of refeeding, externalizing the eating disorder as separate from the adolescent, and explicitly NOT blaming parents**

*Explanation: FBT represents a paradigm shift from older family systems models. Core FBT principles include: (1) Agnostic about cause—doesn't seek to identify who/what caused ED or blame parents, (2) Parents positioned as SOLUTION, not problem—their love and knowledge of their child make them best equipped to help, (3) Parents take charge of refeeding during Phase 1 because adolescent's judgment is compromised by starvation, (4) Externalization—eating disorder viewed as external enemy ("Sarah vs. anorexia"), uniting family against disorder rather than viewing adolescent as problem, (5) Behavioral, present-focused rather than insight-oriented or historical. The famous "family meal" session exemplifies this—therapist coaches parents in real-time to work together getting child to eat. This contradicts option a (exploring past patterns/causes), option c (excluding family), and option d (hands-off approach). FBT research shows 40-50% full remission at treatment end, 60-75% at long-term follow-up—superior to individual therapy for adolescent AN. Success depends on: unified parental approach, externalization reducing blame/shame, behavioral focus (change eating first, understanding comes later), and gradual return of autonomy as recovery progresses (Phase 2). This approach reduced family guilt, provided concrete action steps, and harnessed the most powerful resource—parental love.*

**Question 8:** When a client with both an eating disorder and significant trauma history begins treatment, the MOST appropriate sequencing of interventions would be:

a) Begin intensive trauma processing immediately, as trauma is causing the eating disorder b) Stabilize the eating disorder (medical safety, regular eating, basic emotion regulation skills), THEN address trauma when client is stable and has coping resources c) Treat only the eating disorder and avoid addressing trauma entirely d) Provide trauma treatment and eating disorder treatment simultaneously from day one regardless of severity

**Answer: b) Stabilize the eating disorder (medical safety, regular eating, basic emotion regulation skills), THEN address trauma when client is stable and has coping resources**

*Explanation: Integrated trauma + eating disorder treatment requires careful sequencing. The recommended approach: (1) FIRST: Stabilize acute ED symptoms—ensure medical safety, establish regular eating patterns, reduce dangerous behaviors (severe restriction, purging), develop basic emotion regulation skills beyond ED behaviors, (2) THEN: Address trauma when client has stabilized—medically stable, has coping skills, can tolerate emotional intensity without resorting to ED behaviors. Rationale: Trauma processing is emotionally intense and activates distress. If client's primary coping mechanism is ED behaviors (restricting to numb, bingeing/purging to dissociate), intensive trauma work triggers ED symptom intensification, creating medical crisis and preventing both trauma processing and ED recovery. Building emotion regulation skills FIRST provides alternatives to ED behaviors when trauma material emerges. Option a (immediate trauma processing) is dangerous—likely destabilizes ED. Option c (avoiding trauma) prevents full recovery—trauma often maintains ED and must eventually be addressed. Option d (simultaneous intensive treatment) works only if ED is mild/stable; with severe ED, medical safety must be established first. The client needs education about sequencing: "We WILL address trauma—it's important. But not right now, because we need to ensure you're safe and have tools to manage the emotions that come up. When you're more stable, we'll process the trauma thoroughly." This prevents client feeling dismissed while maintaining safety.*

**Question 9:** Dialectical Behavior Therapy (DBT) for eating disorders teaches clients to use distress tolerance skills when experiencing intense urges to engage in eating disorder behaviors. The PRIMARY goal of distress tolerance skills is to:

a) Eliminate all distressing emotions permanently b) Survive crisis situations without making them worse by engaging in eating disorder behaviors, recognizing that urges peak and then decrease c) Distract from problems indefinitely without ever addressing them d) Convince oneself that urges aren't real and should be ignored

**Answer: b) Survive crisis situations without making them worse by engaging in eating disorder behaviors, recognizing that urges peak and then decrease**

*Explanation: Distress tolerance skills in DBT are specifically designed for crisis survival—getting through intense urges or emotions WITHOUT engaging in behaviors that provide short-term relief but long-term harm (bingeing, purging, restricting). Key concepts: (1) Urges are temporary—they peak and decrease if not acted upon (typically 15-45 minutes), (2) Goal isn't to eliminate distress but to TOLERATE it without making situation worse, (3) Skills include: STOP (Stop, Take step back, Observe, Proceed mindfully), ACCEPTS distraction techniques, self-soothing using five senses, improving the moment. The philosophy is: "This is painful AND I can survive it without using eating disorder behaviors." Option a is unrealistic—no skill eliminates all distress permanently; the goal is managing distress skillfully. Option c misrepresents distress tolerance—these are CRISIS skills for acute situations, not long-term avoidance; DBT also includes emotion regulation skills for long-term change. Option d is inaccurate—DBT validates that urges are real and powerful, not to be denied or ignored, but to be managed skillfully. Clinical application: When client calls in crisis ("I need to purge right now—the urge is unbearable"), therapist coaches: "I know it feels unbearable. AND urges peak and decrease. Let's use STOP—stop moving toward bathroom, take a step back, observe what's happening, what you're feeling. Then use a distraction skill—call a friend, go for a walk, hold ice. Ride the wave of the urge—it will crest and fall."*

**Question 10:** A client with a history of anorexia nervosa has been weight-restored and behaviorally stable for 6 months but continues to experience significant body image distortion and bases self-worth primarily on appearance. This indicates:

a) Treatment has completely failed and the client needs to restart intensive treatment b) This is normal in eating disorder recovery—psychological recovery (body image, overvaluation) often lags behind behavioral/weight recovery and requires continued intervention c) The client is being dishonest about their recovery progress d) Body image disturbance is permanent and unchangeable

**Answer: b) This is normal in eating disorder recovery—psychological recovery (body image, overvaluation) often lags behind behavioral/weight recovery and requires continued intervention**

*Explanation: Recovery occurs in stages, with behavioral/physical recovery typically preceding psychological recovery. A common pattern: (1) Behavioral changes (regular eating, weight restoration) happen first (months 0-6), (2) Psychological changes (thoughts quieting, body image improving, reduced overvaluation) happen more slowly (6-18 months or longer). The client described has achieved important progress (weight restored, behaviors stable) but psychological recovery is incomplete—body image distortion and overvaluation persist. This is EXPECTED and normal, not failure. Continued treatment should address: (1) Body image disturbance through exposure, cognitive restructuring, reducing checking/avoidance, (2) Overvaluation through expanding self-evaluation beyond appearance, developing other valued domains (relationships, accomplishments, values), (3) Cognitive-behavioral interventions targeting shape/weight-based thinking. Option a catastrophizes—this isn't treatment failure requiring restart; it's incomplete recovery requiring continued work. Option c assumes dishonesty without justification—client is accurately reporting their internal experience. Option d is pessimistic and inaccurate—body image CAN improve with appropriate intervention, though it may be among the last symptoms to fully resolve. Setting realistic expectations prevents discouragement: "Behavioral recovery comes first, psychological recovery takes longer. You're doing exactly what's expected—eating is normalized, weight restored. Now we focus on the thoughts and body image—this is the next phase of recovery, not a sign you're not recovering."*

**Course Conclusion: Integration and Application**

Congratulations on completing "Eating Disorders Assessment and Treatment." Over these 6 hours, you've journeyed through the complex landscape of eating disorders—from accurate diagnosis through evidence-based treatment to supporting sustainable recovery.

**Key Takeaways for Clinical Practice**

**1. Eating Disorders Are Medical Emergencies**

Never underestimate the medical seriousness. These are the deadliest psychiatric conditions—not because of psychiatric symptom severity alone, but because they profoundly affect every organ system. Your role includes:

* Recognizing medical warning signs requiring immediate intervention
* Coordinating with physicians for medical monitoring
* Understanding when outpatient treatment is insufficient
* Knowing hospitalization criteria

**2. Assessment Saves Lives**

Thorough, compassionate assessment identifies eating disorders others miss:

* Screen broadly—eating disorders affect all genders, ages, races, body sizes
* Challenge your assumptions about who "looks like" they have an eating disorder
* Ask about weight HISTORY, not just current weight
* Assess behaviors AND psychological factors
* Use validated instruments (EDE-Q, EAT-26)
* Determine appropriate level of care

**3. Evidence-Based Treatment Works**

The research is clear—specific interventions significantly improve outcomes:

* **CBT-E**: Transdiagnostic approach addressing overvaluation and maintaining mechanisms
* **FBT**: Gold standard for adolescent anorexia nervosa
* **DBT**: Effective for bulimia and binge eating, especially with emotion dysregulation
* Don't reinvent the wheel—use what works

**4. Recovery Is Possible**

Despite the severity and chronicity of eating disorders, recovery IS achievable:

* 50-60% full recovery rates with appropriate treatment
* Early intervention dramatically improves prognosis
* Recovery takes time (years, not months), but progress occurs throughout
* Lapses are normal—they don't erase progress
* Hope is realistic and essential

**5. Multidisciplinary Collaboration Is Essential**

You cannot treat eating disorders in isolation:

* Physicians monitor medical status
* Dietitians guide nutritional rehabilitation
* Psychiatrists manage comorbidities and medication
* Families provide crucial support
* Clear communication prevents dangerous gaps in care

**6. Cultural Competence and Inclusivity Matter**

Challenge stereotypes and provide affirming care:

* Eating disorders affect all demographics—recognize diverse presentations
* Address weight stigma and its role in delayed diagnosis
* Use inclusive language and affirming approaches with LGBTQ+ clients
* Understand cultural factors affecting presentation and treatment
* Advocate for equitable access to care

**7. Maintain Professional Boundaries and Self-Care**

Eating disorder work is emotionally intense:

* Supervision and consultation prevent burnout and errors
* Manage countertransference (frustration with ambivalence, anxiety about medical risk, desire to "fix")
* Maintain appropriate boundaries
* Recognize your scope—refer when necessary
* Take care of yourself to sustain this work

**From Knowledge to Action: Your Next Steps**

**Immediate Actions:**

1. Review your current caseload—might you have missed eating disorder symptoms?
2. Implement routine screening using validated measures
3. Identify eating disorder specialists in your area for referrals
4. Establish relationships with physicians, dietitians for consultation

**This Month:**

1. Review your informed consent—does it address eating disorder treatment parameters?
2. Develop crisis protocols for medical emergencies
3. Create resource list for clients (treatment programs, support groups, hotlines)
4. Begin reading evidence-based treatment manuals (CBT-E, FBT, DBT for EDs)

**This Year:**

1. Pursue additional training in evidence-based eating disorder treatments
2. Join professional organizations (Academy for Eating Disorders, NEDA)
3. Develop relationships with multidisciplinary treatment team members
4. Attend eating disorder-specific conferences or workshops
5. Seek consultation/supervision for eating disorder cases

**Resources for Continued Learning**

**Professional Organizations:**

* Academy for Eating Disorders (AED): www.aedweb.org
* National Eating Disorders Association (NEDA): www.nationaleatingdisorders.org
* International Association of Eating Disorders Professionals (iaedp): www.iaedp.com

**Essential Reading:**

* *Cognitive Behavior Therapy and Eating Disorders* by Christopher Fairburn
* *Treatment of Eating Disorders: Bridging the Research-Practice Gap* edited by Heather Thompson-Brenner
* *Help Your Teenager Beat an Eating Disorder* by James Lock and Daniel Le Grange
* *The DBT Solution for Emotional Eating* by Debra Safer, Sarah Adler, and Philip Masson
* *Sick Enough: A Guide to the Medical Complications of Eating Disorders* by Jennifer Gaudiani

**Training Opportunities:**

* CBT-E training through Centre for Research on Eating Disorders at Oxford (CREDO)
* FBT training through Training Institute for Child and Adolescent Eating Disorders (UCSD)
* DBT training through Behavioral Tech

**Assessment Tools:**

* Eating Disorder Examination Questionnaire (EDE-Q): Available free online
* Eating Attitudes Test (EAT-26): Available free online
* SCOFF Questionnaire: Brief 5-item screening tool

**Support Resources for Clients:**

* National Eating Disorders Association Helpline: 1-800-931-2237
* Crisis Text Line: Text "NEDA" to 741741
* NEDA Navigator: Free service connecting individuals to treatment resources
* National Association of Anorexia Nervosa and Associated Disorders (ANAD): Free peer support groups

**A Final Reflection**

Eating disorders are among the most challenging conditions you'll treat. They require medical knowledge beyond typical therapy training, evidence-based interventions rather than general supportive therapy, comfort with medical risk and crisis management, collaboration across disciplines, and patience with ambivalence and slow progress.

But they are also among the most rewarding. You have the opportunity to:

* Save lives—literally
* Restore health and hope
* Support families through impossible situations
* Watch clients reclaim their lives from the eating disorder
* Make a profound difference

The field of eating disorders needs competent, compassionate clinicians who understand the complexity and are willing to do this work with excellence. You've taken an important step by completing this training. Continue learning, seek supervision and consultation, stay current with research, and above all—don't give up on your clients, even when they've given up on themselves.

Every person with an eating disorder deserves a clinician who:

* Recognizes the condition accurately
* Understands the medical seriousness
* Provides evidence-based treatment
* Maintains hope for recovery
* Sees the person beyond the illness

Be that clinician.

**Certificate of Completion**

Upon successful completion of the final examination with a score of 80% or higher (8 out of 10 correct), participants will receive a certificate for **6 continuing education hours** in "Eating Disorders Assessment and Treatment."

**This course meets continuing education requirements for:**

* Licensed Professional Counselors (LPCs)
* Licensed Clinical Social Workers (LCSWs)
* Licensed Marriage and Family Therapists (LMFTs)
* Licensed Psychologists
* Licensed Professional Clinical Counselors (LPCCs)
* Psychiatrists
* Psychiatric Nurses
* Other mental health professionals as approved by their licensing boards

**Learning Objectives Achieved:**

✓ Conducted comprehensive eating disorder assessments identifying diagnostic criteria, medical risk, and level of care needs

✓ Recognized and responded appropriately to medical complications across all organ systems

✓ Implemented evidence-based treatment approaches (CBT-E, FBT, DBT) appropriate to diagnosis and presentation

✓ Addressed comorbid conditions through integrated treatment approaches

✓ Worked effectively with diverse populations using culturally competent, affirming approaches

✓ Collaborated within multidisciplinary teams for coordinated care

✓ Developed relapse prevention strategies supporting sustainable recovery

✓ Navigated ethical challenges unique to eating disorder treatment

**Course Information:**

*Course Title:* Eating Disorders Assessment and Treatment *Course Duration:* 6 Contact Hours *Course Level:* Intermediate *Target Audience:* Mental health professionals treating or planning to treat eating disorders

**Disclaimer:** This course provides educational information about eating disorder assessment and treatment. It does not constitute medical advice, establish treatment standards of care, or replace clinical supervision. Participants should work within their scope of practice and seek appropriate consultation for complex cases.

**Thank you for your commitment to providing excellent eating disorder care. Your dedication to this specialized area of practice makes a life-saving difference.**

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