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Welcome!

DEAR READERS,



Having been a member of the eating disorders community for more than 25 years, I welcome newcomers and send my best to everyone invested in eating disorders prevention and recovery.

As we enter this new decade together, I am emboldened by hope. There is a dynamic wave of optimism spreading throughout our community, led by evidence-based approaches to treatment and prevention, current research that both answers our questions and sparks important new ones, the energy of our activists, and improvements in access to treatment.

Our resources and support services for all aspects of eating disorder recovery continue to reach many, and we appreciate the positive, encouraging feedback we receive. Our contributors are always gracious in sharing their knowledge and wisdom in the pages of each catalogue, and while we can't fit every worthwhile book recommendation in our magazine, we invite you to visit **EDcatalogue.com/books** for additional titles.

Please take a thoughtful look at our Treatment Facilities Index. These centers are dedicated to eating disorder recovery and your well-being, and we are grateful for their support.

WITH WARM REGARDS,

Kathy Cortese

LCSW, ACSW, CEDS
Editor-in-Chief

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Bringing Neuroscience to the Patient

BY GUIDO K.W. FRANK, MD



When anorexia nervosa was first described by Richard Morton in 1689, as what he called “nervous consumption,” and later independently by Gull and Lasègue in 1873, there was little understanding of the causes behind the condition. Then, in the late 1960s and 1970, largely promoted by Hilde Bruch’s writings, including her famous book *The Golden Cage*, a psychodynamic model was adopted that saw the family as the origin and etiology of the problem, like it had been for schizophrenia and autism before. Only over the past three decades has research made tremendous progress in understanding the neurobiological underpinnings of eating and other psychiatric disorders. This has come on the heels of improved technology to study the living human brain, and the fields of neuroscience and psychology developing models to tie behavior with brain function in healthy individuals and test those models in individuals with eating disorders.

Review articles of the brain-imaging literature on anorexia nervosa have repeatedly implicated reward-processing circuits, aside from pathways involved in cognition or emotion processing; nevertheless, understanding the exact neurobiology of anorexia nervosa has been challenging. My lab has pursued the study of reward circuits in anorexia nervosa and specifically the dopamine-associated prediction error model. The dopamine prediction error is a learning signal important for food approach, and animal models have suggested that neuronal dopamine activation has a central role in food intake and restriction.

The dopamine neurotransmitter system has been intensively studied and is well-characterized. Its neurons' cell bodies lie in the brain stem in the ventral tegmental area and substantia nigra, and from there distribute to the cortical and subcortical brain. The basal ganglia, especially the ventral striatum, which includes the nucleus accumbens, receives dopaminergic input and has been involved in the drive to approach rewarding stimuli. Those reward stimuli can be



unconditioned (such as sweet tastes being preferred by babies at birth) or conditioned (learned later in and throughout life), just like in Pavlov's famous conditioning paradigm.

A central feature of dopamine neuron response is that it is triggered by unexpectancy—i.e., a discrepancy between what one expects and what, in fact, happens. After receiving an unexpected reward such as food or money, a dopamine surge is elicited in the striatum and midbrain, called a positive prediction error response. When receiving this reward becomes a regular occurrence and can be associated with a specific predictor or conditioned stimulus, the dopamine signal is elicited by the conditioned stimulus that predicts the reward. However, the dopamine system does not respond when the actual reward is received, because the prediction matches the outcome. If the reward is predicted but not received (there is no food or money after expecting it), there is a dip in dopamine activity in the brain, which reflects the negative prediction error (unexpected omission). The beauty of this model lies in its applicability

to real life. For instance, a colleague surprises a coworker by leaving a piece of cake on his desk, and when he gets to his desk and sees it, he has a surge in dopamine, because there is a reward that was not expected. If this colleague now puts a piece of cake on that person's desk every Monday, he will learn that Monday is a day when he will find a piece of cake on his desk. Biologically what happens is that when the person gets up on Monday morning, he may think of the cake that he will later receive, and "Monday" will become a conditioned stimulus and he will have a dopamine surge. However, when he gets to his desk and finds the cake, there will be no dopamine surge, because the reward received and the reward expected were similar and there was no "error" in expectation or prediction. What happens if the friendly colleague is unexpectedly sick one Monday and cannot bring the cake? The person still had the expectation of getting cake, but since there is no cake and, thus, he is experiencing an unexpected "omission" of the reward, he may feel disappointed, and that is associated with a dip in dopamine neuron activity.

This dynamic can be studied in the living human brain with functional brain imaging during application of a Pavlovian conditioning paradigm: Participants learn to associate sweet tastes or monetary stimuli with pictures of colored shapes that become the conditioned stimulus and appear on the screen before money or sweet solution is delivered. Sometimes when the participants expect to get the reward, they will not get it; at other times, the reward is delivered unexpectedly.

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

NATIONAL EATING DISORDERS ORGANIZATIONS

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

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



BOOK EXCERPT

I CAN BEAT ANOREXIA!

Finding the Motivation, Confidence, and Skills to Recover and Avoid Relapse

In this excerpt from *I Can Beat Anorexia!*, **Dr. Nicola Davies** offers tips on how to jump-start your anorexia recovery.

What Does It Take to Beat Anorexia?

So, what is beating anorexia truly about? It requires embracing a lifestyle change—one that begins with the mind. It isn't just about changing what you eat or what you do, but *wanting* to make changes to how you live the rest of your life. To jump-start your beating anorexia journey, you need to begin by looking closely at your attitudes and behaviors. From there, you need to develop the *willingness, readiness, and confidence* to make the changes required to beat your illness.

Be Willing

Do you really want to live a healthier life? If yes, then you need to be *willing* to look at various aspects of your life, such as the habits and routines that are contributing toward the anorexia. Next, you need to be *willing* to take steps toward reducing or getting rid of these destructive habits.

Rather than focusing on your physical weight, start considering your mental weight and cutting down on the excess weight in your mind—the unhealthy attitudes and habits that are maintaining the anorexia. Some examples of mental weight include the following:

- **Giving in to deeply ingrained unhealthy eating rituals:** “I must

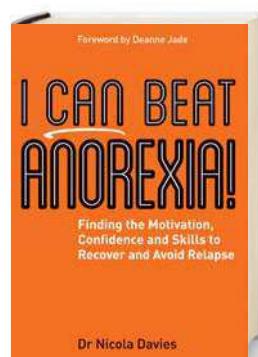
eat the same foods at the same time each day.”

- **Fearing what others might say about your attempts at making a serious change:** “People see me as someone who is in control of her food. What will they think of me if I start eating more?”
- **Postponing lifestyle change plans and blaming it on work demands, peer pressure, or family issues:** “I want to get better, but I need to wait until I am out of this stressful job.”

If you aren't *willing* to examine and identify your unhealthy mental patterns and attitudes, you may find it difficult to motivate yourself to accept and maintain change. In which case, any changes you make will only yield short-term results.

Be Ready

Health psychologists use something known as the Readiness to Change scale to help people change unhealthy behaviors, including behaviors related to anorexia. Understanding and using this tool yourself can help you progress through your journey to beat anorexia. In particular, if you have been unsuccessful in changing your lifestyle in the past, this tool can help you evaluate the obstacles that may be in your way. ◆



Reprinted with permission from Jessica Kingsley Publishers, *I Can Beat Anorexia! Finding the Motivation, Confidence, and Skills to Recover and Avoid Relapse*, by Dr. Nicola Davies, 160 pages, paper, 2017.

DIAGNOSING ANOREXIA NERVOSA

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

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

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

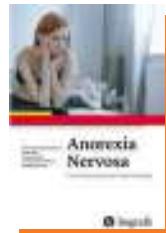
DIAGNOSING OTHER SPECIFIED FEEDING OR EATING DISORDER

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

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



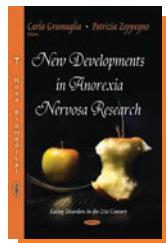
ANOREXIA



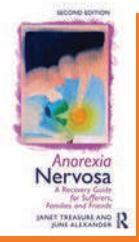
Anorexia Nervosa: Focal Psychodynamic Psychotherapy
Hans-Christoph Friederich, Beate Wild, Stephan Zipfel, Henning Schauenburg & Wolfgang Herzog, 124 pages, paper, 2019



Eating Disorders Anonymous: The Story of How We Recovered from Our Eating Disorders
Janet Treasure & June Alexander, 192 pages, paper, 2016

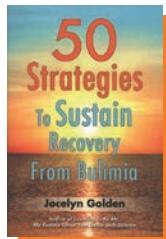


New Developments in Anorexia Nervosa Research: Eating Disorders in the 21st Century
Carla Gramaglia & Patrizia Zeppigno, 208 pages, hardcover, 2014



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

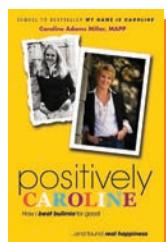
BULIMIA



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



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



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



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The (In)Visible Other: Intersubjectivity, Blackness, and Eating Disorders Treatment

BY MARVICE D. MARCUS, PHD

Identity and Representation

Sociodemographic factors heavily influence our experience of the world. Physical and mental health outcomes are two of the domains in which identity yields fascinating and sometimes harrowing information about individual lives. Arguably one of the most powerful social determinants of life chance is race, an otherwise troublesome organizing principle buttressed by colonial thought. Understood as specious in nature, race as a construct is far-reaching and governs material and immaterial realities. For example, blackness is a sociopolitical construction that engenders a great deal of contested meaning in the public imagination.



Historically, the ascription of blackness has translated to (in)visibility and erasure, ethnoviolence, pernicious commodification, and general social death. Contextually, research suggests that race, among many identity variables, profoundly dictates unmet mental health needs for Black people, with eating disorders treatment being an ongoing topic of discussion in clinical science and education literature.

Scientific inquiry has produced mixed results with regard to incidence of body image disturbances in Black communities, and yet a fundamental curiosity remains: To what extent does racial bias compromise the integrity of epidemiological measures, assessment, and intervention, and psychological practice? Smith and other proponents of rigorous theorizing of culture and human behavior provide concrete tools to critically examine power. Mattering and representation come to exist by way of power and social influence, and thus discussions centered on eating disorders and race must incorporate an analysis thereof. As such, in the sections to follow, salient themes about eating disorders pathology are reviewed as it pertains to Black people, before charting material on intra- and interethnic treatment dyads. Finally, concluding remarks will briefly highlight the significance and utility of advancing criticality principles in mental health and allied fields.

Noteworthy is the phenomenon of cultural mistrust in Black communities. Whaley describes cultural mistrust as a form of healthy paranoia, particularly in health care settings, wherein unfair treatment of Black people is rampant. Questions about provider competence and guardedness are often indicative of cultural mistrust. More recently,

educators who adopt a critical lens of inquiry have, in many ways, nuanced conversations about cultural mistrust by integrating research on antiblackness. A discussion on antiblack racism (ABR) is pertinent to cultural mistrust in light of deafening neoliberalism, which seeks to rewrite America's sordid history of race relations and hostility toward difference. In addition, I contend that ABR, a permutation of racism, provides additional clarity on the reasons why Black people avoid coming into contact with systems, including the counseling/psychotherapy enterprise. How, then, does one thoroughly explain the dynamic interaction between Black subjectivity and body image disturbances? A starting point is an embracing of identity, namely blackness, in the counseling discipline. This contention is supported by the vast stock of literature focused on identity formation, as Black individuals customarily privilege race as a central marker of their subjectivity.

Stock of Literature

Quantitative and qualitative methods have been used to examine disordered eating within Black communities. A universal thread within most, if not all, of the studies is inequality and inequity. More specifically, racial subjugation and acculturative stress are hallmarks that foreground the ubiquity of Black marginality as interpersonal and systemic indignities. The bulk of research, furthermore, tends to focus on Black women and adolescent children, with binge eating emerging as the primary concern. Body image dissatisfaction, including a slight preference for slenderness, has also been observed. Some research suggests that ethnic minority boys are at a greater risk for reporting disordered eating, although sampling

limitations should be considered before overestimating results. At large, eating disorders studies conspicuously focus on White, non-Hispanic women and elucidate a hegemonic cultural production in the collective unconscious. Critical scholars urge us to interrogate the "normal" as "abnormal," while bearing in mind the politics of power, representation, and mattering.

Intraethnic Treatment Dyads

The efficacy of therapist-patient matching has long been a topic of conversation and research, particularly when confronted with the violence of "racial realism" in the greater polity. Cabral and Smith conducted a meta-analytic review of studies focused on therapist-client matching along racial/ethnic lines. Data from the study explicated that Black people moderately prefer a therapist with a shared racial identity. Other research has produced conflicting data sets pertaining to preference, perception, and outcomes. Therapist-patient matching is emblematic of interpersonal dynamics within complex social milieus, which raises curiosities regarding within- and between-group racial subjectivity. In fact, Hall hypothesized that cultural subgroups have their own (collective) unconscious. A narrative approach to service, be it in the form of research or counseling, may assist behavioral scientists and practitioners with making inferences about identity-based ego processes and social functioning. Eating disorders are exceedingly cultural phenomena; therefore, critically interacting with lived stories vis-à-vis therapy is a liberationist intervention.

 [THIS ARTICLE CONTINUES AND CAN BE FOUND IN ITS ENTIRETY AT EDCATALOGUE.COM.](#)

How Do We Reach People Who Can't Access the Treatment They Need?

BY DOUGLAS W. BUNNELL, PHD, FAED, CEDS

Eating disorders affect nearly 30 million people in the United States alone. Virtually everything known about the treatment of eating disorders has evolved on the basis of clinical and research experience with a limited subset of that 30 million. Our best available treatments are accessible to an even smaller subset because of limited clinician availability, cost, dissatisfaction with the nature of the available treatments, and pessimism about treatment effectiveness. We, as a field, need to identify treatment interventions that are both effective and accessible to a much wider population of people who struggle with the full range of eating disorders.

Think about what a typical patient with an eating disorder has to manage. The patient, at one end of the treatment continuum, will need to find and pay a psychotherapist or family therapist, and often a physician, nutritionist, and psychiatrist, as well. Our best evidence-supported treatments recommend 20 or more sessions over the course of six to 12 months. If a patient's eating disorder is more severe, the patient may need more frequent sessions over a longer period of time or may need referrals for higher levels of care, such as partial hospitalization, residential, or inpatient programs, which are even less accessible and considerably

more expensive. Higher levels of care are also often tremendously disruptive to a patient's social, academic, and occupational routines. And, not surprisingly, the limited levels of treatment intensity reflect the needs of providers and payers, not the needs of patients and their carers.

So here is the dilemma: How can we develop and deliver high-quality, evidence-based treatment interventions to a much wider range of people with eating disorders? Might there be ways to provide more flexible, accessible, adaptable, and affordable interventions? Over the past decade, clinical researchers and public health experts have

developed a number of low-intensity and community-based programs that utilize trained nonprofessionals to address depression, anxiety, and post-traumatic stress disorder in countries that lack adequate mental health resources. The Mental Health Innovation Network, in a 2015 review of innovations in mental health service delivery, noted that low-intensity psychological interventions "refer to interventions that do not rely on specialists and are modified, brief evidence-based therapies including guided self-help or e-mental health. They tend to be transdiagnostic, delivered by paraprofessionals, and have a primary focus on teaching self-management skills to clients."

The relative success of these low-intensity, low-cost programs, and the ease with which they can be scaled up and implemented, has sparked tremendous interest in how to adapt the model to address underaddressed mental health needs in the developed world. How might these programs help address the gaps we see in our eating disorder treatment systems?

One solution to these issues is to focus on the development of lower-intensity treatments that are easily accessible, affordable, and scalable across a wide region. Many, if not most, people needing treatment for their eating disorder are not able to access adequate treatment because our treatments tend to be delivered by individual clinicians in a single office for a limited number of hours. The inconvenience and burden of committing to a full course of treatment can be overwhelming and unavoidably activates and empowers ambivalence. We've also seen a consistent and reductionistic consolidation of treatments deemed "evidence-based." Yet we know that the best available treatments for eating disorders, particularly family-based treatment and enhanced cognitive behavioral therapy, do not lead to full recovery in at least half of the patients who enter treatment. Most of our treatment models continue to struggle with premature termination, and we have a limited understanding of why so many people find so many of our treatments to be unacceptable to them. Guided self-help (GSH), telehealth, community or peer support programs, mental health/eating disorder "coaching," and applications such as Recovery Record all try to address these fundamental challenges in our current treatment delivery models by layering in extra interventions and support that are delivered in less costly ways.

These various interventions have research track records that suggest they can have a significant impact for people with eating disorders. GSH is a low-intensity intervention that has shown promise in screening

DO YOU HAVE AN EATING DISORDER?

Respond honestly to these questions. Do you:

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

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

Warning Signs

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

and treating people for a variety of behavioral health issues, including anxiety, depression, and eating disorders. Newer iterations of GSH can now be delivered through the internet, either in groups or on an individual basis. While it seems intuitively obvious that GSH might be

particularly effective for individuals with less severe symptomatology, there is actually considerable evidence that it may be an effective first-line intervention for more severe clinical presentations.

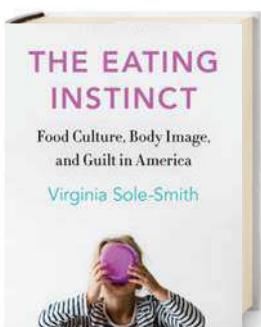
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BOOK EXCERPT

THE EATING INSTINCT:

Food Culture, Body Image, and Guilt in America

In this excerpt from *The Eating Instinct*, **Virginia Sole-Smith** holds a mirror up to America's diet culture and the myth of willpower.



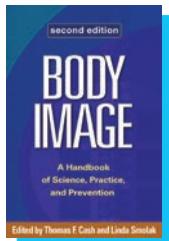
Excerpted from
The Eating Instinct:
Food Culture, Body Image,
and Guilt in America by
Virginia Sole-Smith.
Published by Henry Holt
and Company. Copyright
© 2018 by Virginia Sole-
Smith. All rights reserved.
283 pages, hardcover.

We don't want to be hungry because our culture has told us that we don't want to be fat. Sixty percent of Americans are currently trying to lose weight, and 75 percent have made some effort in the past, according to a survey published by University of Chicago researchers in October 2016. And there is a deeply held belief in our society—one that runs all the way back to the Bible, to the seven deadly sins—that people get fat because they are gluttonous, slothful, and weak, and lack willpower around food. This isn't true: Though some obese people do eat compulsively (as do some thin people), the vast majority do not. Only 3.5 percent of women and 2 percent of men are diagnosed with binge eating disorder (itself a complicated psychological condition that is about much more than self-control), while 68.8 percent of Americans are classified as overweight or obese. Even if binge eating disorder is wildly underdiagnosed, it's a crude mischaracterization to assume that being overweight is only about eating too much. Genetics, biology, psychology, socioeconomic status, and other environmental factors all contribute to body size. "We know there are probably a hundred or more kinds of obesity, each with different causes and clinical characteristics," says Lee M. Kaplan, a gastroenterologist and the director of the Obesity, Metabolism,

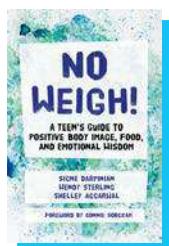
and Nutrition Institute at Massachusetts General Hospital. Burgard argues that even attempting to classify obesity by type or origin is misguided: "We have this fundamental misunderstanding that everyone should be close to the same weight, and therefore higher-weight bodies can never be healthy and well regulated," she explains. "But what if most people's bodies are regulating themselves fine, just at a wider variety of weights than we've been taught to consider acceptable?"

Nevertheless, the willpower misconception persists, and it contributes to our sense that being overweight is dysfunctional and abnormal—that the size of our body is proof that our eating is somehow out of control, and that we'll only have a good life if we can conquer our hunger and lose the weight. Because we think hunger is bad and weight loss is good, the idea that a surgery can remove the former and achieve the latter is deeply seductive. But one consequence of that trade-off is never again eating the other half of the protein bar, let alone the muffuletta sandwich. Is merely removing the experience of physical hunger enough to cancel out that loss? Can someone's ability to eat really be so permanently transformed? The very reasons for weight-loss surgery's purported success also require us to ask: Should we be doing it at all? ♦

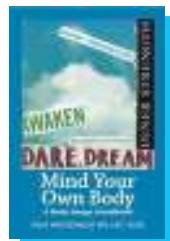
BODY IMAGE



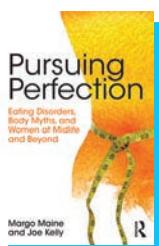
Body Image, Second Edition: A Handbook of Science, Practice, and Prevention
Thomas F. Cash & Linda Smolak, 490 pages, paper, 2012



No Weigh! A Teen's Guide to Positive Body Image, Food, and Emotional Wisdom
Signe Darpinian, Wendy Sterling & Shelley Aggarwal, 192 pages, paper, 2018

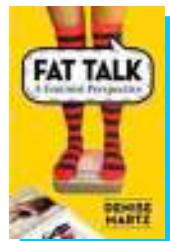


Mind Your Own Body: A Body Image Handbook
Gina Macdonald, 174 pages, paper, 2018



Pursuing Perfection: Eating Disorders, Body Myths, and Women at Midlife and Beyond
Margo Maine & Joe Kelly, 230 pages, hardcover/paper, 2016

PREVENTION



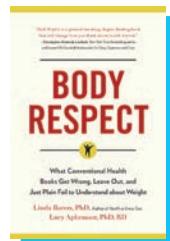
Fat Talk: A Feminist Perspective
Denise Martz, 204 pages, paper, 2019



Fat Tactics: The Rhetoric and Structure of the Fat Acceptance Movement
Eric Smith, 114 pages, hardcover, 2018



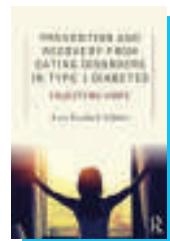
Healthy Habits: The Program Plus Food Guide Index and Easy Recipes: 8 Essential Kid-Friendly Nutrition Lessons Every Parent and Educator Needs
Laura Cipullo, 108 pages, paper, 2013



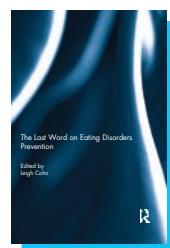
Body Respect: What Conventional Health Books Get Wrong, Leave Out, and Just Plain Fail to Understand About Weight
Linda Bacon & Lucy Aphramor, 240 pages, paper, 2014



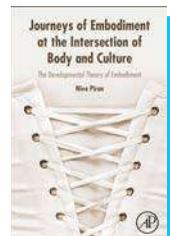
Healthy Bodies (curriculum): Teaching Kids What They Need to Know
Kathy J. Kater, 260 pages, paper, 2012



Prevention and Recovery from Eating Disorders in Type 1 Diabetes: Injecting Hope
Ann Goebel-Fabbri, 152 pages, paper, 2017



The Last Word on Eating Disorders Prevention
Leigh Cohn, editor, 124 pages, hardcover, 2016



Journeys of Embodiment at the Intersection of Body and Culture: The Developmental Theory of Embodiment
Niva Piran, 336 pages, hardcover, 2017

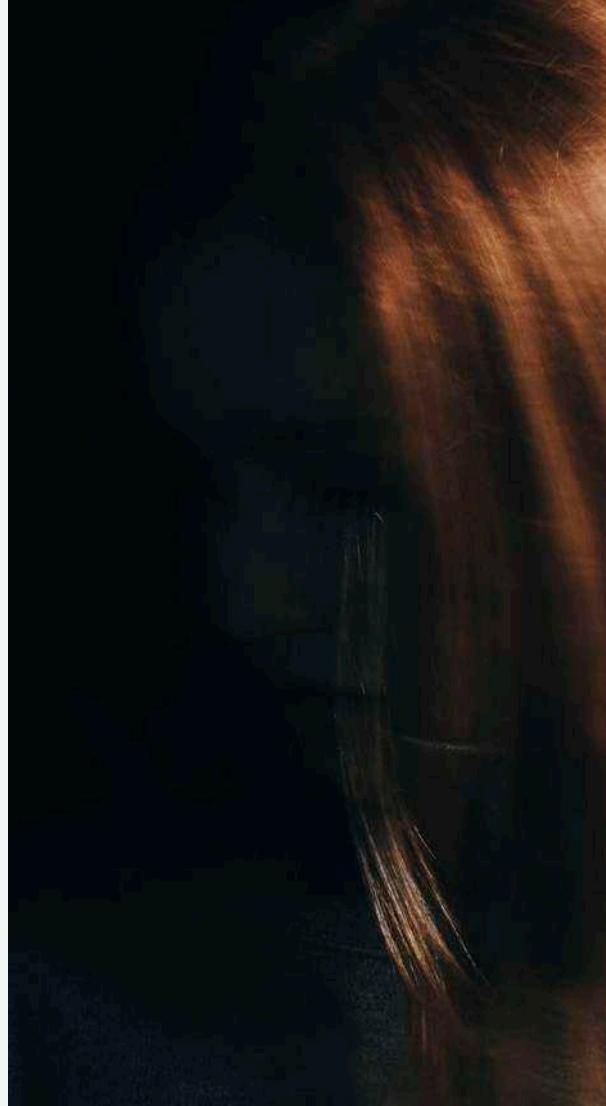


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The Many Faces of Binge Eating Disorder

BY AMY PERSHING, LMSW, ACSW

Binge eating disorder (BED) is endemic in our culture. BED is three times more common than all other eating disorders combined, more prevalent than breast cancer, HIV, or schizophrenia. Binge eating affects people across the life span, in all socioeconomic groups, races, sexual orientations, genders, and all body shapes and sizes. It is by far the most common eating disorder among men (40 percent of people with BED identify as male). BED is present in three to five out of every 10 people seeking weight-loss surgeries. Literally millions of people struggle with the disorder. Yet even with this prevalence, BED is still an eating disorder often missed in clinical and medical assessments. Research suggests that only 40 percent of those with BED will receive treatment in their lifetime (and this is among only those diagnosed). For many with BED, efforts to stop binge eating are short-lived, and resulting yo-yo weight losses and gains are common. By the time people with BED arrive in our offices for help, they are exhausted, hopeless, and ashamed.



I have treated BED for more than 30 years. In that time, I have deeply explored the adaptive roles binge eating plays in the lives of my clients. Among these roles, binge eating creates a temporary disconnection from pain or fear, and allows other feelings like anger and grief to be expressed with more psychological safety. A client of mine, Linda, says this: "Food thoughts and planning a binge gave me a safe harbor when I was afraid or lonely. It got me through my past, my divorce, a whole lot of pain I had no idea how to address." Such a relationship with food brings respite from a psychological and somatic experience that seems impossible to withstand. Molly describes the experience of a binge this way: "The urge happens when I'm thinking about something upsetting or uncomfortable. My thoughts drift



to what 'bad' foods I have to eat. It's a seemingly innocent line of thought. Something like, *Oh, what could make me feel better right now?* And then the decision comes quickly and overwhelmingly. The energy shifts to something compulsive and shameful. Once I've committed to bingeing, I need to do it as soon as possible. The blinders come on, and as soon as I'm in the house, I'm reaching for whatever I can." Binge eating is typically frenetic and impulse-driven, and seems impossible to waylay. As my client Katie notes, "It's eating fast. Shoveling food in. It tastes so good. I want more. It's taking another bite—and another, and another—while still chewing the first bite. I tell myself I deserve it. It's been a long day. It's late. I'm tired. I'll exercise more, soon, tomorrow, next week. I'll make up for it somehow." Allen says this: "I know

I am tired of performing, of getting everything right everywhere. Binge eating is a way to do *nothing right*. In a weird way, it makes me feel powerful for a moment. Then it comes crashing down, and I feel totally out of control." Claudina describes it this way: "I first experience the urge to binge-eat physically. I start to feel anxious in my stomach. I feel a gnawing deep in my belly right above my belly button, but it's not hunger—not physical hunger, anyway. It's feelings of anxiety and self-doubt and worry. I think of it as a mini-tornado in my stomach, twisting and turning furiously and growing bigger and gaining strength until I make it go away with food."

People with BED live myopic and diminished half-lives, often with the sense that some profound characterological weakness must be at the heart of their inability to change. In fact, as clinicians know well, many forces collide to create BED. Genetics, the biological impact of dieting and often severe food restriction, trauma of all kinds (including weight stigma), sociocultural oppression, and access to health care all can play a role.

In my clinical work with BED, I have found four precepts especially important to creating a platform on which recovery from this complex disorder can progress over time. These precepts promote the most critical components of successful treatment: depathologizing the client's relationship with food, and empowering people to listen to themselves (and others) through a lens of curiosity, compassion, and strength.

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

DIAGNOSING BULIMIA NERVOSA

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

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

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

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

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

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

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

BINGE EATING DISORDER: The Journey to Recovery and Beyond

In this excerpt from *Binge Eating Disorder*, **Amy Pershing, LMSW, ACSW, and Chevese Turner** reveal the surprisingly wide breadth of people who struggle with BED.

Who Struggles with BED?

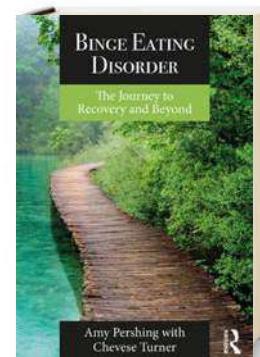
ED is not confined to the eating disorder stereotype of young, white women. Approximately 40 percent of those with binge eating disorder are male. Additionally, over the past few years, there has been evidence of significant disordered eating across racial and ethnic minorities. Analysis of the Minnesota Adolescent Health Study found dieting, a common precursor to BED, was associated with weight dissatisfaction, seeing oneself as “overweight,” and low body pride in *all* ethnic groups. Exact statistics on the prevalence of eating disorders among women of color are still largely unavailable. Additionally, more research is needed to determine if the experience of the disorder is the same for people from different food cultures and differing genetic makeup.

Environmental race-based stress for people of color can trigger the onset of disordered eating patterns as well. Among women of color, the process of acculturation can be one such source of stress. “By definition, acculturation is the process by which one group asserts its influence over another. The result is likely to be difficult, reactive, and conflictual, affecting one’s physical and psychological functioning,” according to Davis and Katzman. The dominant images of femininity in mainstream culture are still thin, white, and young. Body ideals and social and cultural expectations vary, and

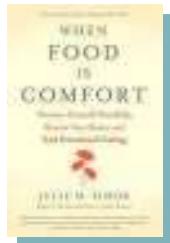
more research will help us determine the nuances of the clinical picture.

Sexual orientation can be a contributing factor in developing BED as well. There remain significant dangers in coming out, including fear of rejection, discrimination, bullying, and violence. Stigma and shame from non-binary gender expressions or transgender identity are common. Body image ideals within some LGBTQ communities may also contribute to body shame. Differences in rates of binge eating within the LGBTQ community have yet to be described in the research, but one thing is clear: Many of these factors can be traumatic, and trauma, as we will see, sharply increases vulnerability to an eating disorder.

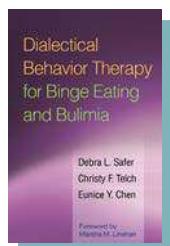
Poverty and food scarcity can also significantly impact the development of binge eating behavior. Research shows an increased prevalence of various eating disorder features, particularly binge eating, in people who are unemployed or underemployed. Poverty is especially hard on young children. The stress and hardship that goes along with growing up poor can cause a child to cope in unhealthy ways, and food may well be one of few available soothing mechanisms. If food itself is scarce or unpredictable, enforced cycles of restriction (as with intentional behavioral weight loss programs) can in and of themselves increase the likelihood of binge eating when food is available. ♦



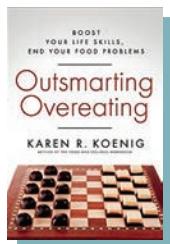
Pershing, A & Turner, C. (2018) *Binge Eating Disorder: The Journey to Recovery and Beyond*. Routledge. 182 pages, paper.



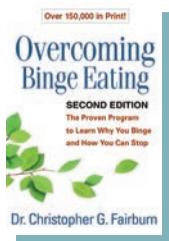
When Food Is Comfort: Nurture Yourself Mindfully, Rewire Your Brain, and End Emotional Eating
Julie M. Simon, 336 pages, paper, 2018



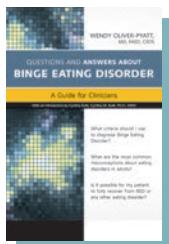
Dialectical Behavior Therapy for Binge Eating and Bulimia, Reprint Edition
Debra L. Safer, Christy F. Telch & Eunice Y. Chen, 244 pages, hardcover/paper, 2017



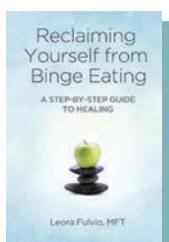
Outsmarting Overeating: Boost Your Life Skills, End Your Food Problems
Karen R. Koenig, 232 pages, paper, 2015



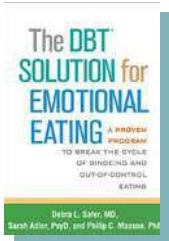
Overcoming Binge Eating, Second Edition: The Proven Program to Learn Why You Binge and How You Can Stop
Christopher G. Fairburn, 243 pages, paper, 2013



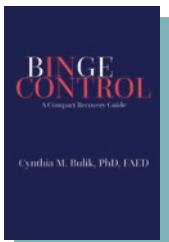
Questions and Answers About Binge Eating Disorder: A Guide for Clinicians
Wendy Oliver-Pyatt, 96 pages, paper, 2017



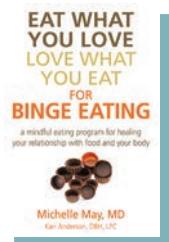
Reclaiming Yourself from Binge Eating: A Step-by-Step Guide to Healing
Leora Fulvio, 327 pages, paper, 2014



The DBT® Solution for Emotional Eating: A Proven Program to Break the Cycle of Bingeing and Out-of-Control Eating
Debra L. Safer, Sarah Adler & Philip C. Masson, 278 pages, hardcover/paper, 2018



Binge Control: A Compact Recovery Guide
Cynthia M. Bulik, PhD, FAED, 38 pages, paper, 2015



Eat What You Love, Love What You Eat for Binge Eating:
Michelle May & Kari Anderson, 194 pages, paper, 2014

DIAGNOSING BINGE EATING DISORDER

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

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

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

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

C. Marked distress regarding binge eating is present.

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

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

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



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DIAGNOSING AVOIDANT/ RESTRICTIVE FOOD INTAKE DISORDER

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

- 1.** Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
 - 2.** Significant nutritional deficiency.
 - 3.** Dependence on enteral feeding or oral nutritional supplements.
 - 4.** Marked interference with psychosocial functioning.
- B.** The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
- C.** The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
- D.** The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

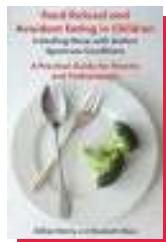
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(DSM-5) © 2013 by American Psychiatric
Publishing

ARFID



Conquer Picky Eating for Teens and Adults: Activities and Strategies for Selective Eaters

Jenny McGlothlin
& Katja Rowell, 162
pages, paper, 2018



Food Refusal and Avoidant Eating in Children, Including Those with Autism Spectrum Conditions: A Practical Guide for Parents and Professionals

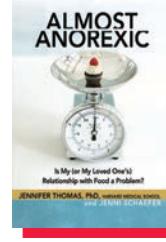
Gillian Harris &
Elizabeth Shea, 232
pages, paper, 2018

PERSONAL STORIES



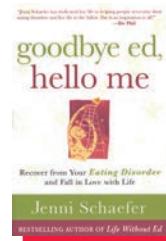
Living Full: Winning My Battle with Eating Disorders

Danielle Sherman-
Lazar, 256 pages,
paper, 2019



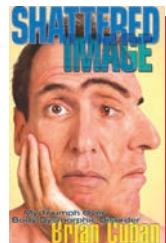
Almost Anorexic: Is My (or My Loved One's) Relationship with Food a Problem?

Jennifer J. Thomas
& Jenni Schaefer,
287 pages,
paper, 2013



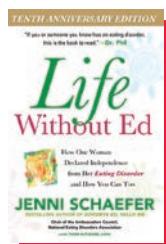
Goodbye Ed, Hello Me: Recover from Your Eating Disorder and Fall in Love with Life

Jenni Schaefer,
249 pages,
paper, 2009



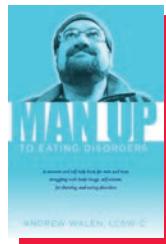
Shattered Image: My Triumph over Body Dysmorphic Disorder

Brian Cuban, 224
pages, paper, 2013



Life Without Ed, 10th Anniversary Edition: How One Woman Declared Independence from Her Eating Disorder and How You Can Too

Jenni Schaefer
with Thom
Rutledge, 188
pages, paper/
audiobook, 2014



Man Up to Eating Disorders

Andrew Walen, 202
pages, paper, 2014



BOOK EXCERPT

Cognitive-Behavioral Therapy for AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER: Children, Adolescents, and Adults

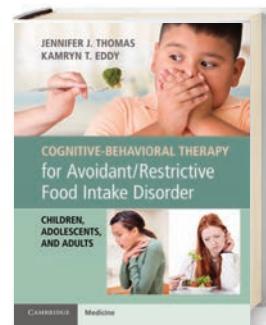
In this excerpt, **Jennifer J. Thomas, PhD, and Kamryn T. Eddy, PhD**, share tips on how to approach patients with ARFID.

Provide psychoeducation on ARFID in general. The therapist should begin by asking the patient (or family) what he or she knows about ARFID. It is important that the therapist not assume a great deal of prior knowledge about the disorder, given its relative newness to the psychiatric nomenclature. Using the initial knowledge as a base, the therapist should review the patient education handout depicted in Fig 6.1 (“What is ARFID?”). Important points to emphasize include that ARFID is a psychiatric disorder and that individuals with ARFID have underlying biological traits that initially made limiting their eating a logical choice. Once established, this pattern of food restriction and avoidance becomes self-reinforcing and highly resistant to change. Fortunately, there are helpful steps that patients and families can take to interrupt this pattern. During this collaborative review, the therapist should ask the patient to highlight any aspects of the handout that feel especially relevant to his or her current situation. The therapist should also encourage the patient (or family) to ask questions.

Psychoeducation is crucial to support treatment engagement, regardless of the patient’s current weight or nutritional status. For example, patients who have ARFID with sensory sensitivity may feel powerless to expand their low-variety diet. Thus, helping

them understand that they are trapped in a vicious cycle that limits their opportunities for exposure is critical. In contrast, those with fear of aversive consequences may believe that their inability to eat without choking represents a physical problem rather than a psychological one. Last, some patients and/or parents might need additional support to push for weight gain because they do not see low weight as a problem, particularly if the patient has not fallen off the growth curve (as in AN), but rather always been slight. Similarly, eating insufficiently or irregularly may become part of the core identity of a person with ARFID—rather than viewed as the symptoms of a disorder—thus limiting insight into negative consequences.

Provide psychoeducation on all maintaining mechanisms relevant for the patient. Although the therapist should review Figs 6.1 (“What is ARFID?”) and 6.5 (“How is ARFID treated?”) with all patients, Figs 6.2, 6.3, and 6.4 should be presented only if they are relevant to the patient’s primary maintaining mechanisms established in the initial assessment. For example, the therapist would only need to present Fig 6.2 (“What happens when you eat a limited variety of food?”), but not Fig 6.3 (“What happens when you eat a limited volume of food?”), for a patient with sensory sensitivity alone. ♦



© Jennifer J. Thomas and Kamryn T. Eddy 2019, published by Cambridge University Press.
Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder: Children, Adolescents, and Adults.
181 pages, paper.

Letting Go of Secrets in Eating Disorder Recovery

BY MARK WARREN, MD, MPH, FAED



If you have ever had an eating disorder, regardless of what kind it was, it is an amazing thing to feel recovered. If, like me, you suffered before the illness was recognized as an illness, never had adequate treatment, and knew that eating disorders were regarded as a social disease, then finding yourself healthy is likely a fantastic relief.

I was probably 10 years into my anorexia before I knew I had it. At that point, I was already on a recovery path. Perhaps this is common. Naturally, I wanted to know what had happened to me: What was my story, how did I get sick, and how did I get better? But I put these questions aside and closed down this part of myself because, of course, why would I not? I was ashamed of my illness, I thought I had caused it, I still had some very odd thoughts about food and body, and I never had any therapy to address it.

I did not really think about my narrative for recovery until I was a well-established professional who was active in the eating disorder field. At that point, I was providing support

to those in recovery, but I was also finding support from them.

I was approached by a colleague at a conference who wanted me to talk about being a professional with an eating disorder. My initial response was no. I didn't want to be *that guy* with the eating disorder. After all, no other male professional at the Academy for Eating Disorders had talked about his personal history. But I did choose to give that talk, and I did become *that guy*. I'm glad I did.

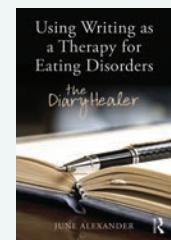
In creating my initial presentation to share my story around 15 years ago, I knew this was an opportunity to clarify a narrative for myself of my experience with anorexia. This narrative, almost by definition, was

focused on what it was like to be a man with an eating disorder at a time when men were not believed to have eating disorders. My narrative focused on triggers, my childhood, the media, the impact of running cross-country, an increase in eating disorder behaviors, weight loss, and the development of behaviors, thoughts, and feelings related to the eating disorder. In the end, my eating disorder behaviors became so severe that they ultimately forced me to discontinue school to pursue some form of treatment.

At this point, I didn't know I had an eating disorder. All I knew was that I was having disturbing thoughts and I could not function. I also did not know how to get better. So, the second part of my narrative focused on what happened next—meeting my wife. When I met my wife, I was struggling with my eating disorder and she was a chef who loved me despite this. She made a condition of our relationship that I had to eat what she cooked. So she was then and still is the star of my story because I began to understand my recovery through that relationship. I understand now that I was involved in some type of family-based treatment,



**Hunger for Connection:
Finding Meaning
in Eating
Disorders**
Alitta Kullman, 168
pages, hardcover/
paper, 2018



**Using Writing
as a Therapy for
Eating Disorders:
The Diary Healer**
June Alexander, 278
pages, paper, 2016



**Recover Your
Perspective:
A Guide to
Understanding
Your Eating
Disorder and
Creating Recovery
Using CBT, DBT,
and ACT**
Janean Anderson, 306
pages, paper, 2018

where through the power of love and connection, I was able to move into a place of weight restoration. This, of course, was very hard, and my behavior was challenging at times, but together through this, we bonded.

I returned to medical school, but following my internship, I dropped out again from medical training because even though my weight was restored, I was not happy. My wife and I decided to spend a couple of years living on a farm with friends, where I learned more about my eating. I learned how to be comfortable eating with others; I also learned a lot about shame, because I was spending all of my time with others. In particular, I got very in touch with the shame I carried about my body.

Of course, this understanding extended into the rest of my life, compelling me to seek therapy about 13 years after my disorder began. I did therapy for many years, primarily Gestalt therapy focused on sensation and awareness.

This narrative is what I told myself, and it became essential to who I was in the eating disorder field. For over 10 years, I spoke to many people about this, did a keynote at an Academy

for Eating Disorders meeting, and went around the country discussing my illness and recovery narrative. So, to a fairly large degree, that narrative started to define who I was. Then, one night a few years ago, at a Renfrew conference, a distinguished professional casually mentioned that she had been exploring the potential for eating disorder recovery using hallucinogenic drugs. I was seized by shame in that moment because this was something that was true for me that I had chosen to delete from my narrative.

I spontaneously shared this part of my history with her and another friend. Between 1982 and 1985, I was doing my residency at Harvard, and I was able to join an MDMA study on the use of the psychedelic as a therapeutic agent, which was fortunately legal at that time. During my experience participating in this study and utilizing MDMA, I experienced a dissolving of body shame and an ability for me to have full contact with my own skin, which was something I'd never had before.

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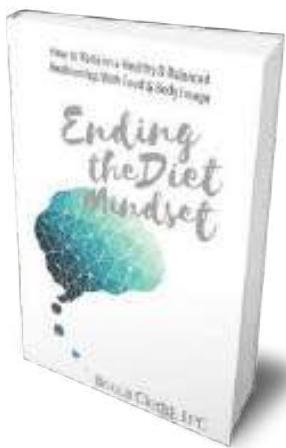
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BOOK EXCERPT

ENDING THE DIET MINDSET:

Reclaim a Healthy and Balanced Relationship with Food and Body Image

In this excerpt from *Ending the Diet Mindset*, **Becca Clegg, LPC, CEDS**, offers a new perspective on setbacks and long-term growth.



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by Becca Clegg,
149 pages, paper.

I have not failed. I've just found 10,000 ways that won't work.

—Thomas Edison

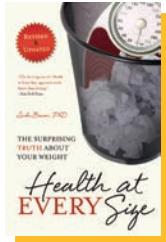
instead of seeing repetition as a sign of being stuck or a lack of progress, embrace repetition as evidence that you are a strong and tenacious warrior committed to creating your best life.

Summary

1. Change is not a linear process, but rather a process full of twists and turns that enhance your experience and teach you the lessons necessary for the change you are trying to achieve.
2. Your journey of change is an internal process where you change perspective and acquire wisdom, as opposed to an external process where external variables change.
3. Failure is a linear, dichotomous-mindset concept. When looked at through a nonlinear, compassionate mindset, however, the concept of failure becomes evidence that we are changing, growing, and actively living our lives. In other words, the old concept of failure is now a badge of honor, signifying that you are indeed courageous and strong.
4. Embracing the inner critic, rather than trying to escape it, allows you to learn from your behaviors rather than react to them or avoid them.
5. Embracing repetition as evidence of success begins to undo the linear mindset and establishes a new growth mindset that embraces a natural part of the nonlinear-change process. ♦

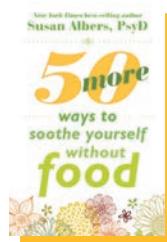


HEALTHY BEHAVIORS



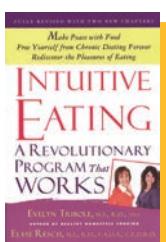
**Health at Every Size:
The Surprising
Truth About
Your Weight**

Linda Bacon,
400 pages,
paper, 2010



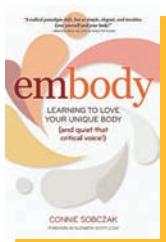
**50 More Ways to
Soothe Yourself
Without Food**

Susan Albers, 336
pages, paper, 2015



**Intuitive Eating:
A Revolutionary
Program That
Works**

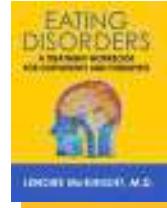
Evelyn Tribole &
Elyse Resch, 344
pages, paper, 2012



**Embody:
Learning to Love
Your Unique Body
(and Quiet That
Critical Voice!)**

Connie Sobczak,
288 pages, paper,
2014

PROFESSIONAL TREATMENT



**Eating Disorders:
A Treatment
Workbook for
Outpatients and
Therapists**

Lenore McKnight,
171 pages, paper,
2019



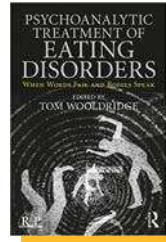
**Embodiment
and Eating
Disorders: Theory,
Research,
Prevention, and
Treatment**

Hillary L. McBride &
Janelle L. Kwee, 392
pages, hardcover/
paper, 2018



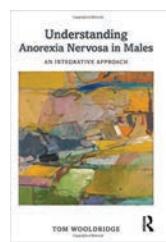
**Taking a Detailed
Eating Disorder
History: A
Comprehensive
Guide for
Clinicians**

James R.
Kirkpatrick, 302
pages, hardcover/
paper, 2018



**Psychoanalytic
Treatment of Eating
Disorders: When
Words Fail and
Bodies Speak**

Tom Wooldridge,
editor, 288 pages,
hardcover/paper, 2018

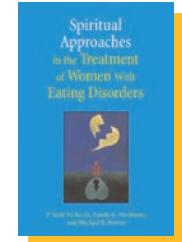


**Understanding
Anorexia Nervosa
in Males: An
Integrative
Approach**

Tom Wooldridge, 146
pages, hardcover/
paper, 2016

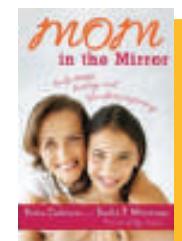


SPIRITUALITY



**Spiritual
Approaches in
the Treatment
of Women with
Eating Disorders**

P. Scott Richards,
Randy K. Hardman
& Michael E.
Berrett, 304 pages,
hardcover, 2007



**Mom in the
Mirror: Body
Image, Beauty,
and Life After
Pregnancy**

Dena Cabrera
& Emily T. Wierenga,
242 pages,
hardcover, 2013



**Brave Is the
New Beautiful:
Finding the
Courage to Be
the Real You**

Lee Wolfe Blum,
224 pages,
paper, 2017



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What Does a Nutrition Therapist Really Do?

BY SONDRA KRONBERG, MS, RD, CDN, CEDRD-S

It's Monday morning, and I now invite you into my office. I want to share a sampling of patients with you and hopefully broaden your understanding of the actual role of a nutritionist when working with a patient struggling with an eating disorder.

My first patient, Sally, is a new patient: Sally is a 40-year-old woman in a larger body. She enters, looks me over, sits down, and says, "What does a skinny broad [really, she says bitch] like you know about losing weight?" Hmmmmm.

Midway through the day, 25-year-old Kaitlyn, who struggles with symptoms of anorexia and exercise bulimia, enters and declares that she won't sit on the chair! She must stand and walk around the room or she won't be able to stay. During the session, she discloses that she ate a muffin with her girlfriends and then went home to cut the word *FAT* onto her arm. Hmmmmm.

My last client, Matthew, an overly anxious 12-year-old, is practically dragged in by his mom, who is equally anxious and weeping hysterically because they had another eating battle this morning. She fluctuates between frustration with and empathy for Matthew. He will only eat five specific foods, of specific

brands, at specific times and exact temperatures. He is also now refusing to go to school. Hmmmm.

I am a seasoned nutritionist with years of experience, better described as a *nutrition therapist* who specializes in the treatment of eating disorders. What is my role? What really goes on in my office? Is it about the food, or is it not about the food? How does a nutrition therapist contribute to the treatment team to help patients recover?

In the early days of my practice, encountering these behaviors would often leave me feeling like a deer in the headlights, immobilized and stuck—perhaps similar to how the patients were feeling. The traditional role of the nutritionist in the medical model is to provide information to the client: to devise and implement a meal plan that fixes the problem and to provide some oversight to ensure accountability or compliance for a relatively short time. Armed with scientific training and medical model concepts, I was geared up for providing patients with information and meal plans. Having acquired the scientific answers about food, nutrition, health, weight, and bodily function, I was now qualified to help others improve their nutritional status. I was naive enough to believe that merely knowing information and providing direction would catalyze action and create change. My job would be to: 1) Assess patients' physiological status; 2) Determine their nutritional needs; 3) Calculate the correct percentage of macronutrients and micronutrients to be included in the daily allotted calorie intake; 4) Produce a food plan that meets their nutrient and energy needs; 5) Provide a brief assist in getting started. While all these tasks are an important part of the nutritionist's role, they are only a piece of the whole when it comes to treating individuals with eating disorders.

The majority of patients who struggle with eating disorders find

themselves in my office because they don't feel good about themselves and they have adapted food and body beliefs as a mechanism of self-evaluation. Most have long ago lost connection to their own inner knowledge, wisdom, and life force. This exhausting struggle with food, weight, and body image often stems from a sense of worthlessness. It is an all-consuming attempt to feel better about themselves, numb their pain, cope with feelings, or gain a sense of control. This eating-disordered symptomology is not only a clever adaptation for survival, but also a crucial means, often the only means, of communication. As destructive as it may seem to the outside world, the eating disorder can be a mechanism of self-care and a measure of security for the person who is struggling. It takes a lot more than information and direction to reach, understand, and shift the eating-disordered thoughts, beliefs, and behaviors that have been purposefully integrated.

No amount of nutritional information and schooling regarding the roles and functions of protein, carbohydrates, and other nutrients, and no amount of meal planning expertise would even touch the depth of what is attached emotionally, physiologically, and behaviorally to these patterns that get communicated through food and body dialogues. How in the world would a 30-minute session about what foods to eat and how to nourish oneself compete with the thoughts and mechanisms that have evolved in the formation of these patients' disordered relationships with their food, their aversions or compulsions, and the embedded perceptions of their weight or bodies?

Understanding the depth of the behaviors, the purposes they serve, and the mechanisms involved has taught me that the role of the nutritionist in the treatment of eating disorders goes well beyond the setting up of a meal plan and the supervision



Step-by-Step: A Three-Year Daily Journal

Kathryn Cortese,
365 pages,
hardcover, 2018



My Story: Healing Through Self-Reflection: A Fill-In Journal

Kathryn Cortese,
102 pages,
hardcover, 2019

of its adherence. Providing a meal plan is a small part of the whole process. Progress and recovery can only really occur through the relationship the patient and nutritionist can develop. Patient willingness to progress is connected to the ability of the nutritionist to both have empathy for the patient's current adaptations and hold hope for a different future.

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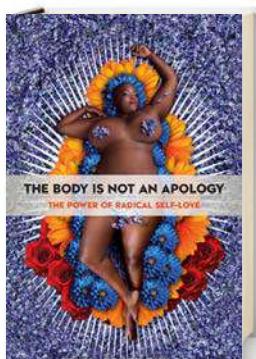


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BOOK EXCERPT

THE BODY IS NOT AN APOLOGY: The Power of Radical Self-Love

In this excerpt from *The Body Is Not an Apology*, **Sonya Renee Taylor** preaches the power of reclaiming self-love.



Excerpted with permission from *The Body Is Not an Apology: The Power of Radical Self-Love*, Sonya Renee Taylor, Berrett-Koehler Publishers, ISBN 1626569762, 137 pages, paper, 2018.

Radical self-love is deeper, wider, and more expansive than anything we would call self-confidence or self-esteem. It is juicier than self-acceptance. Including the word *radical* offers us a self-love that is the root or origin of our relationship to ourselves. We did not start life in a negative partnership with our bodies. I have never seen a toddler lament the size of their thighs, the squishiness of their bellies. Children do not arrive here ashamed of their race, gender, age, or disabilities. Babies love their bodies! Each discovery they encounter is freaking awesome. Have you ever seen an infant realize they have feet? Talk about wonder! That is what an unobstructed relationship with our bodies looks like. You were an infant once, which means there was a time when you thought your body was freaking awesome too. Connecting to that memory may feel as distant as the farthest star. It may not be a memory you can access at all,

but just knowing that there was a point in your history when you once loved your body can be a reminder that body shame is a fantastically crappy inheritance. We didn't give it to ourselves, and we are not obligated to keep it. We arrived on this planet as LOVE.

We need not do anything other than turn on a television for evidence affirming how desperately our society, our world, needs an extreme form of self-love to counter the constant barrage of shame, discrimination, and body-based oppression enacted against us daily. Television shows like *The Biggest Loser* encourage dangerous and unsustainable exercise and food restriction from their contestants while using their bodies as fodder for our entertainment and reinforcing the notion that the most undesirable body one can have is a fat body. Researchers have shown that American news outlets regularly exaggerate crime rates, including a tendency to inflate the rates of Black offenses while depicting Black suspects in a less favorable light than their White counterparts. People with disabilities are virtually nonexistent on television unless they are being trotted out as "inspiration porn." Their stories are often told in ways that exploit their disabilities for the emotional edification of able-bodied people, presenting them as superhuman for doing unspectacular things like reading or going to the store or, worse yet, for overcoming obstacles placed on them by the very society that fails to acknowledge or appropriately accommodate their bodies. *Of course* we need something radical to challenge these messages.

Using the term *radical* elevates the reality that our society requires a drastic political, economic, and social reformation in the ways in which we deal with bodies and body difference. ♦



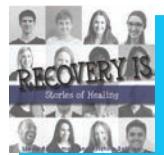
RECOVERY



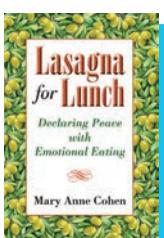
Nourish: How to Heal Your Relationship with Food, Body, and Self
Heidi Schauster, 228 pages, paper, 2018



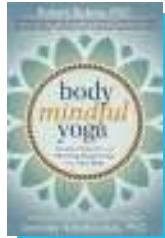
8 Keys to End Emotional Eating
Howard S. Farkas, 174 pages, paper, 2019



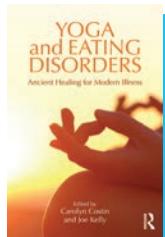
Recovery Is: Stories of Healing
Liana Rosenman & Kristina Saffran, 128 pages, paper, 2015



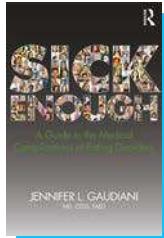
Lasagna for Lunch: Declaring Peace with Emotional Eating
Mary Anne Cohen, 348 pages, paper, 2013



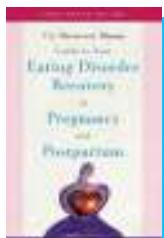
Body Mindful Yoga: Create a Powerful and Affirming Relationship with Your Body
Robert Butera & Jennifer Kreatsoulas, 240 pages, paper, 2018



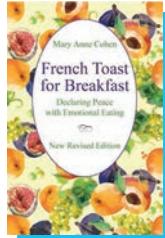
Yoga and Eating Disorders: Ancient Healing for Modern Illness
Carolyn Costin & Joe Kelly, editors, 228 pages, paper, 2016



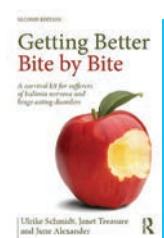
Sick Enough: A Guide to the Medical Complications of Eating Disorders
Jennifer L. Gaudiani, 276 pages, hardcover/paper, 2018



The Recovery Mama Guide to Your Eating Disorder Recovery in Pregnancy and Postpartum
Linda Shanti McCabe, 208 pages, paper, 2019

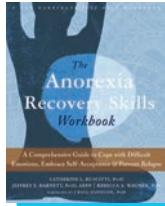


French Toast for Breakfast, New Revised Edition: Declaring Peace with Emotional Eating
Mary Anne Cohen, 246 pages, paper, 2016

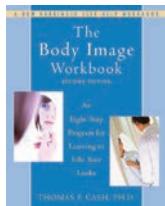


Getting Better Bite by Bite, Second Edition: A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders
Ulrike Schmidt, Janet Treasure & June Alexander, 182 pages, paper, 2015

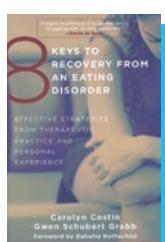
RECOVERY WORKBOOKS



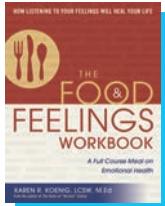
The Anorexia Recovery Skills Workbook: A Comprehensive Guide to Cope with Difficult Emotions, Embrace Self-Acceptance, and Prevent Relapse
Jennifer L. Gaudiani, 276 pages, hardcover/paper, 2018



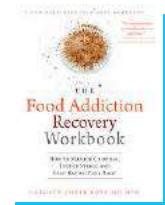
The Body Image Workbook, Second Edition: An Eight-Step Program for Learning to Like Your Looks
Thomas F. Cash, 232 pages, paper, 2008



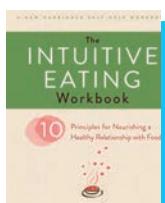
8 Keys to Recovery from an Eating Disorder Workbook
Carolyn Costin, Gwen Schubert Grabb, and June Alexander, 288 pages, paper, 2017



The Food and Feelings Workbook: A Full Course Meal on Emotional Health
Karen K. Koenig, 216 pages, paper, 2007



The Food Addiction Recovery Workbook: How to Manage Cravings, Reduce Stress, and Stop Hating Your Body
Carolyn Coker Ross, 240 pages, paper, 2017



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Evelyn Tribole & Elyse Resch, 244 pages, paper, 2017



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KIDS/TEENS



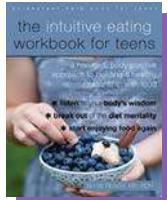
Getting over Overeating for Teens: A Workbook to Transform Your Relationship with Food Using CBT, Mindfulness, and Intuitive Eating (Teen Instant Help)
Andrea Wachter, 184 pages, paper, 2016, teens



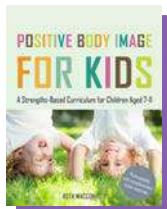
Emily's Guide to Eating Disorders: A Workbook for Children Ages 5-11
Sherri Hicks, illustrated by Stacey Lyddon, 32 pages, paper, 2017, ages 5-11



Amanda's Big Dream
Judith Matz, illustrated by Elizabeth Patch, 32 pages, paper, 2015, ages 4+



The Intuitive Eating Workbook for Teens: A Non-Diet, Body Positive Approach to Building a Healthy Relationship with Food
Elyse Resch, 240 pages, paper, 2019, teens

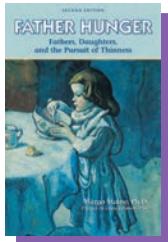


Positive Body Image for Kids: A Strengths-Based Curriculum for Children Aged 7-11
Ruth MacConville, 256 pages, paper, 2017, ages 7-11

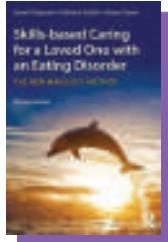


Letting Go of ED – Embracing Me: A Journal of Self-Discovery
Maria Ganci & Linsey Atkins, 234 pages, paper, 2019

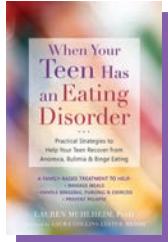
FAMILY AND LOVED ONES



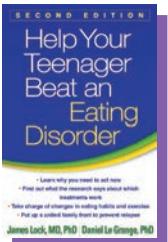
Father Hunger, Second Edition: Fathers, Daughters, and the Pursuit of Thinness
Margo Maine, 288 pages, paper, 2004



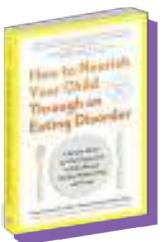
Skills-Based Caring for a Loved One with an Eating Disorder, Second Edition: The New Maudsley Method
Janet Treasure, Gráinne Smith & Anna Crane, 294 pages, hardcover/paper, 2016



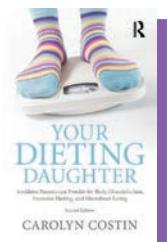
When Your Teen Has an Eating Disorder: Practical Strategies to Help Your Teen Recover from Anorexia, Bulimia, and Binge Eating
Lauren Muhlheim, 168 pages, paper, 2018



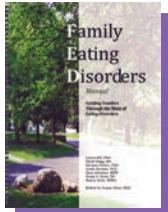
Help Your Teenager Beat an Eating Disorder, Second Edition
James Lock & Daniel Le Grange, 310 pages, hardcover/paper, 2015



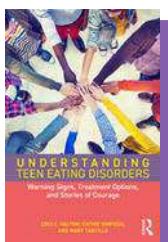
How to Nourish Your Child Through an Eating Disorder
Casey Crosbie & Wendy Sterling, 324 pages, paper, 2018



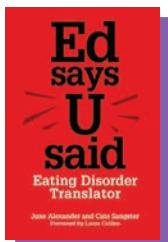
Your Dieting Daughter, Second Edition: Antidotes Parents Can Provide for Body Dissatisfaction, Excessive Dieting, and Disordered Eating
Carolyn Costin, 256 pages, paper, 2013



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



Understanding Teen Eating Disorders: Warning Signs, Treatment Options, and Stories of Courage
Cris E. Haltom, Cathie Simpson & Mary Tantillo, 204 pages, hardcover/paper, 2018



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



LOVING SOMEONE WITH AN EATING DISORDER:

Understanding, Supporting, and Connecting with Your Partner

In this excerpt from *Loving Someone with an Eating Disorder*, **Dana Harron, PsyD**, suggests a few key communication tips for difficult conversations.

Communicating Clearly

All the emotional centeredness and appropriate boundaries in the world won't matter unless you can convey this stance to your partner. Yet, as important as it is, we actually don't talk very much in our culture about how to communicate well. As a result, surprisingly few people learn to speak clearly and listen for understanding. The following communication strategies will help you hit the right tone, convey your intended meaning, and accurately hear what your partner is saying.

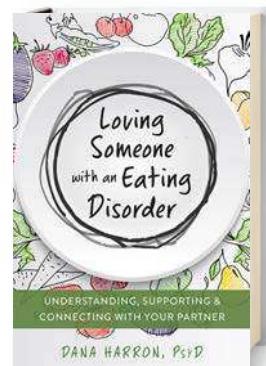
Timing Communications Well

Never ever discuss loaded topics during a meal, when your partner is about to eat, or when he's just eaten. Food situations make people with eating disorders extremely anxious, and you want to have your important conversations at a time that is as calm as possible. To that end, it can be helpful to remember the acronym HALT, which comes from the substance abuse field: Don't pursue the conversation when either you or your partner is hungry, angry, lonely, or tired. Both of you should be in as centered and grounded a place as possible. Remember, you aren't a mind reader, so it's always a good idea to check with your partner if it's a good time to talk before forging ahead with your topic. You can simply ask, "I'd like to talk to you about something. Is this a good time?"

Using I-Statements

Just as important as what you say is what you will want to avoid saying. How do you feel when somebody starts a sentence with, "You are being..." and then goes on to characterize something you did or said? The structure of the *you-statement* usually puts the listener on the defensive, because what you hear next is likely either a criticism or an assumption about your experience (or both). Instead, I recommend using the *I-statement*. The basic idea is that when you want to communicate how you are feeling, you focus on your own feelings. This ensures you are only speaking for yourself, not your partner. Other people are likely to be receptive to I-statements—after all, who can argue with you about what your feelings are?

Using I-statements doesn't mean talking only about yourself, but it does mean that you're talking about experiences only from your perspective. A good I-statement would be, "I am worried about your health when I don't see you eat much." If you are talking about something your partner is doing, try to keep your focus on the behavior instead of the person: "I feel upset when you miss dinner" or "I am sad that you are struggling so much." Keep in mind that I-statements are not accusations; they are a way of providing information to your partner about what is happening for you. ♦



Reprinted with permission: New Harbinger Publications, Inc., copyright © 2019 Dana Harron, PsyD, *Loving Someone with an Eating Disorder: Understanding, Supporting, and Connecting with Your Partner*, 163 pages, paper.

Fertility and Pregnancy in Eating Disorders

BY MITTSI CROSSMAN, MD, CEDS

Fertility and pregnancy in eating disorders are important topics, as eating disorders affect many young women. The purpose of this article is to provide an overview of these areas as well as recommendations for further reading. Consider the following vignettes:

Vignette 1

A young woman with irregular menses and anorexia nervosa (AN), restricting type, since her early teens struggles to get pregnant. After consultations with endocrinologists and fertility specialists, and continued work with her treatment team, which specializes in eating disorders, she slowly weight restores and eventually conceives. During pregnancy, she...

- a. continues to gain weight appropriately, learns to integrate regular eating, finds normalization in meals and hunger and fullness cues, and carries to full term without complications.
- b. struggles to gain the weight

needed. She also has increasing anxiety, depression, and worsening body image. Her pregnancy, labor, and delivery are significant for a healthy-but-small-for-gestational-age baby.
c. believes that the weight she gained while trying to become pregnant should be adequate for the duration of her pregnancy. Eating disorder symptoms increase as she struggles to prevent additional weight gain. She experiences a fall from a spontaneous hip fracture early in her third trimester, which induces preterm labor. Her premature baby requires treatment in the neonatal intensive care unit (NICU).



Vignette 2

A young woman with a history of nicotine and alcohol use disorder, as well as bulimia nervosa (BN), with irregular and infrequent periods, becomes pregnant. She stops smoking and drinking alcohol, and significantly minimizes purging. She struggles with urges to binge. During the first trimester, she experiences significant morning sickness (hyperemesis gravidarum), which she finds confusing and triggering. She strengthens her skills to tolerate the physical discomfort and nausea more easily than she did with BN because she accepts these physical symptoms as "normal" in pregnancy. During checkups with her obstetrician, she has blinded weigh-ins. Her previous fear of weight gain if she stopped purging is obscured by the expected weight gain of pregnancy. With this neutralization of weight-gain fears, she is able to put her efforts into stopping purging and, eventually, bingeing. After delivery of her baby, she...

- a. continues to maintain the skills



that she accomplished during pregnancy.

- b.** finds that without the protective factor of the baby in utero, she is more susceptible to engaging in bingeing and purging again.
- c.** continues to refrain from bingeing and purging but begins to restrict, especially with the justifications of stress and the busy life of new motherhood.

Vignette 3

A young woman, a self-proclaimed "exercise addict," fad dieter, and emotional overeater, prone to depression and anxiety, finds herself unexpectedly pregnant with her long-term partner. During her first trimester, she continues to exercise at pre-pregnancy levels and is pleased to find that her weight remains relatively stable. As she enters her second trimester, her exercise tolerance diminishes and her body begins to change more visibly, yet she fully embraces pregnancy as she shares her exciting news with family and friends. During this time, she relishes

her food cravings and gives in to them, trusting that her baby must "need" the foods that she usually wouldn't eat. As pregnancy continues...

- a.** she continues to struggle with cravings, overeating, and binge eating, as well as low-grade depression and anxiety.
- b.** she gains weight in excess of her expectations as her tolerance for exercise diminishes and she indulges in foods that she had normally considered forbidden. She doesn't see the point in "dieting" while pregnant and develops symptoms consistent with binge eating disorder (BED). She has complications during labor and requires a Cesarean section.
- c.** she develops gestational diabetes and begins working with a dietitian. She learns about intuitive eating and better understands her eating behaviors. She remains nourished in pregnancy, and overeating diminishes. She delivers a healthy baby without complications.

Fertility in Eating Disorders

Hormones

Eating disorders occur more frequently in women than in men and frequently coincide with puberty, when sex hormone levels increase. Within a menstrual cycle, food intake and meal size can fluctuate cyclically. During pregnancy, estradiol and progesterone increase until childbirth and then decrease postpartum; however, eating disorder symptoms don't seem to correlate with hormone increases. At menopause, there are decreases in estradiol and progesterone. Menopause is associated with increased body weight, fat accumulation, and food intake, and hormone replacement with estradiol reverses these postmenopausal effects (the risks and benefits of hormone replacement therapy should be discussed with one's doctor).

Nutrition and Menstruation

Nutritional deficits found in eating disorders cause decreased production of hormones, including the sex hormones estradiol and progesterone, which regulate menstrual cycles, ovulation, and pregnancy. With malnutrition, the primitive hardwired brain registers famine or extreme stress, and the body downregulates hormone production to preserve available resources for the most vital life-maintenance functions. We are still learning the precise biological mechanisms as to how hormone production is regulated, but it may include leptin in individuals with AN or BN, and insulin and testosterone in individuals with BED.

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

BOOK EXCERPT

The Clinical Guide to FERTILITY, MOTHERHOOD, AND EATING DISORDERS: From Shame to Self-Acceptance

In this excerpt from *The Clinical Guide to Fertility, Motherhood, and Eating Disorders*, **Kate B. Daigle, MA, LPC, CEDS**, discusses the unique challenges faced by women who have dealt with ED.

You may be thinking that getting pregnant is the best gift you could possibly experience after many years of struggling with yourself, your body, and food. And you are right—the gift of getting pregnant is unlike any other.

However, even for women who desire to have a family *so badly*, the changes that occur emotionally and physically during pregnancy may take them off-guard. Your body changes more rapidly when you are pregnant than at any other time of your life. In the first trimester, your body may once again feel as if it's against you, or you against it. Symptoms of early pregnancy include nausea, constipation, weight gain/bloat, dizziness, lack of appetite or increased appetite, and sleep disturbances, among other things. All of these are messages from your body to you, saying that it's working extra hard and trying to grow another human inside of it.

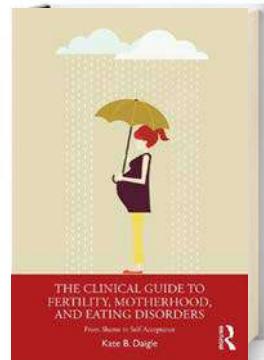
These changes continue during the length of the pregnancy as the child grows larger and stronger and begins to demand more and more energy, food, resources, and brainpower from the mother's body. Pregnancy is also a time where women will get weighed by their doctor consistently and their weight will be monitored and discussed more than any other time of their lives. If the scale has been given absolute power over a woman's self-esteem, as may happen in the presence of an eating disorder, this focus on weight and numbers

can be triggering and obsessive, especially if the woman's medical team overemphasizes the role of weight in fertility health (or any form of health).

Finding trust in your body and working to believe that it is telling you exactly what it needs to create a healthy baby may seem like an utterly foreign concept for someone who is struggling with an eating disorder. When a woman has dealt with infertility, as many of the women who I interviewed had done for years, getting pregnant and attempting to develop or revitalize that trust in their body can also be very challenging and wrought with loss.

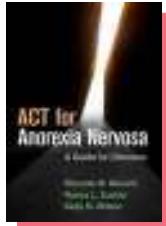
While no one chooses to have an eating disorder, one can choose recovery for the first time or re-enter recovery if they have slipped. A woman and her partner can choose to start a family, and yet once a woman is pregnant, there is so much out of her control that can be big triggers for her. A few of these are:

- Weight gain
- Food cravings
- Emotional mood swings and hormone fluctuations
- Nausea and morning sickness
- Stretch marks and growth of hips/breasts
- Back problems
- Forgetfulness, memory loss
- Exhaustion
- Insomnia/sleep issues ◆

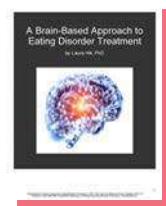


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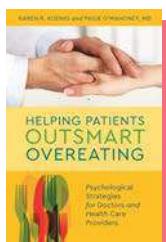
PROFESSIONAL TREATMENT



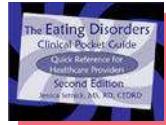
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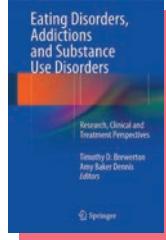
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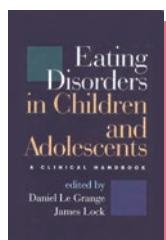
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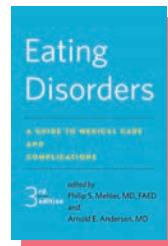
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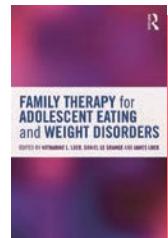
SOURCE BOOKS



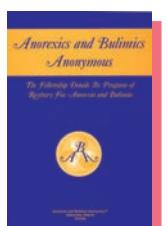
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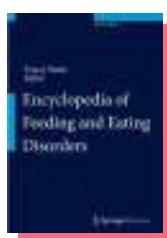
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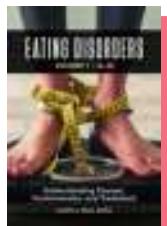
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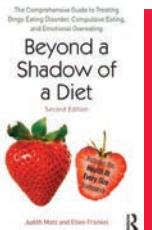
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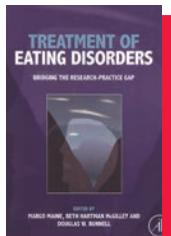


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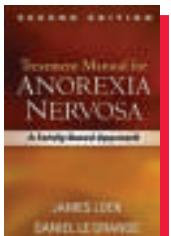
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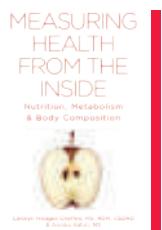
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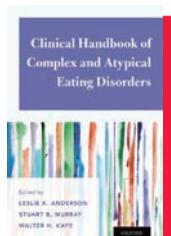
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In 1996, I recognized a gap in eating disorder treatment and opened the first licensed residential treatment center in a home setting.

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www.CarolynCostinInstitute.com



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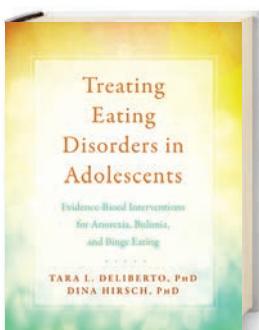
M.A., M.Ed., MFT, CEDS, FAED, LMFT 13192

Founder and CEO

BOOK EXCERPT

TREATING EATING DISORDERS IN ADOLESCENTS

In this excerpt from *Treating Eating Disorders in Adolescents*, **Tara L. Deliberto, PhD, and Dina Hirsch, PhD**, expose the complications of ED-protecting behaviors.



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L. Deliberto and Dina
Hirsch, *Treating Eating
Disorders in Adolescents:
Evidence-Based
Interventions for Anorexia,
Bulimia, and Binge Eating*,
304 pages, paper.

Eating Disorder—Protecting Behaviors

As mentioned earlier, people with eating disorders experience intense negative emotions, which include, but are not limited to, fear of “fatness” and weight gain, guilt, and disgust. Once the eating disorder is in place, behaviors such as food restriction, food avoidance, purging, calorie counting, compulsive exercise, and so forth, serve to decrease these negative emotions temporarily.

Probably because these behaviors are so effective at reducing negative emotions, it quickly becomes apparent in treatment that patients are resistant to change when they are pushed to meet treatment goals. Patients display behaviors that serve to protect the eating disorder from treatment. More specifically, patients display behaviors that block reinforcement of recovery-oriented and non-eating-disorder behaviors. For instance, after a patient finishes a meal, the therapist may say, “Good job finishing the meal,” to which the patient may respond, “I hate you when you say that.” The therapist’s “good job” remark was intended to reinforce the patient’s recovery-oriented behavior, but patients with ego-syntonic (self-eclipsing) eating disorders often react rather aggressively to the tried-

and-true behavioral intervention of providing praise.... From this perspective, the emotional escalation is interpreted as an effort to block reinforcement of the meal completion, in service of protecting the eating disorder. If the eating disorder is protected, the person is also protected from feeling all the negative emotions that the eating disorder regulates (fear of weight gain, guilt after eating, disgust with one’s body, and so forth). We have even heard patients say, “If you keep saying, ‘Good job,’ it will make me fat.”

Eating Disorder—Exacerbating Behaviors

Just as eating disorder-protecting behaviors involve the deflection of recovery-fostering reinforcement, and therefore block progress in treatment, other types of behaviors appear to actively exacerbate the eating disorder. In particular, we have noted a disturbing phenomenon in the context of eating disorders—namely, patients asking for others to body-shame them about their weight. Specifically, patients report seeking out abusive comments about their body as “motivation” to further restrict caloric intake, avoid foods, exercise, and engage in other eating disorder behaviors. For instance, on pro-anorexia (pro-ana) websites, people can post pictures of themselves and ask others to “guess” their weight in a mean-spirited way. Other participants in the forum will then intentionally “guess” clearly higher weights. There is even a term for this, *meanspo*, which is a variant on the more popular *thinspiration* (*thinspo*) or *fitspiration* (*fitspo*). The latter two terms are certainly maladaptive, but *thinspo* or *fitspo* content is not as disparaging and abusive as *meanspo* content is. *Do not introduce these terms to patients, because they may look them up and start engaging in these behaviors or participating in online meanspo forums.* Further, introducing the specific term *meanspo* to carers may also be unwise, because some carers may discuss this term with the patient. It is best to avoid introducing this term into any conversation in which the patient hasn’t used it first. ♦

Recognizing Institutionalized Weight Bias

BY JANELL MENSINGER, PHD, FAED

“It is inherently dangerous to be a fat woman in the eating disorders world.”

These powerful and somewhat jarring words were relayed to me in a conversation with Chevese Turner, then founder and CEO of the former Binge Eating Disorder Association (now integrated into the National Eating Disorders Association). I am beginning this commentary with that particular statement because, before writing anything at all, I want to underscore the fact that there is a pure *lack of safety* (yes, SAFETY—one of our very basic needs) for people in larger bodies in the health care community, and this very much includes the eating disorders profession. While this conversation occurred many years ago, I carry the message with me every day in my work as an eating disorder professional. I am eternally

grateful for the profound insights Chevese—and many other advocates, teachers, scholars, and clinicians from the Health at Every Size® (HAES®) community—has given me about the issues of the structural weight stigma in our community. Know that I stand on their wise shoulders as I write this.

For any readers who may be questioning the accuracy of the opening statement, I challenge you to observe the body sizes of your colleagues the next time you find yourself at an eating disorders conference or a gathering of eating disorders professionals. Compare this to a representative sample of our population, and undoubtedly, it will be clear to you that our field is drastically askew from the population parameters. For the scientists in the audience, it would be true even if we matched them by education and other demographic characteristics to minimize some confounding variables. Some might argue that this is not due to fat phobia in our field, but rather because the field tends to draw many people who have lived experience with disordered eating.

Before you allow that explanation to justify why you are surrounded by thin white women at the majority of your eating disorder events, think about this statistic from a recent epidemiological study: Individuals with a BMI over 30 have a *12-fold increased probability* of disordered eating compared with their peers with a BMI less than 25 (and there are multiple studies showing very similar figures regarding prevalence of eating disorders and weight status). Now ask yourself, where is *this* representation—not just among those who show up at conferences, but in the field as a whole? (Not to mention the representation of folks with black and brown skin—but that is a whole other needed commentary...) When we truly take in the body sizes of the majority of our peers at eating disorder conferences, it is ever apparent that it *must be* inherently dangerous to show up in a fat body. Let this brief diatribe, that will only scratch the very surface of the nature of the issues at hand, help you recognize the amount of work we have to do in order to change this.

When I was initially asked to write this article on weight stigma for the Gürze/Salucore Eating Disorders Resource Catalogue, I began to reflect on the content of that conversation with Chevese (as well as many others I have had with fellow members of the HAES® community and advocates for fat acceptance). Honestly, my first thought was, Should I be the one writing about this?

To allay my anxiety, I reminded myself of my professional qualifications: I have conducted research studies, reviewed journal articles, participated in expert panels, and read many hundreds of scientific papers on the topic of weight stigma. This hesitation was not about a lack of qualifications or passion about this topic. I have gained all of this experience through my personal and professional commitments to educate people about the harmful effects of weight stigma. And yet, when I sat down to write this article, I began questioning how readers would

respond to someone who has never been the target of anti-fat prejudice writing it.

Ultimately, I decided to move forward with writing this article because I have never been the target of anti-fat prejudice. I am a thin, white, cisgender woman with education, employment, health care access, food, and housing security. I *should* be the one writing this article. Some might ask, why? The efforts of educating others about weight stigma should not be on those with more marginalized identities. I also recognize there is the reality that

part of why I am given opportunities to use my voice like this is *because of* my privilege, and when possible, I try to center the voices of my more marginalized peers. It should not be the case that we repeatedly see thin, white cis-women (and men) given platforms in the eating disorder field, and that is what happened here. For readers who felt irritated by this, know that I see and hear you, and you have a right to your anger. The complexity grows...

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



BOOK EXCERPT

EATING MINDFULLY FOR TEENS

In this excerpt from *Eating Mindfully for Teens*, **Susan Albers, PsyD**, discusses how to cope with stuck thinking.

CHLOE: *Whenever I eat too much, I tell myself that I'm awful. I completely ruined everything, so I might as well keep eating. I wish I could think rationally and say, "Just stop now!"*

for you to know

It's easy to fall into the trap of black-and-white thinking. The situation is all good or all bad, perfect or awful—you get the idea. There is no gray area. What about in your life? Have you witnessed or experienced all-or-nothing thinking? Have you ever heard yourself thinking things like this?

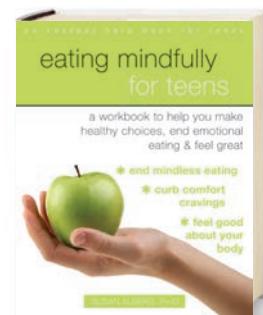
- *I ate perfectly today. I was good today.*
- *I did terribly on my exam. I was completely awful.*
- *I already ate too many chips, so I might as well eat the entire bag.*

for you to do

Look at these examples of black-and-white thinking, and put a check mark next to the ones that are like things you have thought. It's OK if you check a lot of boxes. The idea isn't to be right or wrong (all or nothing!); the idea is to understand the messages your brain might be sending you without you even realizing it.

- ❑ I was making a joke and accidentally upset my friend. She'll never talk to me again.
- ❑ I failed my math quiz. Now I'll never get into the college I wanted to.

- ❑ I ate one cupcake. I might as well eat the rest of them.
- ❑ I forgot to do my chores, and Mom got mad at me. I'm nothing but a screw-up.
- ❑ I came in last in the race today. My running career is over.
- ❑ I backed into the mailbox with my dad's car. He's never going to trust me again.
- ❑ I'm not thin and beautiful like [insert celebrity name]. Nobody will ever ask me out.
- ❑ My belly is too big, I know everyone sees it and wonders if I'm pregnant.
- ❑ I'm a guy who has a crush on another guy. If anybody finds out, they'll hate me.
- ❑ I had a sip of beer for the first time today. I'm going to become an alcoholic.



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Albers, PsyD, *Eating
Mindfully for Teens: A
Workbook to Help You
Make Healthy Choices, End
Emotional Eating, and Feel
Great*, 151 pages, paper.

Think about how the statements above made you feel. Did you have a knot in your stomach? Did your chest feel tight? Black-and-white thinking can feel similar to the fight-or-flight response we experience when we're in danger. ♦



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TREATMENT CENTER

	STATE	PG	CHILDREN	TEENS	ADULTS	FEMALES	MALES	ALL GENDERS*
Center for Change (males PHP, IOP, and Outpatient)	UT, ID	43		●	●	●	●	●
Eating Recovery Center	CA, CO, IL, MD, OH, SC, TX, WA	2	●	●	●	●	●	●
EDCare	CO, KS, NE	45		●	●	●	●	●
The Healthy Teen Project	CA	45		●		●	●	●
Hidden River Eating Disorder Treatment	NJ	46	●	●	●	●		
Laureate Eating Disorders Program (males outpatient only)	OK	48		●	●	●	●	●
McLean Klarman Eating Disorders Center	MA	5		●	●	●	●	
Penn Medicine Princeton Center for Eating Disorders	NJ	47	●	●	●	●	●	●
Reasons Eating Disorder Center	CA	45		●	●	●	●	●
The Renfrew Center	CA, CT, FL, GA, IL, MA, MD, NJ, NY, NC, PA, TN	42		●	●	●	●	●
Rogers Behavioral Health	FL, IL, MN, TN, WI	44	●	●	●	●	●	●
Upstate New York Eating Disorder Service	NY	46	●	●	●	●	●	●
Veritas Collaborative	GA, NC, VA	3	●	●	●	●	●	●

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



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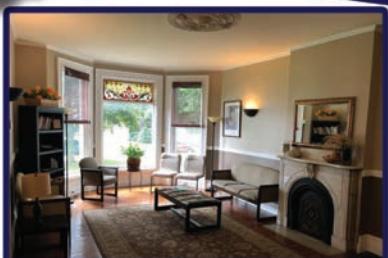
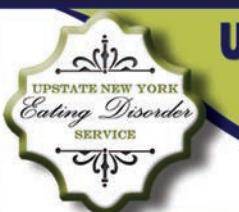


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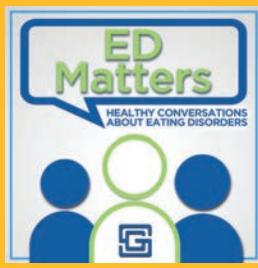
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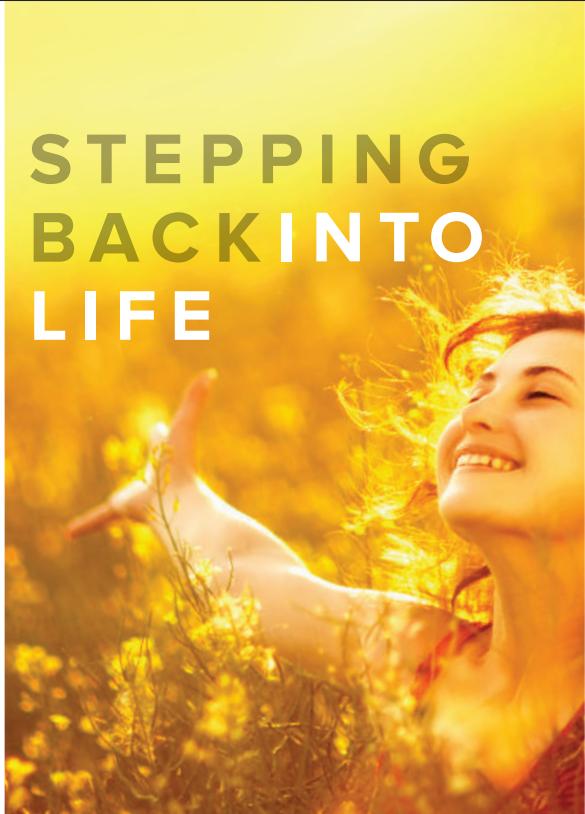
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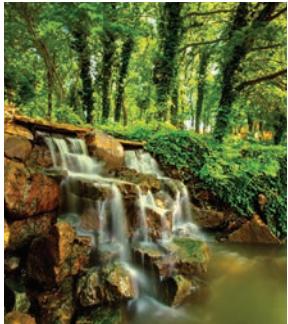
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