Parenting *through*
Eating Disorders

We help parents become their child's most powerful resource for recovery.

Working with Families Toward Eating Disorder Recovery

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Rebecca Brumm, LPC, CEDS-S

13 years in eating disorder treatment at all levels of care

Certified Eating Disorder Specialist- Supervisor

Certified Intuitive Eating Counselor since 2017

Started an outpatient specialty clinic with multidisciplinary care

Chief Clinical Officer of Within Health- intentionally remote ED care

Co-owner of Whole Hive Counseling, Eating Disorder Speciality, Tulsa, OK

Co-creator of Parenting Through Eating Disorders

Presentation Outline

Understand why families are so vital in the recovery process

How to engage families to be partners in recovery

Understand how family work sustains recover

What families need to know to engage and support recovery

- The biopsychosocial storms that create eating disorders and why parents are not to blame!
- How eating disorders are treated
- Emotion coaching caregivers

Train Parents like Staff

Two years past graduation to specialize in eating disorders

Parents get plunged into the deep end with little to no preparation

Training parents to become recovery coaches is similar to training staff to treat eating disorders

We'll do both today

Parents do not cause eating disorders

So many factors go into the development of an eating disorder

Parental blame is inaccurate and immobilizing

Engaging parents can shift dynamics to allow the relationship to heal and to set a foundation of enduring collaborative problems solving with mutual respect throughout the relationship's history.

Parents can be your biggest ally in treatment if educated to do so.

“...families are often our best allies in treatment—they don't cause the disorders, they are our allies in recovery. It’s our job to help give them the blueprint about what they need to do to become allies in recovery.” **Cindy Bulik, PhD**

Genetic/ Epigenetic

Temperament/Super-feeler

Family environment

Puberty

Social & cultural factors

Life stressors

Many others...

Emotion processing

Mental Health Issues

Improved treatment outcomes

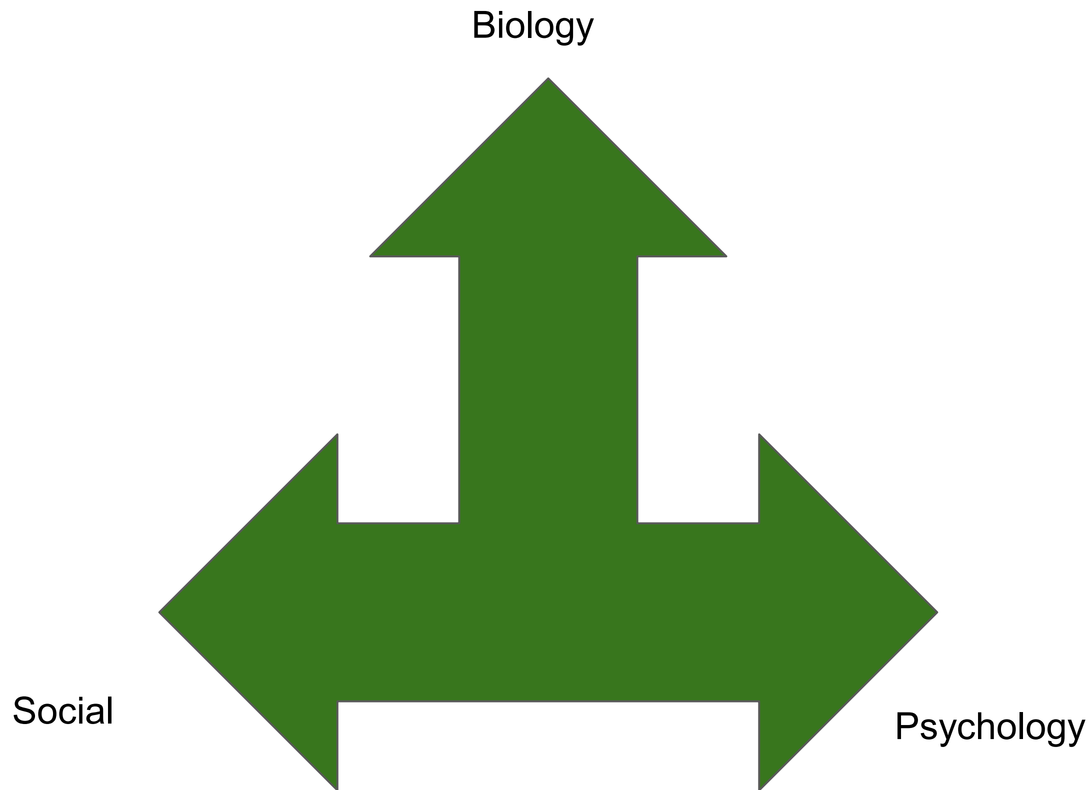
There are two types of families

Relapse rates for eating disorders are high

Recovery takes anywhere from 18 months to seven years

No one can recover from a life threatening illness alone

Eating Disorders, The Perfect Storm



- Bio- genetics
- Psycho- disordered thinking patterns
- Social- the environment creates a ripeness of conditions

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Biological Risk Factors

- **Short fuse for energy restriction (Brain reward system for food is wired backward)**
- **Brain abnormalities identified in eating disordered clients**
- **Relative with ED history or anxiety DO**
- **Genotype- 7 to 12 times more likely**
- **History of dieting/Restriction**
- **Negative energy balance**
- **Diabetes**
- **Puberty**

Psychological Risk Factors

- **Anxiety disorder**
- **Poor self esteem**
- **Life transitions**
- **Body dissatisfaction**
- **Temperament**
  - **obsessive thinking**
  - **perfectionism**
  - **rejection sensitive, sensitivity to reward and punishment**
  - **harm avoidance**
  - **emotional instability**
  - **hypersensitivity**
  - **impulsivity**

Social Risk Factors

- **Diet centric culture**
- **Thinness and muscularity is idealized**
- **Valuing people based on looks rather than internal characteristics**
- **Narrow definitions of ideals**
- **Discrimination based on size/weight**
- **Family history of dieting**
- **Being teased about weight (fat shaming normalized)**
- **Appearance based sports**

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Considerations for Treatment

- Top teeth- environmental risks
- Bottom teeth- bio/psycho precursors
- Fly- a restricted diet
- Treatment needs to work from outside and within

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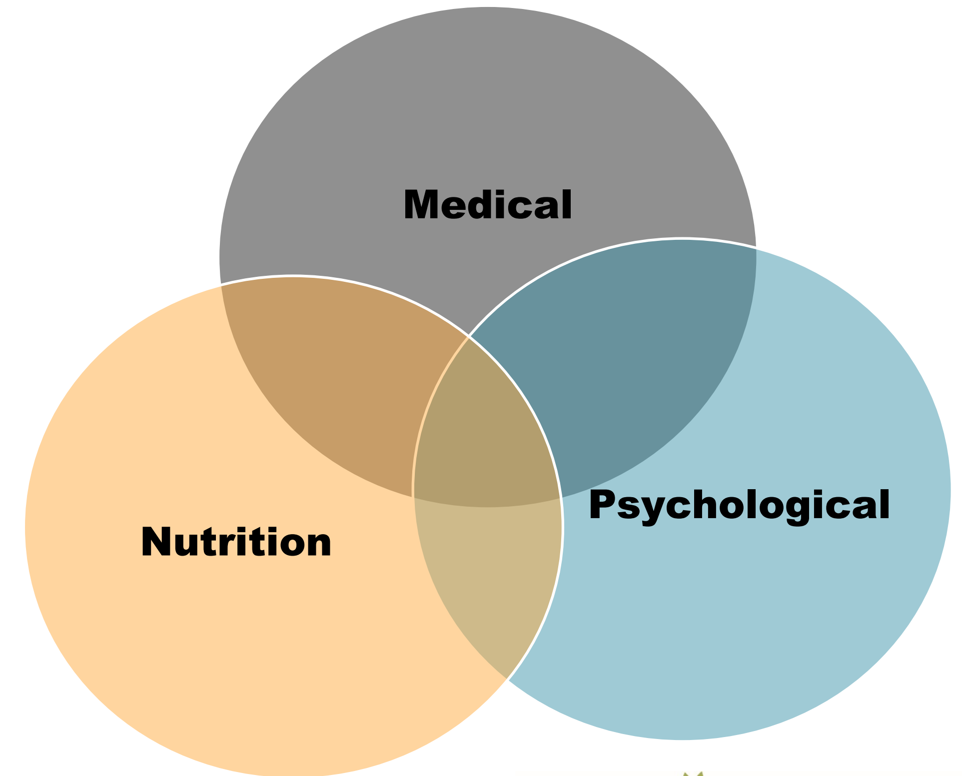
THE TREATMENT OF EATING DISORDERS

Biopsychosocial Disorders

- Advanced knowledge of :
    - How the body operates and struggles under ED conditions
    - The brain and psyche distortions that maintain ED behaviors
    - Nutritional deficiency and vulnerabilities and how to correct for that
    - Comprehensive treatment requires communication, cooperation,

      and collaboration between disciplines.

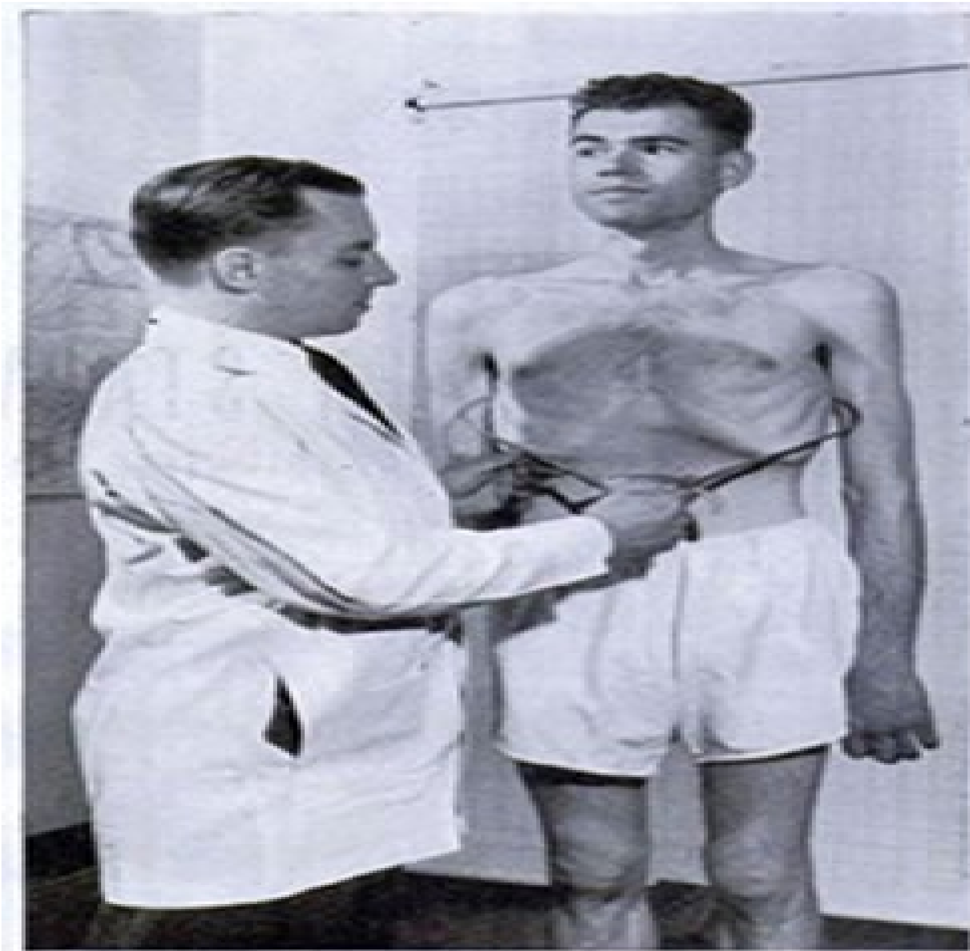


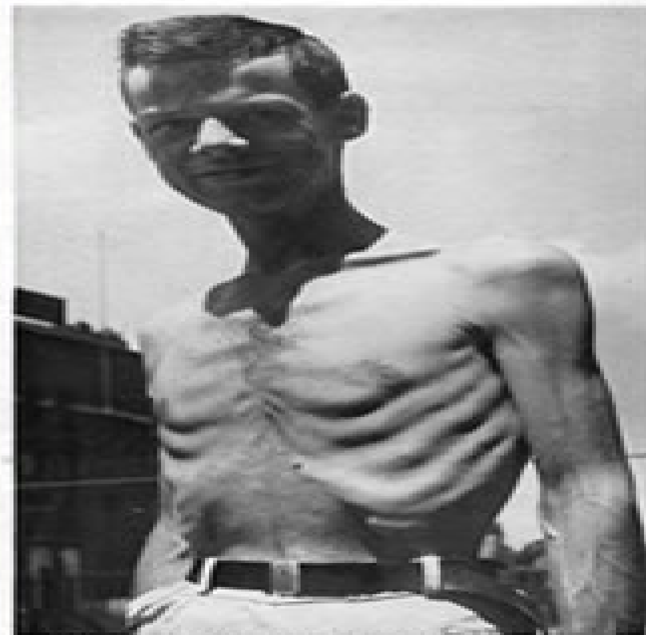
Treatment Team Members:

- Therapist
- Dietician
- Psychiatrist
- PCP

Overlap of Medical, Psychological and Nutritional Impact of Starvation

Minnesota Starvation Experiment





MEN STARVE IN MINNESOTA

CONSCIENTIOUS OBJECTORS VOLUNTEER FOR STRICT HUNGER TESTS TO STUDY EUROPE'S FOOD PROBLEM

Above:
Conscientious objectors during starvation experiment.
Life magazine - July 30, 1945. Volume 19, Number 5, p. 43.
Credit: Wallace Kirkland/Time Life Pictures/Getty Images.

Left:
Dr Ancel Keys measures the chest width of James Plaugher.

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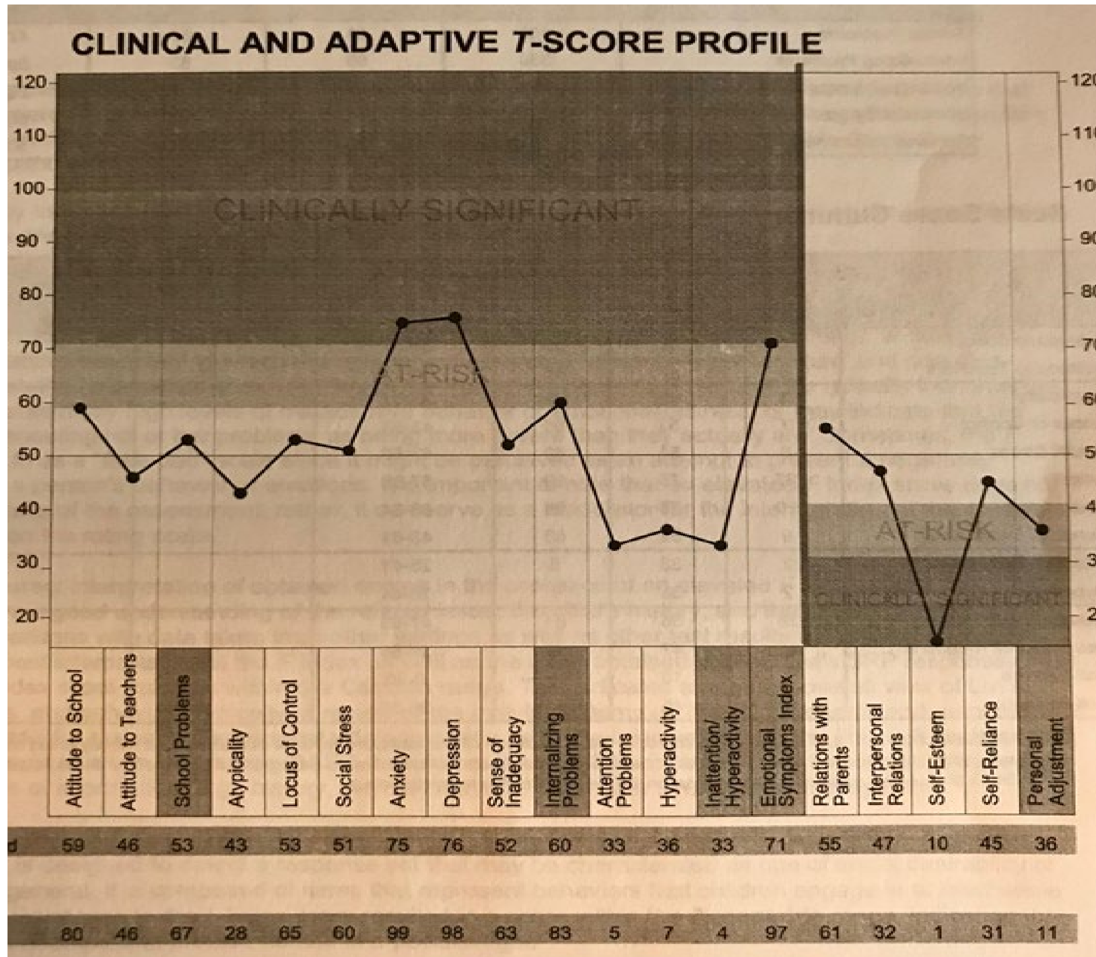
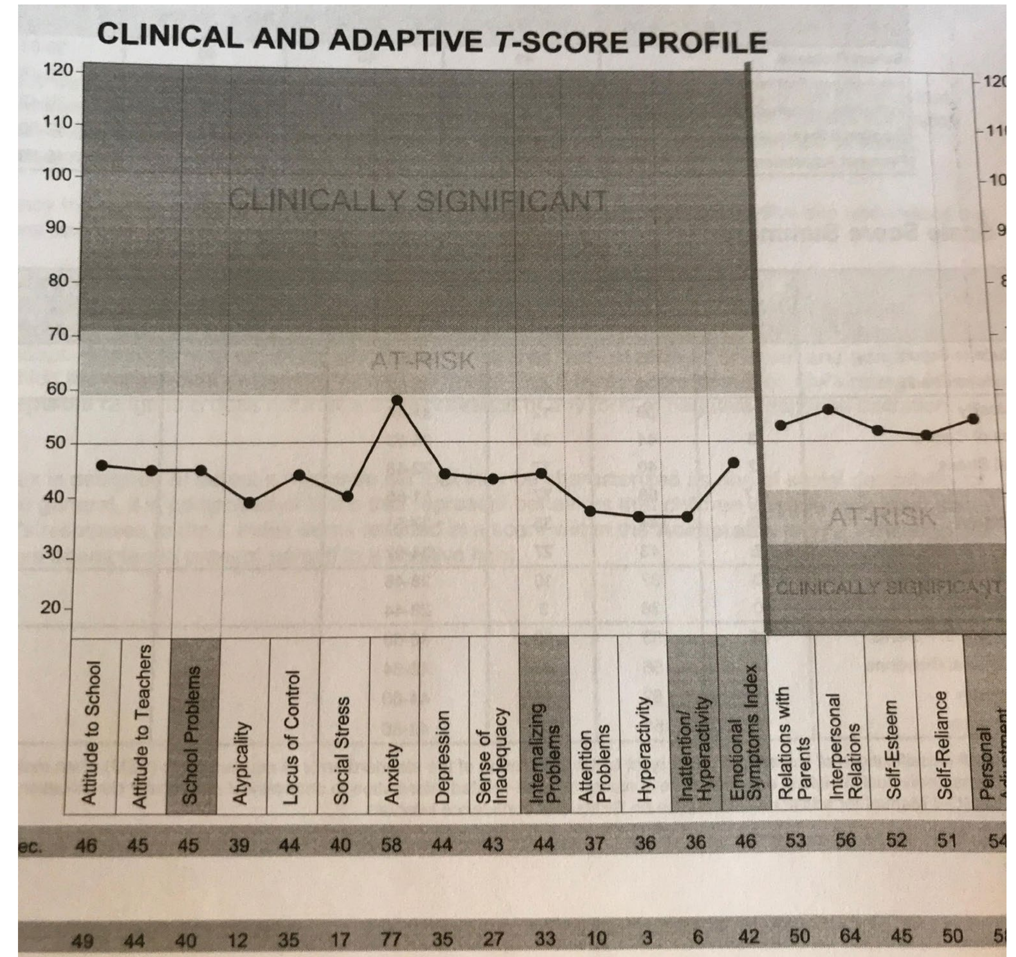
Photograph from Life magazine on July 30, 1945 (volume 19, number 5, p. 43) showing men enrolled in the Minnesota Starvation Study during the semi-starvation diet.

Minnesota Starvation Experiment Findings:

- **Decreases in strength and stamina, body temp, heart rate, basal metabolic rate and sex drive**
- **Food obsession, dream, fantasize, read and talk about food (during starvation and rehabilitation phases)**
- **Reported fatigue, irritability, depression, and sadness. Most reported periods of severe emotional distress and depression.**
- **Extreme reports of psychological effects including self-mutilation. (amputated three fingers with an axe- unsure of why)**
- **Decline in reported concentration, comprehension, and judgment**
- **Refeeding phase included periods of extreme over eating and continued preoccupation with food**





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Helping Caregivers Become Coaches

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Parents lend information, perspective and support

In addition to providing information, the caregiver is active in leading or co-leading behavioral and emotion-focused interventions with their loved one of ANY age in session, at home, by telephone, text or email in the service of reducing symptoms and increasing self-efficacy with emotions (Lafrance, 2017).

Why

Trauma to the entire family

Requires more support than you can give

Scared caregivers can behave in ways that do not support recovery

Culture perpetuates ED maintaining beliefs

IMPROVE TREATMENT OUTCOMES

Parent, Loved One and Caregivers- how they are impacted

- I worry about someone else's eating behavior or appearance concerns.
- I tell lies to cover up for someone else's eating or appearance behaviors.
- If the person with eating or body image disorders really cared about me,they would stop the destructive behaviors.
- I blame their behavior on relatives, friends, or companions.
- Plans, meals, family gathering, or holidays are upset, delayed, canceled,or spoiled because of their eating or body image problems.
- I make threats, e.g., "If you don't start [fill in the blank], I'll leave you."
- I secretly snoop around to discover whether they've been purging,restricting, or engaging in other dangerous eating behavior.

upagainsted.com- Joe Kelly

Parent, Loved One and Caregivers- how they are impacted

- I am afraid to upset them for fear it will set off an episode of purging,anger, depression, or other problems.
- I’ve felt furious about the situation.
- I’ve been hurt or embarrassed by their behavior.
- I’ve felt hopeless about the situation
- I search for hidden diet pills, laxatives & other tools of disordered eating.
- I’ve refused social invitations out of fear or anxiety.
- I feel like a failure because I can’t control their self-destructive behavior.
- I think that if they stopped these eating or body obsessions, our other problems would be solved.
- I have (even once) threatened to hurt myself to scare them.
- I feel angry, confused, or depressed a lot of the time.
- I feel there is no one who understands my problems or our situation.

upagainsted.com- Joe Kelly

Most important reason to involve caregivers in care

Improved outcomes for patients and their caregivers across the lifespan when we do

- reduced psychopathology
- improved quality of life
- reduced hospital stays
- reduced expressed emotion in the family
- reduced caregiver burden

Caregiver Involvement - Antidote to Burden

What is most detrimental to the mental health of a parent or caregiver is to witness a loved one's suffering, and feel helpless or ineffective in the face of it (Monin, 2016).

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Take time to understand both parent's perspective

Of the illness

Of their concerns

Of their worries

Of their vision of the factors at play

"...families are often our best allies in treatment—they don't cause the disorders, they are our allies in recovery. It's our job to help give them the blueprint about what they need to do to become allies in recovery." **Cindy Bulik, PhD**

Trauma to the entire family

Mom-

neglect other responsibilities to tend to child with ED

- Marriage
- Work
- Other children
- Self

See herself as having failed her child

To blame for the illness

Exhaustion, repressed anger, resentment, secret desire to have space from the child

Trauma to the entire family

Dad's

Pushed aside

Feel inept to help

Culturally have hurdles to asking for inclusion and to being asked for inclusion

Secretly think they "caused" the ED

More likely to think the disorder is due to character deficits in the child and family

Engaging Male Loved Ones

- Joe Kelly
- Male Loved Ones Coach
- Up Against ED
- upagainsted@gmail.com

Engaging male loved ones

Men are less likely to:

- Understand benefits of therapy
- Spend time with their children & be actively involved in their lives (vs. moms),
- Believe they have time to participate in help-seeking for child, ,
- Believe that they are as emotionally close to children (compared to mothers),
- Believe that other men seek help,
- Believe that they are a resource for a loved one's mental or physical health
- Attend therapy if they were separated from their fathers as children
- Admit defects in themselves

Engaging male loved ones

Men are *more* likely to:

- Assign depression a stigma of mental illness and “feminine” emotionality
- Believe child’s behavior is similar to his growing up, ,
- Believe child’s behavior problem is caused by lack of motivation
- Manage disruptive behavior with spanking
- Allow children to participate in treatment if his own participation is voluntary (vs. court-ordered)
- Be concerned that therapists will treat them badly (e.g., showing bias, attacking masculinity)

Engaging male loved ones

Men are *less* likely to:

- Recognize feelings of distress
- Label distress as an emotional problem
- Accept that a loved one has a mental health problem
- Understand benefits of therapy
- Spend time with their children & be actively involved in their lives (vs. moms)
- Believe they have time to participate in help-seeking for child
- Believe that they are as emotionally close to children (compared to mothers)
- Believe that other men seek help

Engaging male loved ones

Concerns and Motivators in Treatment:

- Male coping styles tend to be more active
- Most comfortable working to “solve” a problem
- Men tend to perceive talking about a problem as “passive” and ineffective

Engaging male loved ones

Practices of Providers Who Successfully Engage MLO’s

- Expect & demand engagement by male loved one
- Explicitly and personally invite MLOs to participate
- Acknowledge/Emphasize the importance of MLO’s opinion and perspective
- Talk directly to the MLO regardless of setting
- Acknowledge MLO’s feelings of frustration and feelings of powerlessness
- Value influence of MLOs (live-away dad, ex, stepdad, other male relatives & friends)
- Meet individually with the MLO, but without the identified client/patient

- Interview MLO for his perspective on and theory about the identified client/patient's situation/symptom use
- Challenge MLO's "too busy" excuses and provide flexible scheduling
- Go from concrete to abstract in conversation & education
- Frame work as a coaching process
- Make physical environment male-welcoming,
- Help MLO practice healthy responses through role play, scripting, multi-step planning,
- Use analogy
- Use examples from recreational & sporting settings
- Engage in lifelong learning

Siblings

Feel afraid

Feel resentful

Feel responsible

Feel forgotten

Barriers to engaging family

Patient resistance

Dual role with patient and family

Needs of the family and it’s members can be as demanding as the patients

Time

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Eating disorders require more support than you can give

- EDs involve difficulties with behavior modification – leading to a need for behavioral support outside of therapy

- EDs are also characterized by emotional processing deficits – parents have the most ability to provide skillful emotional management alternatives

- Neuroscience supports the healing power of supportive parent-child/caregiver-loved one interaction; even if imperfect

Wolf in Sheep’s Clothing

- Eating Disorders are serious conditions that affect mental and physical health, which can be life threatening
- Eating Disorders have the second highest mortality rate of any psychiatric illness (higher than depression, Schizophrenia, or bipolar)- bypassed as long standing first by Opioid addiction in 2014
- Medical complications, most common cause, followed by suicide
  - Suddenly and without warning
  - SUDS is 50% mortality
- Mortality rate 12 times higher that general population for females ages 15-24 (Anorexia)
- Mortality rate for Other Specified Feeding or Eating Disorder (OSFED) is 5%

Scared Caregivers

Caregiver traps- make it difficult for caregivers to perform their role in treatment

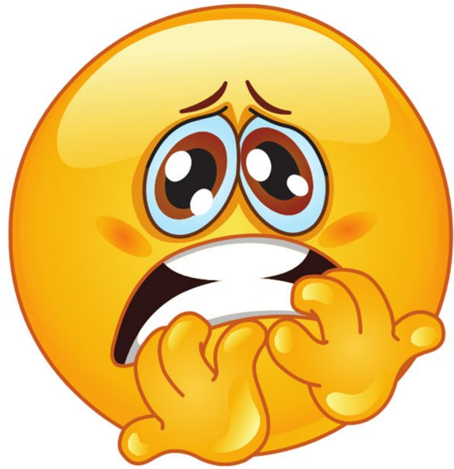
We need them to:
Support recovery oriented behaviors

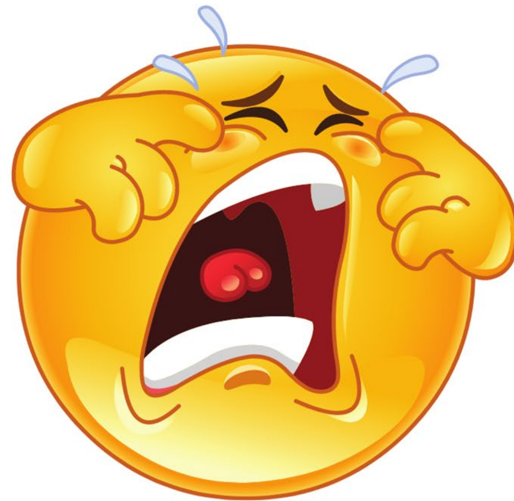
Scaffold new skillful emotional management tools

Help develop insight, awareness, and courage to approach emotional states

Maintain loving boundaries

Be aware of and not act on enabling urges from fear





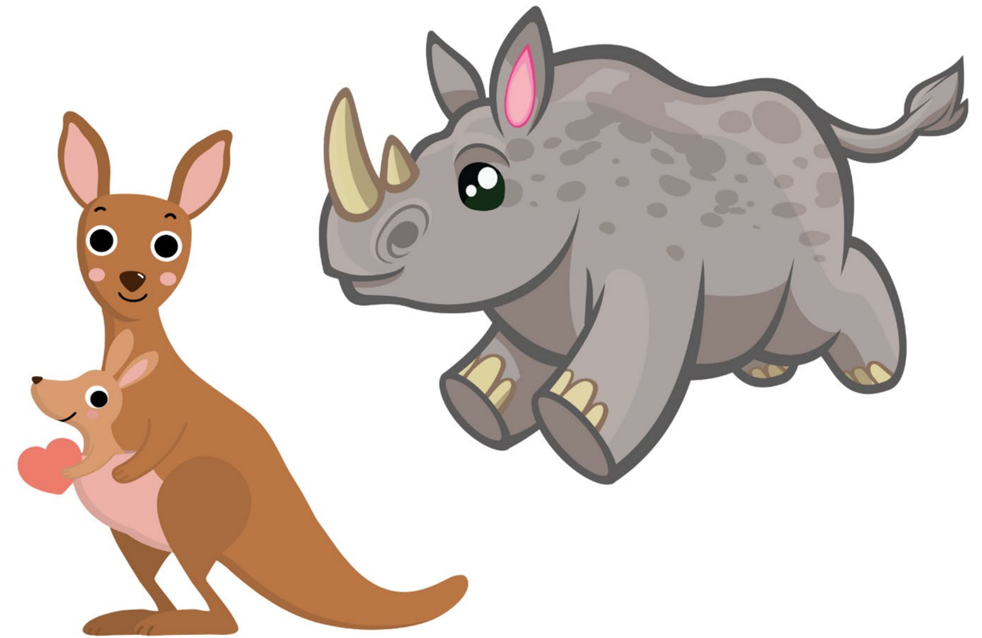
How do we communicate when we are afraid?

What type of caregiver are you?

Which are you more likely to fall toward when circumstances with your loved one are challenging?

- Kangaroo: On the overprotective side, desire to protect and shelter loved one by putting in their pouch and doing things for them

- Rhino: On the controlling side, debates, urges to push down and barrel through



Dolphin: Just enough direction, follows when possible, leads when necessary, trusts that there is growth in figuring it out

REMEMBER: Challenges are opportunities for growth.

What are your caregiving tendencies under stress?

Which are you more likely to fall toward when circumstances with your loved one are challenging?

- Jellyfish: May have big emotions and struggle to keep them in check. Might be openly distressed and may feel wobbly.

- Ostrich: May avoid thinking, feeling, and dealing with emotions or situations.

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Saint Bernard: Steady, warm, calm, persevering, enduring

What drives our behavior?
EFFT Tree

Learning to tolerate your loved one’s distress through this process is very important

In order to do this, you will need to learn to manage your own discomfort this will bring up.

Most common caregiver blocks:

- Fear of serious self-injury or suicide
- Fear of permanent relationship breach
- Fear of loved one running away/leaving, prison, homeless, or destined for extremely low quality of life
- Fear of making the disorder worse

Managing distress: you must put your oxygen mask on first

- What fills your cup?
- Square breathing- 4 counts in, hold for 4, 4 counts out, pause for 4
- Breathing out through a straw
- Radical acceptance- willingness to accept (or welcome even!) the discomfort required for change
- Acknowledge acts with caring
- Self-soothe: engage in self-care regularly (driving in a snow storm) and for short bursts in the middle of challenging times
  - Walk
  - Bath
  - Cup of tea
  - Hug by partner
  - Snuggle a pet
  - Light a candle
  - Podcast

Caregiver Trap Scale

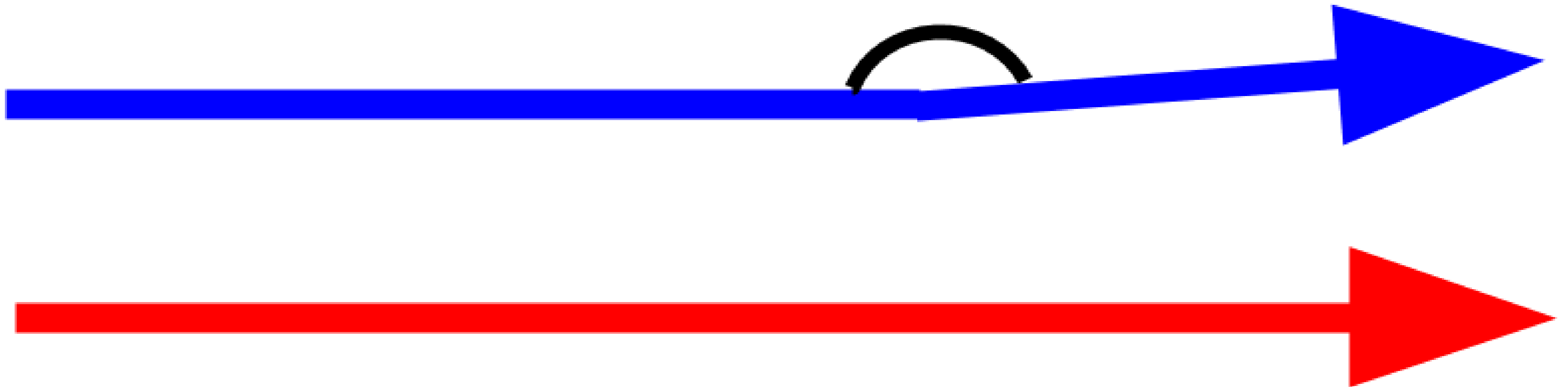
- I worry about being rejected by my loved one
- I worry about putting strain on my couple relationship.
- I worry about alienating other family members / significant relationships (besides one's partner)
- I worry that my loved one will be seen as abnormal or mentally ill
- I worry that my loved one will miss out on normal activities or special occasions
- I worry that I will do/say something I will regret out of frustration or anger
- I worry about being unable to follow through with interventions (e.g. in the face of resistance, due to time constraints).
- I worry about causing suffering to my loved one/others

Caregiver Trap Scale

- I worry about breaking down or burning out throughout the process
- I worry about coddling my loved one and preventing her /him from becoming independent
- I worry about having to face my own past along the way
- I worry that my loved one's symptoms will shift (e.g. from cutting to substance use, etc.)
- I worry about pushing my loved one "too far" leading to a worsening of symptoms, withdrawal, running away, suicide, etc.
- I worry about being blamed or being to blame if it doesn’t go well.

https://www2.unbc.ca/sites/default/files/events/42463/lighting-way-attachment-trauma-and-resilience/caregivertrapsscale.pdf

One degree of change...



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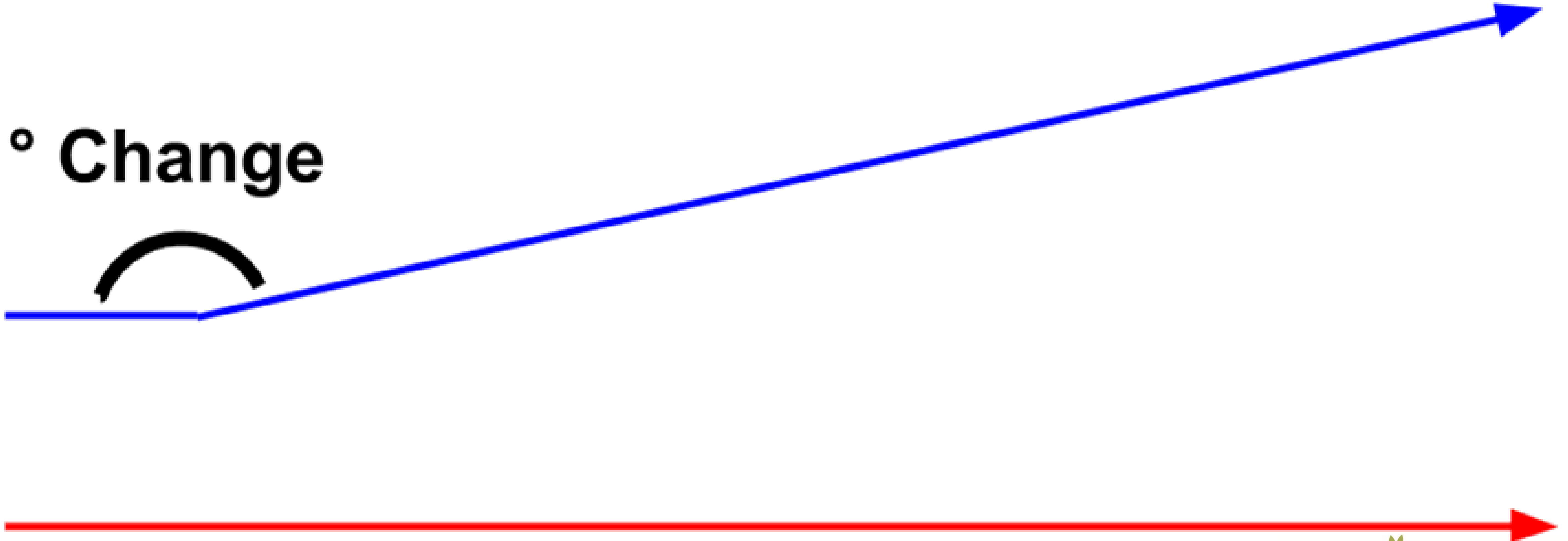
One degree of change… over time



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Parents only need to get it “right” about 30- 50% of the time to have a positive impact on change.

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Core Skills for Caregivers: Emotion-focused Family Therapy

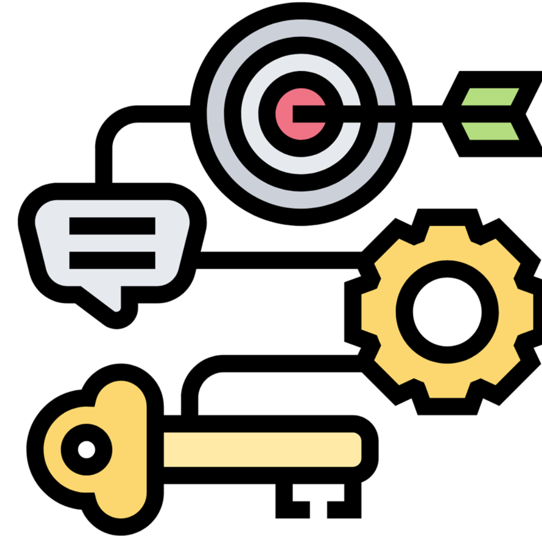
Intended to help caregivers help their loved ones regulate.

Get back to a brain state of flexibility and logical thinking.

Key Outcomes

In the moment:

- Increase in cooperation
- Avoidance of escalation
- De-escalation
- Regulation



Over time:

- Internalization of self-regulation capacities

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Support Sequence

1. Validation- until activation levels come down
2. Emotional support
3. Practical support

How does it work? Validate & Support

Step 1 - Validate

A. Convey understanding of their experience & prove that you “get it”.

Step 2 - Support

A. Emotional Support

B. Practical Support

Starting with Validation

“No one cares how much you know until they know how much you care.” - Theodore Roosevelt

Validation

Is not agreement.

Recognition or affirmation that a person or their feelings or opinions are valid or worthwhile.

- Reassurance
- Understanding
- Insight
- Problem-solving

Because, Because, Because

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How does validation help?

Validation provides language for the emotional experience.

People organize their brains with conversation.

Name it to tame it.

The validation process scaffolds the process of identifying emotions, understanding their causes, and helps to calm and regulate the other person.

Through validation the other person experiences co-regulation through you. This allows for de-escalation, greater access to problem solving skills, and emotional regulation.

It opens the door for readiness for emotional and behavioral support.

Emotional Support

- Comfort (a hand, a hug or loving words)
- Reassurance (“It’s going to be ok”)
- Communication of positive regard (“I know you are doing the best you can right now”)
- Communication of belief in the other (“I believe in you; “I believe you can do this”)
- Communication of togetherness (“We’re in this together”; “I want the best for you too” Sit with you through this time.)
- Space (Why don’t I give you a few minutes and we’ll try again) space can be physical or psychological *and* time-limited in that the plan for reconnection must be clearly communicated

Behavioral Support

- Proceed with plan
- Suggest a distraction activity (walk, movie, music, etc)
- Redirect to another thought or activity
- Teach skills
- Exposure to the anxiety-provoking stimulus (in a gradual way)
- Offer solutions to solve the practical problem or take over to solve the problem
- Set a limit
- N/A (sometimes, once the other is validated and supported emotionally, no more is required)

Practical Tips

1. Validation is critical but it's a 2-step process. It is targeted strategy with heart.

1. Go through the open door, play whack-a-mole

1. Use tentative language grounded in sincerity (best guesses are more effective than questions)

1. Work towards approaching non-verbals for maximum effectiveness (tone, volume, facial expression, body language)

1. Need to practice - or your brain will default to your go-to

Example:

Validation-
It makes sense that you might want to give up on the recovery process.
Because, because, because-
You are trying many new skills, you’ve relied on your eating disorder to cope for a long time, and it is hard to have me watch you struggle.
Emotional support-
I believe in you and I am going to be here for you while you walk this path.
Behavioral support-
Let’s sit down together and tackle it together.

Review: Support Sequence

1. Validation- until activation levels come down
2. Emotional support
3. Practical support

Example one:

1. I want to ____________. (purge, binge, cut)

It makes sense to me that you would want to __________________ because:

1.
2.
3.

Emotional support sentence:

Practical support suggestion:

Example Two:

2. I don't want to _______________ . (do treatment anymore, eat my meal plan)

No wonder you wouldn't want to ____________________ because:

1.
2.
3.

Emotional support sentence:

Practical support suggestion:

Example Three:

3. I feel so________________________. (fat, ugly, unmotivated, disgusting)

I can understand that you might feel so________________________ because:

1.
2.
3.

Emotional support sentence:

Practical support suggestion:

Example Four:

4. Why are you trying to talk to me like that? (said after you've gone through the steps of EC)

I can understand why you'd react in this way to what I'm saying because:

1.
2.
3.

Emotional support sentence:

Practical support suggestion:

Important tips to know:

*Clumsy is ok

* It is ok to move slowly and take your time

*You can’t get it wrong- even trying to see if from their point of view builds connection.

*The intent is not to get the person to do what you want them to. It’s to build a bridge of emotional regulation and skill development. It’s more about the long term than the short term.

*Getting it “right” as little as 30% of the time has an enormous positive change in trajectory

Take-home messages

- It's hard to remain in a resistant state
- It's not what you say, It's what you convey (sometimes the words don't even matter so much)
- Feedback is not required for connection and deep emotion processing
- "No pressure", "sticking with" and "making educated guesses" are the best way to transform the resistance
- You can't always trust your bodily felt sense re: what's working

What if they screw up?

- Breaks and repairs lead to a stronger bond (like muscle fibres and bones!)

- If they make a mistake - encourage them to go back. It's the opposite of avoidance and it can be very powerful

- When emotion coaching:

it's not what happens, it's what happens NEXT!

Core Skill: Moving from BUT to BECAUSE...

"I can understand why you might feel/think/want (_________) but…"

is transformed into:

"I can understand that you might feel/think/want (_________) because…" x3

When the external environment mirrors the internal experience, the alarm bells in the brain reduce in intensity

Summary - Emotion Coaching

- Teach to caregivers and for use by staff with clients
  - General skill + micro-skills
  - Targeted use
- Requires practice to go against conditioning

- Not a perfect solution, but possible outcomes include:
  - Increase flexibility / engagement / cooperation
  - De-escalate outbursts
  - Reduce use of more invasive procedures
  - Improve relationships
  - Increase self-efficacy with emotion / self-regulation in all involved

Practice Emotion Coaching

Step One

Convey understanding of their experience (from their point of view):

I could understand you…

I could imagine you…

No wonder you…

It would make sense that you…

When I put myself in your shoes, I could imagine you…

+ …might feel/think/want to/not want to ____________________

Step Two

Because, because, because

Demonstrate that you “get it” with sincerity and in a way that reflects their positive intentions, vulnerable feelings, or attempts for relief from pain:

because #1: ___________________ because #2: ___________________ because #3: ___________________

Important tips

** Match similar emotion with downward emphasis onto the third statement*

**BECAUSE or AND, not BUT!*

What can you validate?

Emotions and emotional states

Sad, mad, lonely, shameful, frustrated, hurt

Attitudes

This is stupid, there's no point, annoyed

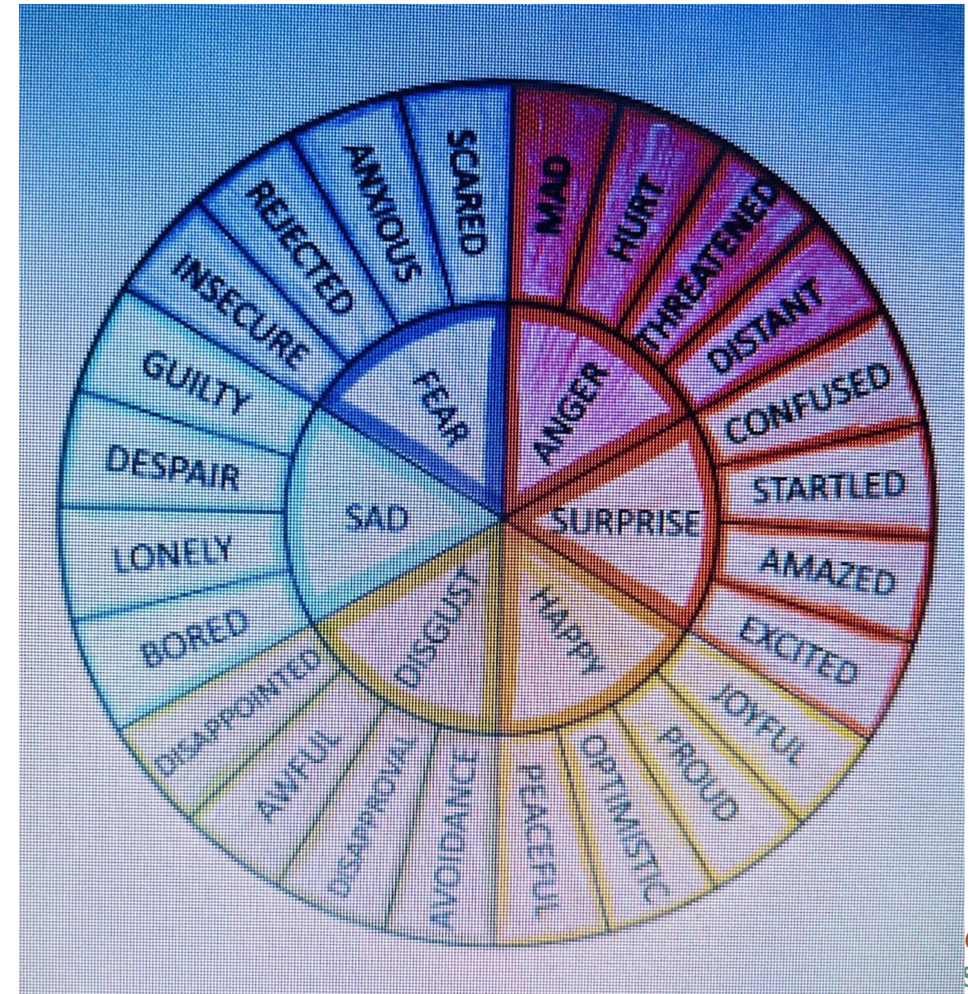
Urges

I want to binge/restrict, skip a meal, not do a challenge

Behaviors

Cut, throw plates or food

Silence



Functionally Dysfunctional

We do not repeat behaviors that do not have some payoff for us.

Often eating disorder behaviors help us cope in ways that we might not fully understand.

Ambivalence is way of understanding that often we want to change and we do not want to change. These mixed feelings create confusion, chaos and frustration for the person and for the caregiver.

This is normal and part of the change process

Understanding what the eating disorder provides can help to find better ways to meet that need

It’s about the food- But it’s not

Adapted from The Eating Disorder Source Book- Carolyn Costin

1. Poor Self-esteem
   - I am afraid of myself and being out of control.
   - I’m not worthy.
   - People don’t like me.
   - I can’t trust my own judgments or make decisions.
2. Need for distraction
   - When I’m bingeing or throwing up I don’t think about anything else.
   - I need something that distracts me from my thoughts and feelings.
   - Worrying about my weight keeps me from worrying about other things.

3. Fill up the emptiness

- Something is missing in my life and I try to fill it with my eating disorder.
- I feel empty inside and bingeing takes me away from that temporarily.
- Eating fills up my emptiness.
- All my eating disorder rituals help me fill up a void in my life.

4. Belief in a Myth

- I will be happy and successful when I am thin.
- Thinner people are happier.
- I have to be thin to be attractive and desirable.
- Losing weight will solve all my problems.

5. Drive for Perfection

- I have to be the best at everything, whether it is taking a test or dieting.
- I have the willpower to do things others can't do.
- I'm either fat or thin.
- If I can't win or be the best, I won't try.

6. High-Achievement Oriented

- I feel constant internal pressure to work hard and achieve.
- I can only achieve a good body through my eating disorder.
- I am driven everywhere else and use my bulimia as a release. Restricting is a real achievement, mind over matter, literally.

7. Desire to be Special/Unique

- I get a lot of attention for my willpower over food.
- I don't know who I would be without my eating disorder.
- My eating disorder causes others to worry about me and take care of me.
- My eating disorder makes me stand out and be different.
- My low weight is the only special thing I have.

8. Need to be in Control

- I have to be in control of my body, and what goes in and out of it.
- My eating disorder helps me feel in control of my "out of control-ness".
- My eating disorder behaviors keep my feelings under control. My eating disorder is the one thing no one has control over but me.

9. Desire for Power over Self, Others, Family, Life

- My eating disorder gives me power over my body.
- I feel powerless most of the time, except when it comes to my eating disorder.
- My eating disorder gives me power over others.
- It is powerful to be able to resist food, like a saint or a monk.

10. Desire for Respect and Admiration

- I finally got respect from my peers when I lost weight.
- I wanted to be admired and tried restricting to lose weight, but I couldn't do it, so I had to throw up.
- When I binge I am rebelling because I know I will never get the respect and admiration that people get for being thin. People respect my ability to restrict food.

11. Difficulty Expressing Feelings

- I don't know how to express my anger, so I binge and purge. I feel like I swallow my feelings when I binge.
- I can't deal with conflict or confrontation so I resort to my eating disorder.
- Restricting helps me shut down and deny my feelings.

12. Need for a “Safe Place to Go”/ Lack of Coping Skills

- My eating disorder is a special world created to keep all the bad out.
- If I follow my own imposed rules, it helps me feel safe.
- My eating disorder helps me get taken care of without asking for help.
- My eating disorder has helped me avoid taking on adult responsibilities.

13. Lack of Trust in Self and Others

- I don’t trust people so I isolate myself from them with my eating disorder.
- I don’t trust anybody, I use my eating disorder as my best friend.
- I can never make a decision; bingeing and purging provide procrastination.
- It is easier just to follow my eating disorder rules than trusting myself or anyone else.

14. Intense Fear of Not Measuring Up

- I know I can’t compete, so I let my eating disorder take me out of the running.
- I won’t have anything if I don’t have my eating disorder.
- I’m constantly comparing myself to everyone.
- I am terrified of being fat.
- I am terrified of being deprived.
- I am terrified of being deprived and of being fat.

Culture Maintains Illness

Parents are human

Many of our ways of viewing the world are culturally lead

Cultural beliefs support eating disorder thinking

Create the environment where there is some armor against this type of ideology

Creates more challenge for family and treatment to be in conflict

Recovery Culture	Current Culture
Healthy bodies come in many different sizes.	The thinner you are the healthier you are.
There is room for all foods in a balanced diet.	"Bad" foods will harm your health.
Diets are unhealthy and do not work.	There is a diet that will make you lose weight quickly and permanently.
It isn't the size of the person that determines their worth and attractiveness.	There's no such thing as too thin, you should constantly be working at being thinner and more fit.
Fat, on the body and in the diet, play an important role in the body's proper functioning and is imperative to total health.	Fat is disgusting and associated with many negative attributes including laziness, unattractiveness, and stupidity. The less fat you have the better.
The body wants to be healthy and will use hunger and fullness cues to guide your intake and help you meet its needs.	You cannot trust yourself around food. You must rely on dieting rules to combat your hunger and decide your food choices or your eating will be out of control.
Policing your foods and assigning them “good” and “bad” labels backfires by creating a psychological and emotional urges.	Labeling and categorizing foods will help me avoid food that will make me too heavy and damage my health. I must avoid “bad” food.
Genetics play a large role in the body’s retention of and distribution of fat. The size and shape of your body is largely out of your control.	Everyone can and should be lean. If you aren’t you are not trying hard enough and should be disappointed in yourself.

Parenting *through* Eating Disorders

“HAES supports people of all sizes in addressing health directly by adopting healthy behaviors. It is an inclusive movement, recognizing that our social characteristics, such as our size, race, national origin, sexuality, gender, disability status, and other attributes, are assets, and acknowledges and challenges the structural and systemic forces that impinge on living well.”

(ASDAH, Health at Every Size Principles, www.sizediversityandhealth.org.)

Health at Every Size (HAES)

HEALTH AT EVERY SIZE PRINCIPLES:

- Accepting and respecting the diversity of body shapes and sizes
- Recognizing that health and well-being are multi-dimensional and that they include physical, social, spiritual, occupational, emotional, and intellectual aspects
- Promoting all aspects of health and well-being for people of all sizes
- Promoting eating in a manner that balances individual nutritional needs, hunger, satiety, appetite, and pleasure
- Promoting individually appropriate, enjoyable, life-enhancing physical activity, rather than exercise that is focused on a goal of weight loss

HAES - Continued

Health at Every Size

Respect

●- Celebrates body diversity

● - Honors differences in size, age, race, ethnicity, gender, dis/ability, sexual orientation, religion, class, and other human attributes.

Critical Awareness

●- Challenges scientific and cultural assumptions

●- Values body knowledge and lived experiences

Compassionate Self-care

●- Finding the joy in moving one's body and being physically active

●- Eating in a flexible and attuned manner that values pleasure and honors internal cues of hunger, satiety, and appetite, while respecting the social conditions that frame eating options.

●Source: Retrieved from: https://haescommunity.com

Dieting Predicts Weight Gain

UCLA Review of 31 long-term studies on dieting found:

- Dieting leads to more weight gain over time than non dieting.
- Dieting is a consistent predictor of weight gain. Up to 2/3 of people gained more weight than they lost.
- The benefits from dieting are simply too small and the potential harms of dieting are too large for it to be recommended as a safe and effective treatment for obesity.

Dieting Predicts Weight Gain

Twin Study- 2,000 twins from Finland (16-25)

- Showed dieting itself, independent of genetics, is significantly associated with accelerated weight gain and increase of becoming overweight.

- After just one intentional weight loss episode, the twin was 2 to 3 times more likely to become overweight as compared to their non-dieting twin.

- This risk compounded with each additional dieting episode.

-(Pietilaineet et al. 2011)

Dieting Predicts Weight Gain

- "Findings clearly indicate that dieting and unhealthy weight control, as reported by adolescence, predict significant weight gain over time." Journal of Adolescent Health, 2012
- "…in the long term, dieting to control weight is not only ineffective, it may actually promote weight gain." Pediatrics, 2003
- Dieting teenagers have twice the risk of becoming overweight, compared to non- dieting teenagers. (Neumark-Sztainer et al. 2006)

FAT IS NOT A FEELING
IT IS AN INDICATION OF NEED

- What does a client need when they say ‘I feel fat.’
- We live in a culture that purports that fat is one of the worst things a person can be, and we see this play out in our own biases, media, in-person discrimination, access issues, it’s no wonder our clients are terrified of becoming fat(ter).
- Our culture has normalized, especially for women, the idea that bonding includes talking poorly about our bodies.
- How can you connect with your client to really understand what they mean when they say “I feel fat.”
- What does being ‘fat’ mean to your client? Is what they believe true?
- Would your client state these beliefs to a child or a friend?
- What is scary or embarrassing for the client about identifying and discussing their underlying beliefs and needs?

- I’m lonely
- I’m worried that I’m unlovable
- I’m scared of connecting to people, and I don’t know how to
- I’m fearful of rejection
- I need to feel accepted
- I’m exhausted
- I’m overwhelmed
- I’m heartbroken
- I’m terrified to tell you what really is going on and it’s easier to talk about how much I hate my body than my trauma
- Hating my body is the only way I know how to feel connected to my mom.
- If I tell you I already know how bad my body is, maybe you won’t think I’m disgusting. I need to be liked.
- I feel out of control
- I’m anxious
- I need physical contact
- I am worthless

Becoming aware of our bias

- Questions to ask yourself:
  - How do II make assumptions based on only weight regarding a person's character, intelligence, professional success, health status, or lifestyle behaviors?
  - Am I comfortable working with people of all shapes and sizes?
  - Am I sensitive to the needs and concerns of people of different sizes?
  - How am I an ally?
  - In what ways do I feel defensive toward this information and why
  - Harvard Implicit Bias Inventory

Phases of Recovery

1. **I DON'T THINK I HAVE A PROBLEM.**
    - **It's my body so leave me alone.**
    - **There are people who are a lot thinner (worse) than I am.**

2. I MIGHT HAVE A PROBLEM BUT IT'S NOT THAT BAD.

- **I only throw up once in a while.**
- **My physical didn't show anything wrong so I am OK.**

3. I HAVE A PROBLEM BUT I DON'T CARE.

- **I know throwing up isn't good for me, but it's working for me so I don't care.**
- **I could change if I wanted to, but I don't.**

4. I WANT TO CHANGE BUT I DON'T KNOW HOW AND I'M SCARED.

- **I want to eat normally, but I am afraid I will get fat (gain weight).**
- **I want to stop bingeing, but I can't figure out where to start.**

5. I TRIED TO CHANGE BUT I COULDN'T.

- **I told myself that I would not (fill in the blank) but I found myself doing it again.**
- **I don't feel like I can really ever (change) get well, so why keep trying?**

Phases of Recovery…continued

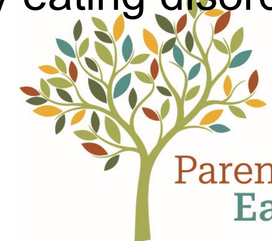
6. I CAN STOP SOME OF THE BEHAVIORS BUT NOT ALL OF THEM.
   - I could stop purging, but I will not be able to eat more.
   - My eating has gotten better, but my exercise is out of control.

7. I CAN STOP THE BEHAVIORS, BUT NOT MY THOUGHTS.
   - I can't stop thinking about food and bingeing all the time. □ I keep counting calories over and over in my head and still want to lose weight.

7. I AM OFTEN FREE FROM BEHAVIORS AND THOUGHTS, BUT NOT ALL THE TIME.
   - I feel fine all day, but under stress I revert back to my unhealthy behaviors.
   - I was fine, but wearing a bathing suit triggered my eating disorder thoughts, and with it some related behaviors.

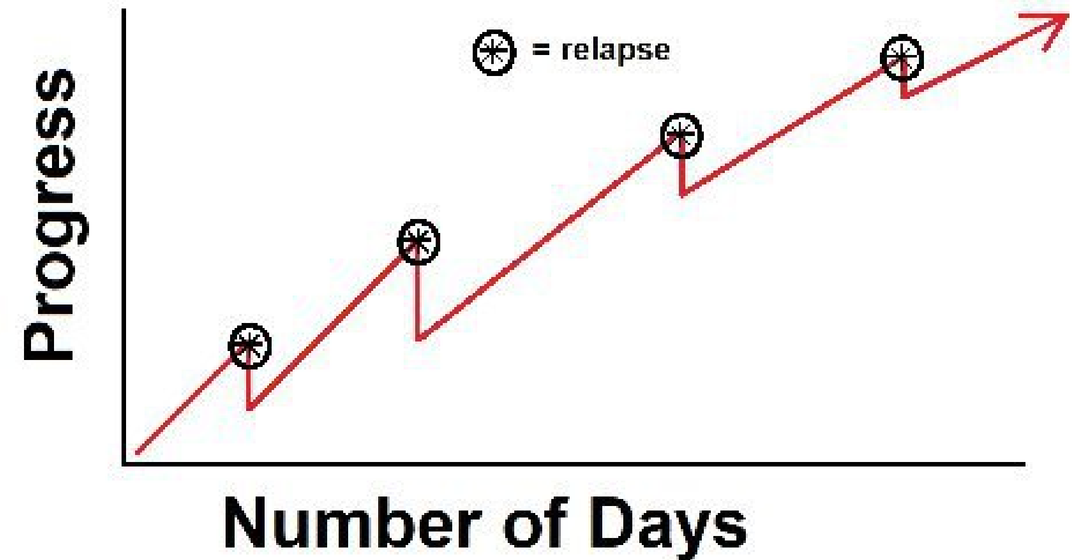
8. I AM FREE FROM BEHAVIORS AND THOUGHTS.
   - I feel mostly OK in my body and am able to eat things I want and not feel guilty or anxious afterwards.
   - Once I had stopped the behaviors for a period of time, at some point I realized that I was no longer having the thoughts or urges.

10. I AM RECOVERED.
   - For a long time now, I no longer have thoughts, feelings, or behaviors related to my eating disorder.
   - I accept my body's natural size. My eating disorder is a thing of the past.



The Recovery Curve

<u>What progress *actually* looks like (so long as you keep trying and never give up)</u>



Parenting *through* Eating Disorders

Treatment

How Are Eating Disorders Treated?

Refeeding and weight restoration

Symptom containment and interruption

The effects of starvation on the body mirror mental illness

Regulating intake is important at all levels

Refeeding can be a very uncomfortable but necessary part of the process

Why is it so hard to JUST STOP?

- Dopamine flood in an already less sensitive reward system (AN)
- Dopamine scarcity, then dopamine surge in active reward neural pathways (BN, BED)
- Praise, admiration, acceptance, envy, attention from others
- Anesthetization and distraction from trauma
- Reduced capacity for emotional nuance (AN)
- Reduced hormones that aren't necessary (low/no sex drive, reduced hunger urges, blunted emotions & reactions) (AN)
- Measurable meaning and achievement (I can be good, the scale tells me so, my calorie deficit tells me so, my Fitbit tells me so, new praise and attention tell me so)
- Feelings of purity, divinity, goodness (AN, BN)
- Attachment seeking in those with Ambivalent, Disorganized, or Avoidant attachment.
- Specialness, identity – the answer to 'Who am I, what is my purpose?'
- For some, keeps them young/small/needy then they can enact 'no one cares for me' or 'sick enough/not sick enough'
- A reason to be cared for if the client does not feel worthy or deserving of care.

(Neda, Nd). Rewards and Neurotransmitters, Troscianko, 2018)

Psychological Treatment for Eating Disorders

- Cognitive Behavioral Therapy-CBT, CBT-E
- Family Based Therapy- FBT
- Internal Family Systems- IFS
- Acceptance and Commitment Therapy- ACT
- Exposure and Response Prevention-E&RP
- Intuitive Eating-IE

Treatment

The Dragon

and the gatekeeper

Parenting *through* Eating Disorders

CBT

- I’m starving for…
- I’m full of…
- I need to get rid of…
- Identify ED rules
- I’ve been taught to feel this way
- Identify irrational fears

Parenting *through*
Eating Disorders

Thinking Errors & Negative Body Image

1. Physically attractive people have it all.
2. The first thing people notice about me is what's wrong with my appearance.
3. Outward appearance is a sign of the worth of the person.
4. If I could just change ____________________, my life would be happier.
5. By controlling my appearance, I can control my self-esteem/social life/emotions.
6. My appearance is responsible for what has happened to me in my life.
7. It's my duty to always look my best.
8. The media's messages make it impossible for me ever to be satisfied with my looks.
9. I can only like my looks if I change them.

Parenting *through*
Eating Disorders

Externalizing the Disorder

- Acknowledging the eating disorder is not you, but a brain shift
- Build space between it and the wise mind, inner nurturer
- Learning to observe it as a warning system
- Work to understand why it emerged, what purpose it served

Parenting *through* Eating Disorders

CBT-E

- Stage one: Self monitoring (Recovery Record), Weekly Weighing, Psychoeducation, Establish regular eating patterns
- Stage two: Assess readiness to transition to stage three
- Stage three: Assessing distortions; Over evaluation of shape and weight, Addressing dietary rules, Addressing clinical perfectionism, low self-esteem and interpersonal problems
- Stage four: Termination preparation, Minimizing risk of relapse.

FBT

- Family-Based Therapy Part 1: Parents Taking Charge
- Family-Based Therapy Part 2: There Is No Blame for Eating Disorders
- Family-Based Therapy Part 3: Focus on the Now
- Family-Based Therapy Part 4: No One Chooses to Have an Eating Disorder
- Family-Based Therapy Part 5: Everyone in the Family Has a Role in Eating Disorder Recovery

Parenting *through*
Eating Disorders

Internal Family Systems

Blends effective tools- Mindfulness, Schema, VC, ACT

BASIC ASSUMPTIONS OF THE IFS MODEL

- We all have multiple parts to our personality. This is normal and healthy.
- The self can and should lead the system.
- There are no bad parts.
- The goal of therapy is not to eliminate parts but to assist them in finding their non extreme roles.
- When the system is reorganized part can change rapidly.

Parenting *through* Eating Disorders

Goals of Therapy- IFS

- To achieve balance and harmony within the internal system
- To differentiate and elevate the Self so it can be an effective leader in the system
- When the Self is in the lead, the parts will provide input to the Self but will respect the leadership and ultimate decision making of the Self.
- All parts will exist and lend talents that reflect their non-extreme intentions.

Parenting *through*
Eating Disorders

Acceptance & Commitment Therapy

- Values Clarification
- Mindfulness
- Radical Acceptance

Values Clarification

- Deeper connection to personal values
- Identify discrepancies in actions
- What do you want to be remembered for?
- How are women/ men valued in society?
- What makes the women/ men in your life valuable to you?
- Make a list of all the things your body is capable of doing and why you appreciate them

Mindfulness

- Disconnection from the body
- Interoceptive awareness
- Awareness of primitive brain messages
- Awareness of societal programming
- Awareness of urges, schema triggers

Parenting *through* Eating Disorders

Exposure and Response Prevention

- Tools to manage anxiety
- Organize fear hierarchy
- Begin with lowest level fears
- Assist client in riding out fears consistently and repeatedly until extinction

- Foods
- Appearance
- Eating with others
- Throwing up

Psychodynamic Psychotherapy

- Attachment is where ED treatment lives.
- Recovery requires understanding the genesis and roots of the eating disorder.
- Symptoms are seen as expressions of the client's unmet, often unconscious needs.
- Looks at unconscious drives, dissonance, motives, emotions. Once these are understood, excavated, resolved, and brought to consciousness, the eating disorder will resolve.
- How does the way the client relates to food mirror their relationship with the outside world

(NEDA.Org)

Dialectical Behavior Therapy

- Most evidenced-based for AN, BN, BED
- The DBT skills focus on mindfulness, increased effectiveness in relationships, especially regarding clear, direct communication, regulation of emotions, and distress tolerance.
- DBT treatment for Eds asks the client to develop skills to replace maladaptive behaviors associated eating disorders.
- The stance of DBT is that changing behaviors is the most effective starting point for treatment.
- DBT is effective for SUDs and Borderline treatment, disorders which are highly co-occurring with EDs.

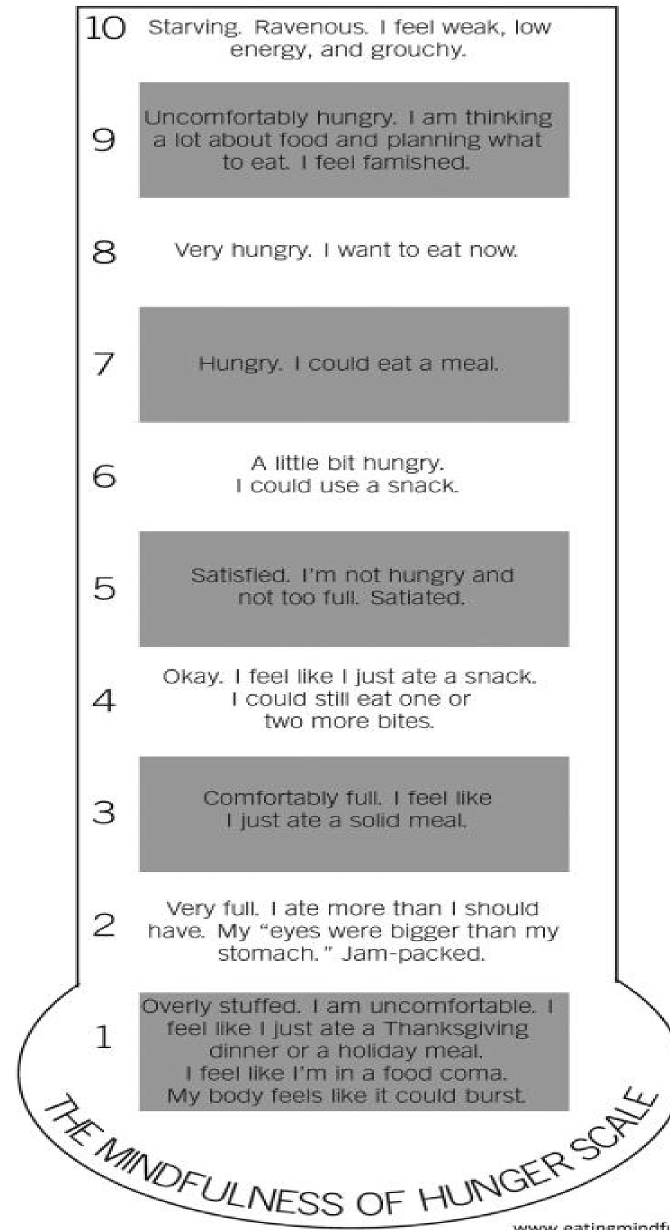
(NEDA.Org)

Exercise, Yoga, and Meditation

- Exercise is a tricky subject when it comes to ED recovery.
- Some bodies need to weight restore before exercise is safe
- Exercise can be a trigger for some clients, and relationship to exercise should be processed.
- Eventually, exercise (moving the body regularly in a gentle, joyful way is acceptable for people who don't like to go-hard or for whom this is out of reach) needs to be integrated into the client's life in a safe and supported way. There is no rush to do this – it can take a long time for some clients.
- Yoga is often an extremely useful tool for ED recovery as there are many different kinds of yoga (from gentle to strenuous).
- Yoga helps clients re engage with their bodies, create a mind-body connection, increase body awareness, and increase brain health.
- Yoga that includes meditation helps clients practice body, emotion, and nervous-system regulation, mindfulness, increases distress tolerance and endurance, and can help decrease reactivity.

Intuitive Eating

- Honor hunger as a physiological need (trust body)
- Respect fullness, cravings
- Challenge food police, make peace with food
- Enjoy and be present with your food experience



Intuitive Eating

“The Dynamic Interplay of Instinct, Emotion, and Thought” (Resch, 2019)

The Intuitive Eating approach was developed by Elyse Resch (MS, RDN, CEDRD, FAND) and Evelyn Tribole (MS, RD). It aims to heal people from diet mentality/chronic dieting disordered eating, and eating disorders by developing body positivity, body-respect, and reconnecting each individual with his or her own natural hunger, fullness, and satiety cues. Intuitive Eating has become an important modality in the treatment of Eating Disorders as it removes the “morality” of food – no food is off limits, no food is “good” or “bad.”

(Resch, 2019, HAESCommunity.org Nd)

Intuitive Eating – The 10 Principles

1. Reject Diet Mentality
2. Honor Your Hunger
3. Make Peace With Food
4. Challenge The Food Police
5. Respect Your Fullness
6. Respect Your Satisfaction
7. Honor Your Feelings Without Using Food
8. Respect Your Body
9. Exercise Joyfully
10. Honor Your Health

(Resch, Tribole, E.,2013)

Intuitive Eating

- Intuitive eating asks the client to put weight-loss on the back burner and to focus on integrating the principles.
- This can be harder than it sounds, as these seemingly simple principles are actually quite radical
- Clients may fear that if they listen to their bodies they'll eat only ice cream forever. Really attuning to their bodies, clients will begin to learn what their body needs and why. This may include ice cream and that is OK!
- Some clients do experience intense cravings for foods previously on the 'scary' list.' This is a natural reaction to previous restriction.
- Intuitive Eating takes the position that food has no moral value – a cookie and celery are the same. There is no 'good' or 'bad' food.
- Some food is energy dense, some is nutrient dense, and some are both.
- Intuitive Eating does not say 'junk food,' the terminology is 'play food.' In general a healthy diet should be satisfying to both body AND mind, and this can include play food.

Where does body image come from?

- Body image
  - Parents
  - Peers
  - Media
- Body dissatisfaction comes from
  - Subscribing to ideals
  - Perceived failure to meet them
  - Assigning meaning and worth to that

Those who suffer with this have a tendency to

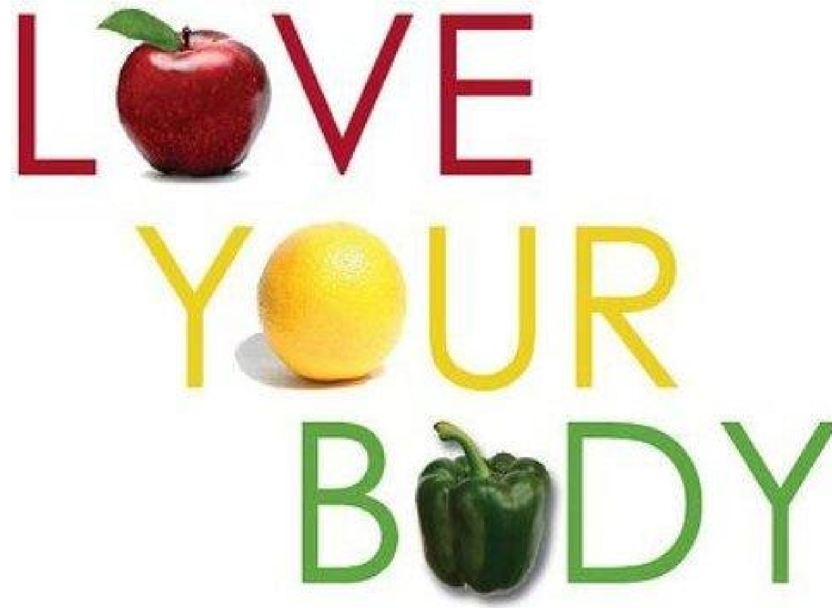
- Internalize societal ideals
- Make comparisons to others

Stages of Recovery – Carolyn Costin

- Ten stages
- One through three- no problem or don't care
- Four through six- working on stopping ED behaviors
- Seven through nine- working on stopping ED thoughts
- Ten- recovered – Free from thoughts, feelings, behaviors
    - Body acceptance

Clinically

- There are a lot of steps to becoming recovered while one must still wrestle with body dissatisfaction
- If body acceptance doesn't come until much later in recovery what kind of bridge can be built?
- Body Neutrality



Parenting *through* Eating Disorders

Body Neutrality

Body Neutrality

- sets the stage for
  - decreased criticism of the body
  - greater acceptance of the body as it is
  - decreased rumination regarding the body
  - more gratitude for the body
  - more self care

In Action

- Awareness of how labeling creates pain
- Brings awareness to faulty thinking
- Is actively engaging in order to stop the repetitive loop of obsession

Pull to suppression

- White Bear exercise

- When we attempt to avoid, we reinforce it
- True for thoughts and emotions

- Allowing without judgement helps us to let a thought or emotion come or go

Parenting *through* Eating Disorders

Observe and describe

- Observations vs. judgments
- Hair- long and brown vs. beautiful and luxurious
- Room- Grey couch, Dim light vs. Bad carpet, pretty picture

- Emotionally charged words?

- Good/Bad
- Beautiful/Ugly
- Expensive/Cheap
- Rich/Poor
- Yes/No

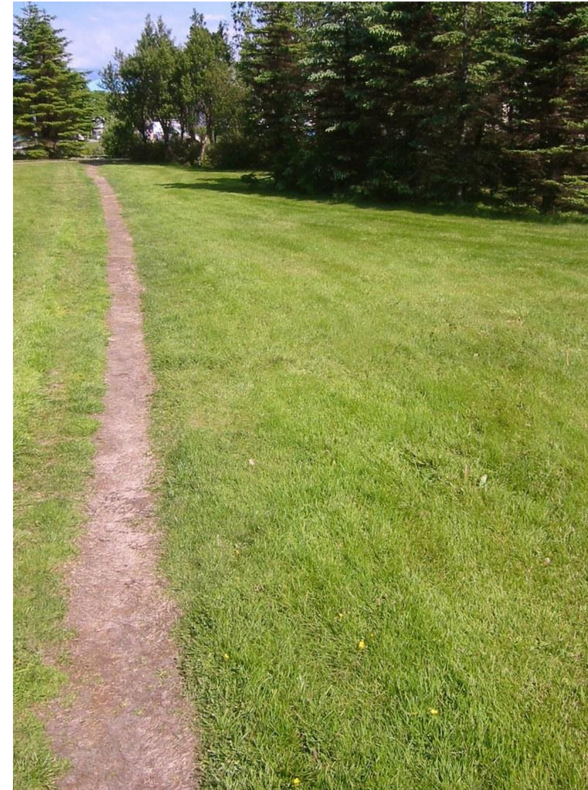
- Be curious about why these words are emotionally charged

Comparison

- Social comparison theory: People have a drive to evaluate their progress and standing.
- In the absence of **objective standards**, people will use comparison to others to know where they stand.
- Not everyone compares- personal story

Patients with eating disorders compare

- **Those that do this have:**
  - **A heightened awareness of the self**
  - **Higher sensitivity to the thoughts and feelings of others**
  - **More negative self-affect and uncertainty**
  - **A greater tendency to make social comparisons and be more impacted by those comparisons**
  - **Comparing one's self to those who meet the ideal serves to strengthen the ideal**
  - **Appearance comparison is a strong predictor of body dissatisfaction**



Parenting *through* Eating Disorders

Getting Rid of comparisons

- Refrain from body comments all together- criticisms and compliments
- Challenge to think of ways we are more interesting
- Consider how comparative messages might serve to sell to you, distract you, scare you into compliance
- For the next week can you go without complimenting appearance?

How do these beliefs develop?

- Parents
- Peers
- Media

Parental figures

- How did they speak about their bodies?
- About the bodies of others?
- Your body?
- Can help to consider what their core beliefs are rooted in

Parenting *through* Eating Disorders

Peers

- Adolescents
- Time of increased sensitivity to how they are perceived- may work as a protective factor
- Consider how peers may also have been influenced by family of origin and culture

Parenting *through* Eating Disorders

Media

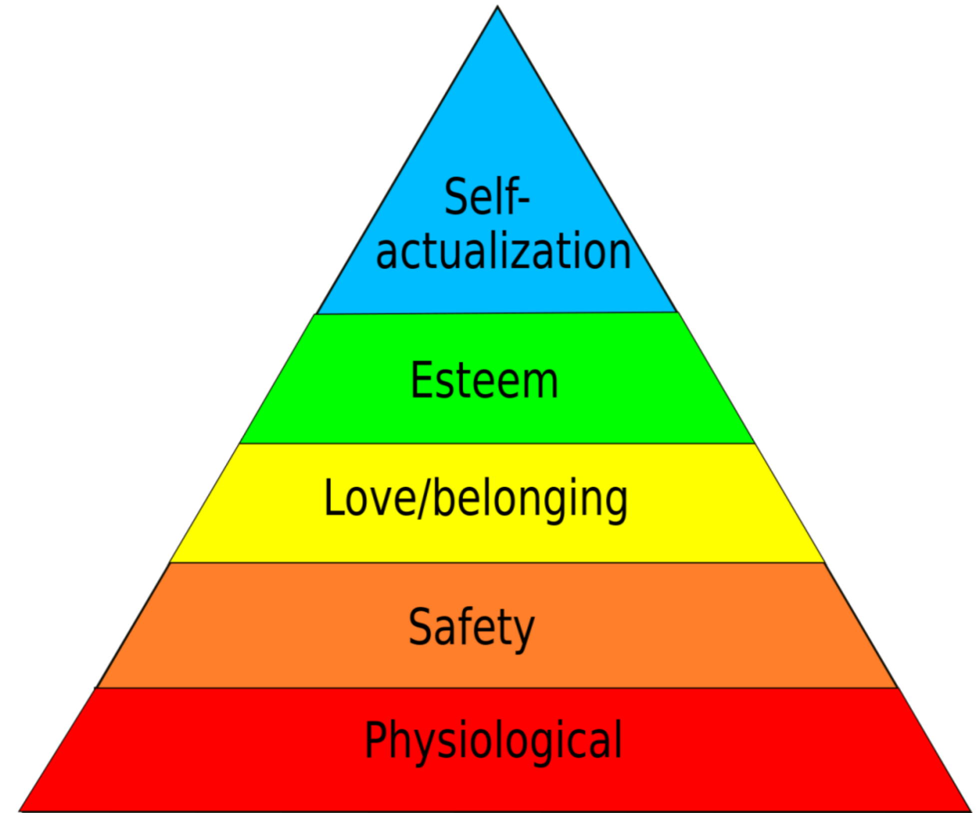
- Evolution of media

Citation:
https://www.timetoast.com/timelines/evolution-of-media-traditional-media-to-new-media

Parenting *through* Eating Disorders

Industrialization - 10 years onset of ED's

- Creating a need- if a product can make you feel insecure and lacking it's likely to sell you
- Creating a goal that most will never reach is good for the economy
- In 1998 adolescents in rural Fiji were introduced to western television.
- This new media exposure resulted in significant preoccupations related to shape and weight, purging behavior to control weight, and negative body image.



Social media impact

- Research
- Greater time on Facebook=
  - increase in body image concerns
  - self-objectification
  - negative mood
  - more thoughts of dieting and exercise
- Women reported more appearance comparison through social media than any other media

Parenting *through* Eating Disorders

Anti-fat bias in the media

- Are there characteristics associated with body types in the media?
- Headless bodies- depersonalization allows us to treat others worse

Beliefs associated with weight:

- Weight can tell you about a person
- People prefer thin people
- Weight is a controllable attribute

Culture Influences who is "Ideal"

- Our culture teaches us what is valuable
- The majority of an ideal is a social construct
- Consider how you came to value what you do- social learning
- Different ideals all over the world
- Often rooted in extremes or things that are difficult to achieve

Extreme ideals

- https://www.youtube.com/watch?v=xKQdwjGiF-s

Body Neutrality mantra

- I’ve been conditioned to think this is the only way beauty/handsome can look.

- The thought and belief is present- but we don’t have to buy it.

Reflection

- How have you been conditioned to believe what was valuable vs. not

How is worthiness, or lack thereof, is conveyed to you?

Challenge yourself to understand-

Mom makeup story

THE TREATMENT OF EATING DISORDERS

Levels of Care:

- Outpatient Treatment Team
- Intensive Outpatient Treatment Team (IOP)
- Partial Hospitalization Program
- Residential Treatment
- Inpatient Hospitalization

As an outpatient provider you need:

AED manual https://connectedchildhealth.files.wordpress.com/2021/10/eating-disorders-guide-to-medical-care.pdf

Know who the ED therapists and dietitians are in your community (OEDA)

Seek supervision

Know who your higher level care providers are

Indicators of Appropriate Fit for Levels of Care

- Residential Treatment appropriate when:

- Patient is less than 75% of ideal body weight
- Labs are abnormal
- Electrolyte imbalance
- Heart rate is below 49 BPM
- Psychiatric instability
- Unwillingness to engage in treatment

Criteria for Hospitalization for Acute Medical Stabilization

PRESENCE OF ONE OR MORE OF THE FOLLOWING:

1. ≤ 75% median BMI for age, sex, and height
2. Hypoglycemia
3. Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia and/or metabolic acidosis or alkalosis)
4. ECG abnormalities (e.g., prolonged QTc > 450, bradycardia, other arrhythmias)
5. Hemodynamic instability — Bradycardia — Hypotension — Hypothermia
6. Orthostasis
7. Acute medical complications of malnutrition (e.g., syncope, seizures, cardiac failure, pancreatitis, etc.)
8. Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (e.g., severe depression, suicidal ideation, obsessive compulsive disorder, type 1 diabetes mellitus)
9. Uncertainty of the diagnosis of an ED

Academy for Eating Disorders: A Guide to Medical Care 2016

Parenting *through*
Eating Disorders

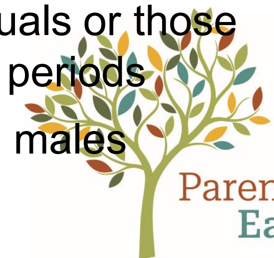
Recommended Medical & Lab Tests for Evaluation

Academy for Eating Disorders: A Guide to Medical Care 2016

- Electrocardiogram
- Bone density test (DEXA scan)
- Urinalysis with specific gravity
- Other tests as indicated:
  - Chest X-ray
  - Urine pregnancy test
  - Ionized calcium
  - Amylase
  - Lipase
  - FSH, LH, prolactin
  - MRI of the brain (where cognitive changes are seen or severe malnutrition)

Blood Work

- Chemistry panel, including electrolytes, glucose, calcium (consider an ionized calcium), liver functions, BUN, creatinine, albumin, total protein
- CBC with differential
- Thyroid function tests
- 25-OH vitamin D
- Magnesium and phosphorus, especially in low weight individuals
- Estradiol in low weight individuals or those who have lost their menstrual periods
- Testosterone in malnourished males



Vital Signs

Vital signs play a critical role in individuals with eating disorders.

- Vitals protocol
- With history provides 80% of info to determine severity of status

Temperature

- Lowered body temp
- Body will lower its core temp in effort to conserve energy and protect the heart

Vital Signs…continued

Pulse

- Bradycardia
  - Often confused with athletic heart syndrome- Heart rate should not be below 50

Blood Pressure

- Orthostatic
  - Orthostatic pulse criteria: an increase of 20 bpm from supine to standing position is significant. If the supine HR is below 50 bpm the an increase of would be helpful to use a percentage rate instead
  - Most often these changes are due to dehydration, but can also indicate symptoms of malnourishment

Weight

- Less emphasis
- Trends and progression
- Highly susceptible to manipulation

Body System Vulnerabilities: Cardiac

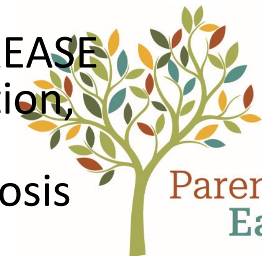
- Starvation, Malnutrition, Purging
  - Cardiac muscle atrophy
  - Pericardial effusion
  - Bradycardia
  - Mitral valve prolapse

- Conditions reversible

Body System Vulnerabilities: Gastrointestinal

- Acute gastric dilation/ perforation
- Superior Mesenteric Artery (SMA) syndrome
- Dysphagia, increased risk of aspiration
- Dental cavities, soreness or loss of teeth
- Sialadenosis (enlarged salivary glands)
- Gastroesophageal Reflux Disease (GERD)
- Foreign bodies (from toothbrushes, etc. swallowed while inducing purging)
- GI bleeding (can be severe, include rupture of the esophagus and stomach)
- Pre-cancer and cancer of the esophagus

- Gastroparesis (delayed emptying of stomach) and general slowed motility of intestine
- Elevated liver function tests
- Chronic constipation
- Intestinal paralysis from stimulant laxative abuse
- Pancreatitis, usually from purging or high lipid levels from binging
- Asthma (from GERD)
- Pseudo Bartter's Syndrome: Purging leads to , this activates the kidneys renin–angiotensin–aldosterone system (regulates blood pressure and fluid balance), resulting in an INCREASE of sodium bicarbonate absorption and a DECREASE in potassium and hydrogen absorption, which further results in hypokalemia and metabolic alkalosis



Parenting *through* Eating Disorders

Body System Vulnerabilities: Endocrine

Starvation, Malnutrition & Purging

- Low Thyroid levels- Euthyroid sick syndrome – should not be treated for hypothyroidism
- Low Testosterone and Estradiol, assess lack of menses
- Breast atrophy

Body System Vulnerabilities: Bone

Starvation, Malnutrition, Purging

- Early onset of Osteopenia, Osteoporosis leads to Increased risk of permanent bone damage
- Suppression of bone marrow (decrease in WBC, RBC and platelets)- increased risk of infection, clotting problems, and anemia
- Increased incidence of fractures

Body System Vulnerabilities: Renal & Hepatic

Starvation, Malnutrition & Purging

- Decreased BP and volume depletion and/or hypokalemia can cause:
  - Chronic kidney stones
  - Renal insufficiency
  - Creatinine levels may increase due to renal insufficiency but those with decreased muscle mass would have low levels. Therefore use caution when interpreting creatinine levels.

Prolonged starvation increases breakdown of muscles and fat cells, increasing the amount sent to liver, leading to elevated AST and ALT with AST>ALT and Non-Alcoholic Fatty Liver Disease (NAFLD)

- Degree of malnutrition increases risk for hypophosphatemia
- **Jennifer L. Gaudiani, MD, CEDS, FAED (8)**
  - Low blood sugar- resulting from rapid weight loss or underweight results in low blood sugar
  - When the liver is depleted it can't build blood sugar. Between meals the blood sugar can fall dangerously low especially overnight leading to asymptomatic stopping of the heart and the brain.

Body System Vulnerabilities:
Risk of Infection, Delayed Healing, Other

Starvation, Malnutrition, Purging

- Sepsis - normal warning signs are blunted (temp, WBC and sedimentation rate decrease) a two to three degree increase in patient temp could indicate infection
- Increased risk for pneumomediastinum and pneumothorax
- Refeeding syndrome
  - The clinical features of refeeding syndrome include edema, cardiac and/or respiratory failure, gastrointestinal problems, profound muscle weakness, delirium and, in extreme cases, death. Refeeding syndrome can occur in patients of any age and weight, and is a potentially fatal condition requiring specialized care on an inpatient unit.

SCOFF QUESTIONNAIRE

1. Do you make yourself sick because you feel uncomfortably full?
2. Do you worry you have lost control over how much you eat?
3. Have you recently lost over 14 pounds in a three-month period?
4. Do you believe yourself to be fat when others say you are too thin?
5. Would you say that food dominates your life?

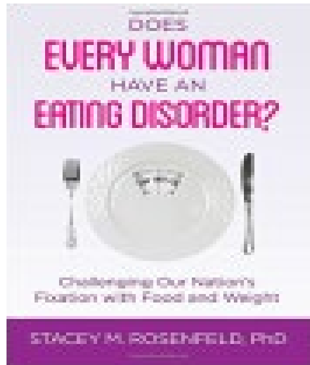
- Easy to score: 1 point for each yes answer
- Score of 2 or more indicates a likely case of anorexia nervosa or bulimia nervosa
- Brief but systematic set of questions for eating disorder behaviors

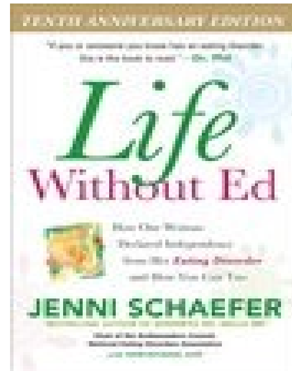
Eating Attitudes Test

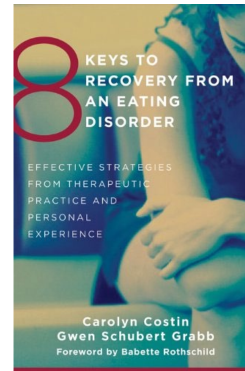
https://www.eat-26.com/eat-26/

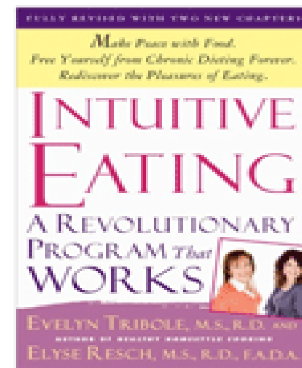
Assesses behaviors and attitudes toward food and body

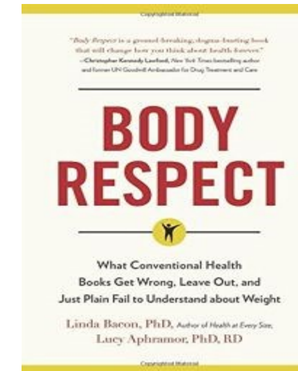
Book Resources

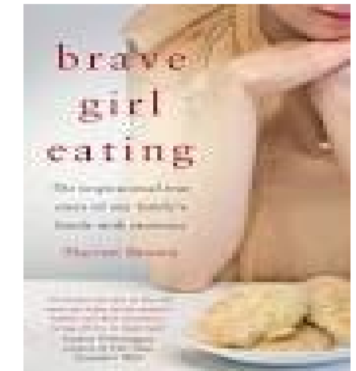


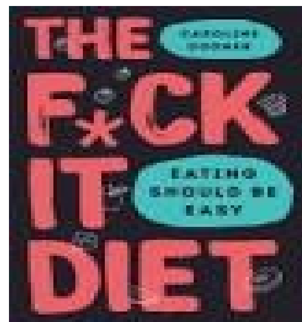


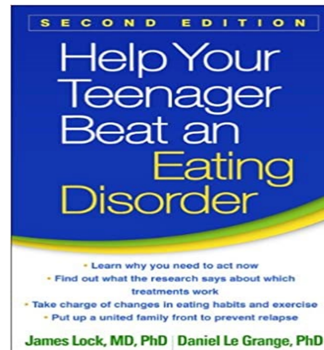












More great books

- *Sick Enough* by Dr. Jennifer Gaudiani
- *The Intuitive Eating Workbook for Teens* - Elyse Resch
- *Fathers and Daughters*-Joe Kelly
- *Health at Every Size* - Linda Bacon
- *Befriending Your Body* - Ann Saffi Biasetti
- Helping Patients Outsmart Overeating – Koenig and O'Mahoney
- Born to Eat – Schilling & Peterson
- Recover Your Perspective – Janean Anderson

Instagram

@asafeplaceinsideyourhead

@selfcareisapriority

@emotions_therapy

@together.heal

@twentysevenlkld

@selfcareisforeveryone

@stacieswift

@millennial.therapist – Sara Kuburic, MA, CCC
@laurajaneillustrations – Laura Jones
@britandco
@bad_fatty
@Chr1styharrison- Christy Harrison, RD/LD
@Dietitiananna- Anna Sweeny, RD/LD, CEDRD
@Guadianiclinic- Dr Guadiani and staff
@fatpositivefertility
@Jennys_fat_and_happy_life

More Resources

Podcasts

- ED Matters
- Food Psych
- Comfort Food
- Fierce Fatty
- She's All Fat
- Peach, Please!
- Fat Girls Club
- Woman of Size

Books

- Does Every Woman Have an Eating Disorder
- Body Respect
- Health at Every Size
- Body of Truth
- Fat?So!
- Things No One Will Tell Fat Girls
- Fat and Fertile
- Fat Girls in Black Bodies
- What We Don't Talk About When We Talk About Fat
- Happy Fat
- Fattily Ever After
- Train Happy

Learn more

International Association of Eating Disorder Professionals

- iaedp- CEDS

Oklahoma Eating Disorder Association

- OEDA - www.okeatingdisorders.org
    - Conversations of Hope, Sept 29th
    - Fall Symposium, Nov 4th

RESOURCES

- National Eating Disorders Association (NEDA)
  - https://www.eatingdisorderhope.com
- The Alliance for Eating Disorders Awareness
  - https://www.allianceforeatingdisorders.com
- Eating Disorder Hope: Parent Support Groups
  - https://www.eatingdisorderhope.com/blog/parent-support-groups-what-resources-are-available-for-parents-of-individuals-struggling-with-anorexia

Parenting Through Eating Disorders

Coaching program for parents with children with diagnosed or suspected eating disorders

15+ psychoeducation modules

2 weekly group coaching sessions- milieu based for mastery

daily check ins with a highly trained eating disorder expert coach

12 weeks to allow for skill attainment with trial and error and support through it

Support providers work with patients

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- Burnout
- Parenting
- Anxiety
- Eating Disorders
- Binge Eating
- Intuitive Eating
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- Grief

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Eating Disorders

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