



Family Resources

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Understanding Eating Disorders

Learn more about the impact of eating disorders
and their different presentations.

Facts about eating disorders

- Eating disorders affect at least 9% of the population, meaning 28.8 million Americans will have an eating disorder in their lifetime.²
- Less than 6% of people with eating disorders are medically diagnosed as “underweight.” Eating disorders exist in bodies of all sizes.
- Eating disorders have the highest mortality rate of all mental illnesses, with 10,200 deaths each year being the direct result of an eating disorder.
- About 26% of people with eating disorders attempt suicide.
- 30% of people dealing with eating disorders have experienced sexual abuse.
- The economic cost of eating disorders is \$64.7 billion every year.
- 35-57% of adolescent girls engage in crash dieting, fasting, self-induced vomiting, diet pills, or laxatives.
- In a college campus survey, 91% of the women admitted to controlling their weight through dieting.
- Athletes are more likely to screen positive for an eating disorder than non-athletes, though they may be less likely to seek treatment due to stigma, accessibility, and sport-specific barriers.
- People in larger bodies are half as likely as those at a “normal weight” or “underweight” to be diagnosed with an eating disorder.
- Nearly nine in ten (87%) LGBTQ youth reported being dissatisfied with their body.
- BIPOC are significantly less likely than white people to have been asked by a doctor about eating disorder symptoms.
- BIPOC with eating disorders are half as likely to be diagnosed or to receive treatment.

[Adapted from ANAD: Eating Disorder Statistics](#)



Presentations of eating disorders

Anorexia Nervosa

For Anorexia Nervosa to be diagnosed, the DSM-5 specifies that the individual must engage in persistent energy intake restriction, have an intense fear of gaining weight or becoming fat, or be engaging in a persistent behavior that interferes with weight gain, and the individual has a disturbance in their own perception of their body weight or shape.

Bulimia Nervosa

Bulimia Nervosa is characterized by three essential features: “recurrent episodes of binge eating, recurrent inappropriate compensatory behaviors to prevent weight gain, and self-evaluation that is unduly influenced by body shape and weight.”

An individual must engage in these behaviors at least once per week for three months to meet the criteria for diagnosis.

Referring to the first feature, a binge is characterized by an individual “eating, in a discrete period of time, an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances” and that the individuals feel “a sense of lack of control overeating during the episode.”

Binge Eating Disorder (BED)

Binge Eating Disorder, commonly referred to as BED is the most common eating disorder diagnosis among all others. The DSM-5 specifies that BED involves binge eating episodes defined as mentioned above in the Bulimia Nervosa diagnosis.

BED differs from Bulimia Nervosa in that BED involves no recurrent use of inappropriate behaviors to compensate for binge episodes and does not occur exclusively during anorexia or bulimia episodes.



BED also does not include an individual's perception of body shape and weight in diagnostic criteria.

Other Specified Feeding or Eating Disorder (OSFED)

This category is intended for cases wherein symptoms of a feeding or eating disorder are present and cause clinically significant distress or impairment but do not meet the full criteria for the above-specified disorders.

OSFED Disorders include:

- Atypical Anorexia Nervosa: An individual meeting all criteria for anorexia are met except the individual's weight is within or above the normal range.
- Bulimia Nervosa (of low frequency and/or limited duration: As the individual meets, all criteria for bulimia except binge eating and compensatory behaviors occur less than once a week and/or for less than three months.
- Binge Eating Disorder (of low frequency and/or limited duration): An individual meets all criteria for BED except binge eating episodes occur less than once/week and/or for less than three months.
- Purging Disorder: An individual engages in regular purging behavior to influence body weight or shape but does not engage in binge eating behaviors.

Eating Disorder Symptoms

Eating disorders manifest in varying ways as they are complicated disorders that impact psychological, physical, and sociological health. Determining whether someone is struggling with an eating disorder is not an exact science due to the many manifestations of these disorders, but there are some symptoms that can present as warning signs.

Emotional & Behavioral ED Symptoms

Our physical bodies, psychological, functioning, cognitive wellness, and choices and behaviors are all deeply intertwined and impactful of one another. Below are a few emotional and behavioral symptoms that may indicate an individual is struggling with eating disorder beliefs or behaviors.



- Beliefs/patterns/choices that indicate a focus on weight loss, dieting, food rules, or eating patterns.
- Extreme mood swings.
- Difficulty
- Checking in the mirror often.
- Withdrawing from others, decreased socializing, especially when food is involved.
- Presenting as hyper-focused on weight, food, calories, nutritional content of food.
- Eating alone or hiding food.
- Skipping meals.
- Intense fear of gaining weight.
- Distorted body image.
- Tangential thought process and difficulty concentrating.

Physical Warning Signs of an Eating Disorder

A starved brain and body cannot function optimally. Therefore, an individual struggling with an eating disorder will present with at least some, if not all, of the physical signs of an eating disorder below:

- Weight fluctuations (both up and down) that occur rapidly.
- Severe constipation.
- Low blood pressure
- Slowed breathing and pulse.
- Lethargy, sluggishness, or consistent reports of feeling tired.
- Brittle hair and nails.
- Dry, yellowish skin.
- Loss of menstrual cycle (amenorrhea).
- Growth of soft hair all over body (lanugo).
- Stomach/gastrointestinal issues.
- Dizziness/fainting/lightheadedness.
- Muscle weakness.
- Impaired immune system functioning.



Risk Factors for Eating Disorders

It is unsurprising with all the physical, emotional, and behavioral symptoms of eating disorders above that the long-term consequences can be severe. The malnourishment that results from disordered eating impacts all organ systems in the body including the brain as well as the cardiovascular, endocrine, and gastrointestinal systems.

Due to malnourishment, the body breaks down its own tissues, including the heart, which leads to a lack of energy to pump blood through the body, lowering pulse and blood pressure and increasing the risk of heart failure. The electrolyte imbalance caused by vomiting or laxative use or excessive water intake can also increase the risk of heart failure.

Lack of fat and cholesterol through disordered eating impacts functions of the endocrine system, such as the production of sex and thyroid hormones. For this reason, individuals may experience loss of or irregularities in the menstrual cycle. This also impacts bone density, metabolic rate, and issues regulating core body temperature (which can result in hypothermia).

It is difficult for the brain to function when it is not receiving proper and consistent nourishment. This leads to difficulty concentrating, sleeping, or staying asleep, sleep apnea, and dizziness or fainting. The electrolytes mentioned above are also used to create signals in the brain, meaning malnourishment disrupts the ability of the brain to communicate effectively to the body.

Finally, gastrointestinally, eating disorders impact stomach emptying and absorption of nutrients which can lead to severe stomach issues. Consistent vomiting can wear down the esophagus causing it to rupture, which is life-threatening. Binge eating can also cause a life-threatening emergency in that it can lead to a stomach rupture. Essentially, all of the organs and gastrointestinal functions are severely disturbed in eating disorder behaviors and can result in many life-threatening illnesses and issues.

Cited from Eating Disorder Hope





Treatment Modalities

Information that can promote a better understanding of mental and emotional processes in the healing journey.

Evidence based treatments

Cognitive Behavioral Therapy – Enhanced (CBT-E)

Enhanced Cognitive Behavioral Therapy is a very personalized form of transdiagnostic psychotherapy. Since the symptoms of eating disorders tend to overlap, this method can be used to treat virtually any eating disorder. CBT-E aims to identify the processes maintaining an individual's eating disorder (i.e.: body image issues, the need to be “in control”, perfectionism, etc.). Every individual will have their own unique set of processes fueling their eating disorder. By identifying these processes, patients learn to recognize disordered thinking and can work to normalize their eating behaviors. CBT-E treatment generally has four stages spanning over a set length of time.

1. Stage one: Starting Well. Treatment planning and building therapeutic alliance
2. Stage Two: Treatment evaluation and progress
3. Stage Three: ongoing assessments of body image concerns, eating disordered patterns and behaviors, meal planning, events and emotion regulation
4. Stage four: Ending well: relapse prevention planning, continuation of care

Dialectical Behavior Therapy (DBT)

DBT is a type of cognitive behavioral therapy originally developed to treat borderline personality disorder. It is now used to treat other mental health issues including anorexia, bulimia, and binge eating disorder. ‘Dialectical’ refers to the integration of opposites; the balance between acceptance and change. DBT helps patients develop new skills and strategies to reduce anxiety, regulate emotions, build self-esteem, control disordered eating behaviors and ultimately allows the individual to become more self-sufficient.

DBT helps individuals connect with their authentic selves through four modules:

1. Mindfulness
2. Interpersonal Effectiveness
3. Distress Tolerance
4. Emotion Regulation



Acceptance and Commitment Therapy (ACT)

ACT looks at how the human brain works in producing our thoughts. When we understand the basic functions and processes of our brain we can begin to understand our reactions. In eating disorder treatment, ACT teaches mindfulness skills to help patients change their actions, rather than their thoughts and feelings. By identifying core values and shaping goals that work to fulfill those values, patients learn to remain connected to the present and ultimately their authentic selves. It teaches individuals how to deal with their emotions, both good and bad and take positive action.

A – Accept your thoughts and feelings, be present

C – Choose a valued direction

T – Take action

The Six Core Processes of ACT

1. Being Present
2. Diffusion
3. Acceptance
4. Self-as-context (pure awareness)
5. Values
6. Committed Action

Source: EDCare



Radically Open Dialectical Behavior Therapy

While traditional DBT has proven to be a beneficial form of therapy for individuals with eating disorders, a new type of DBT treatment has emerged that may prove even more effective at treating adolescents with ED. Radically Open Dialectical Behavior Therapy (RO-DBT) is specifically designed to target overcontrol (OC) disorders like anorexia nervosa, obsessive-compulsive disorder (OCD), and chronic depression.

Some mental illnesses are characterized by excessive amounts of self-control or overcontrol (OC). Individuals with overcontrol tend to be perfectionistic, disciplined, conscientious, cautious, inflexible, restrained, and detail focused.

While these characteristics of self-control are not inherently bad or harmful, experts say they may be masking emotional pain and stressors. And when self-control is used as a coping style, it can become excessive and harmful, leading to social isolation, poor relationship skills, and even severe mental health difficulties like anorexia, OCD, and depression.

Openness: Learn to take new risks and accept critical feedback.

Overcontrolled behaviors can create an unfulfilling life. You may be naturally suspicious and miss the benefits of trying novel behaviors. Biologically based skills help you stay calm when trying new things. Similarly, RO DBT skills can help you accept unexpected feedback that would usually upset you.

Flexibility: Learn to free yourself from perfectionism and rigidity.

Staying rigid is impractical in a world that is ever-changing. RO DBT teaches skills that help you downregulate your hyperactive safety system, allowing you to adapt more readily to a changing environment. Mindfulness skills and cultivating healthy self-doubt help you stay in a flexible mindset.

Social Connectedness: Learn to successfully connect with others.

Overcontrolled individuals often feel uncomfortable and incapable of facilitating intimacy. RO DBT uses the science of social signaling to enhance your ability to connect with others. Additionally, skills help you cope with social shame, bitterness, and envy. By cultivating and skillfully applying vulnerability to your social interactions, you can improve your connections with others.





Psychoeducation

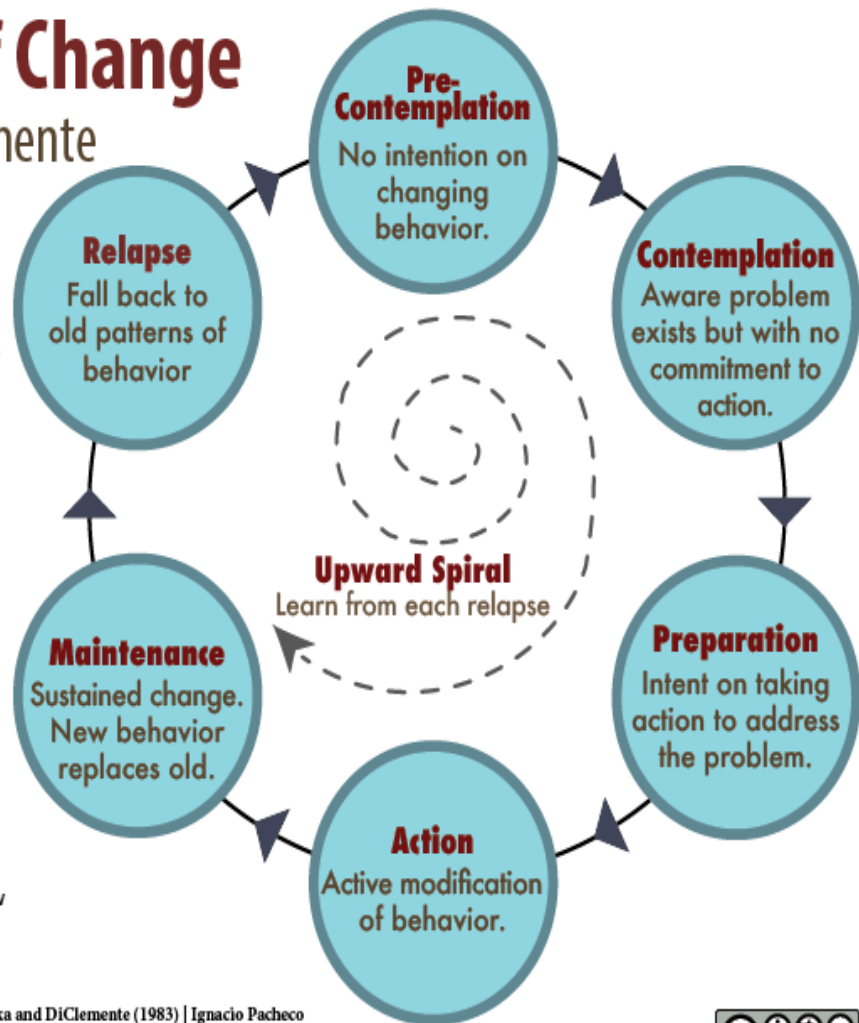
Information that can promote a better understanding of mental and emotional processes in the healing journey.

Stages of Change

This model shows the stages we go through when trying to change our behavior.
 Behavior modification occurs when tackling maladaptive coping or unwanted behaviors.

The Cycle of Change Prochaska & DiClemente

- **Precontemplation:** A logical starting point for the model, where there is no intention of changing behavior; the person may be unaware that a problem exists
- **Contemplation:** The person becomes aware that there is a problem, but has made no commitment to change
- **Preparation:** The person is intent on taking action to correct the problem; usually requires buy-in from the client (i.e. the client is convinced that the change is good) and increased self-efficacy (i.e. the client believes s/he can make change)
- **Action:** The person is in active modification of behavior
- **Maintenance:** Sustained change occurs and new behavior(s) replaces old ones. Per this model, this stage is also transitional
- **Relapse:** The person falls back into old patterns of behavior
- **Upward Spiral:** Each time a person goes through the cycle, they learn from each relapse and (hopefully) grow stronger so that relapse is shorter or less devastating.



The Cycle of Change
 Adapted from a work by Prochaska and DiClemente (1983) | Ignacio Pacheco
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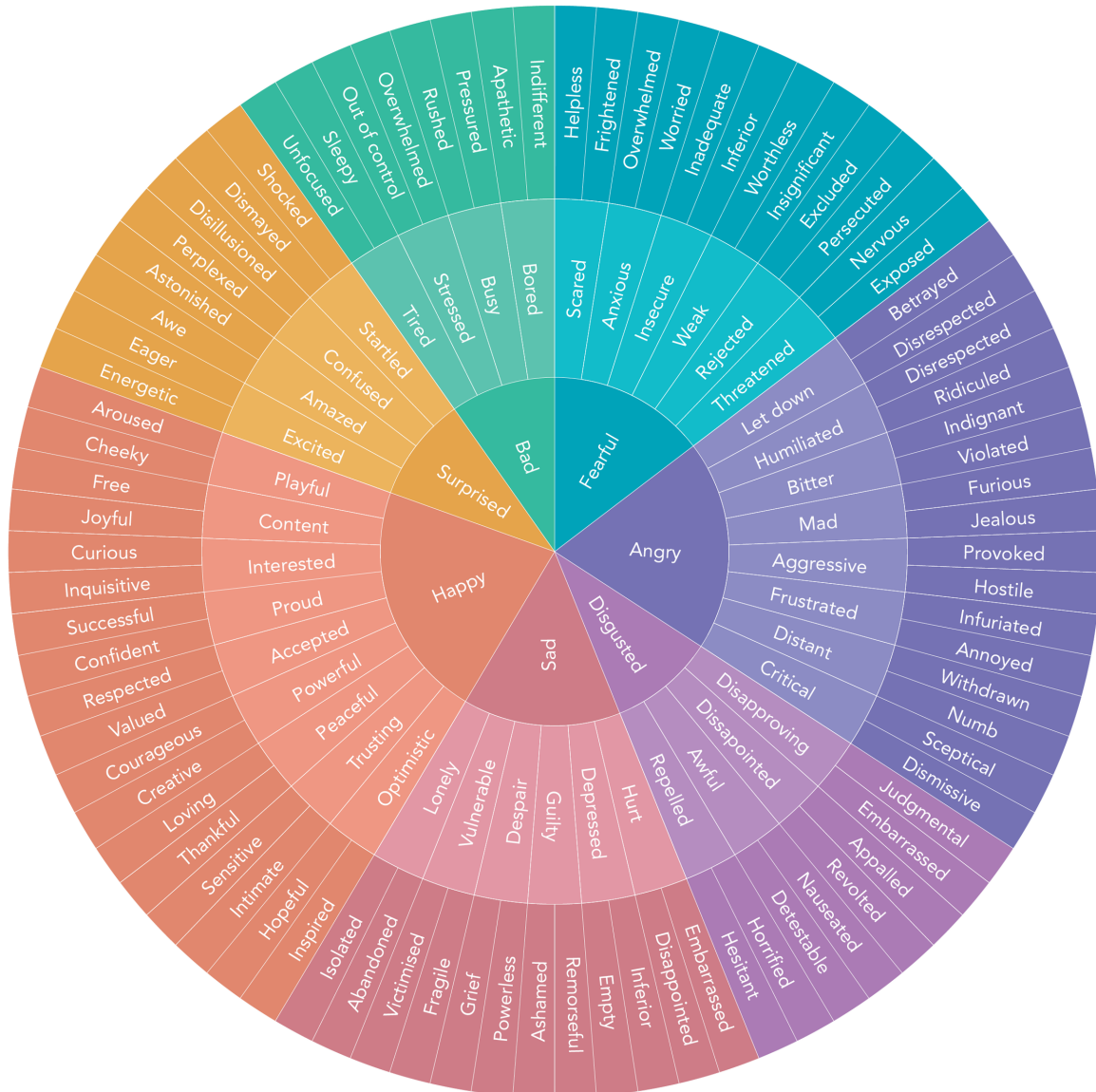


Source: [Emily Program family resource deep dive into stages of change for ED + supports](#)



Feelings Wheel

A helpful tool for identifying feelings as a part of emotion regulation skill work.



Source: [Calm blog](https://www.calm.com)





Support Strategies

Ways to communicate with and support your loved one on their recovery journey.

Communication Tips

Areas to focus on:

1. Health – physical and mental:
 - a. "Food is your medicine."
 - b. "Your health is non-negotiable."
 - c. "Your attention/concentration seems better today."
 - d. Convey the seriousness of this illness to the patient and family.
 - e. Ask about any improvement in mood, sleep, or energy.
2. Nutritional stabilization and weight gain:
 - a. "Eating is simple, but not easy."
 - b. "I'm proud of you for making progress on your goals."
 - c. Provide encouragement to follow their meal plan
3. Engage in conversation unrelated to weight, shape, appearance, food
 - a. Discuss Activities they enjoy
 - b. Favorite books/shows/classes
 - c. Family vacations

Avoid:

1. Negotiating with the eating disorder:
 - a. It's natural to want to make adjustments to help your child feel more comfortable in the moment, but when in doubt, consult your team!
2. Focusing on body shape/size:
 - a. "You look good / healthy."
 - b. "You're gaining weight really well."
 - c. "You look like you're normal (healthy) weight. I wouldn't have even known you were engaging in behaviors!"
3. Drawing attention to amount or type of food they are eating (unless very concerning):
 - a. Make comment about food on their plates
 - b. "You should just eat a cheeseburger!"
4. Discussing your own weight, eating habits, diets, or exercise routines
5. Minimizing how difficult it is to eat.
 - a. "Just eat, what's the big deal?"
 - b. "I wish I could just eat less/more like you!"



DO realize there is not a quick and easy solution.	DON'T ever give up; this is a long-term illness and people recover daily. Know to let go and let your loved one be responsible.
DO talk to your loved one about your concerns, ask questions and listen.	DON'T ignore the problem and hope it will go away; talk about it. Set boundaries about when to intervene.
DO express your feelings honestly with your loved one; he or she sense how you are feeling anyway.	DON'T skip meals or talk about being on a diet.
DO genuinely let your loved one know qualities/characteristics (other than physical) you appreciate about him or her.	DON'T discuss financial cost; this could make your loved one feel like a burden.
DO plan social activities that do not involve food.	DON'T panic; seek the appropriate support you need.
DO empower the individual to make their own decisions and be accountable for their decisions.	DON'T assume there isn't a problem if your loved one doesn't show physical symptoms.
DO allow your loved one to be in charge of his or her routines of daily life, realizing that by giving up your control you're setting the	DON'T force the person to eat or tell him or her to "just eat," but be there to support him or her emotionally.



stage for your loved one to develop healthy self-control.	
DO encourage your loved one to get a professional assessment from a practitioner experienced in eating disorders.	DON'T make your love a condition of your loved one's appearance, health, weight, achievements or any other attribute.
DO realize your loved one is ambivalent about getting well.	DON'T comment positively or negatively on appearance or weight.
DO realize your loved one takes comfort and feels safe in the control and rituals of the disorder without commenting on it.	DON'T feel you must walk on eggshells so the person with the eating disorder won't be upset.
DO express concern and interest in seeing the person get well.	DON'T let the eating disorder disrupt family routines.
DO inform yourself about the disorder and its treatment, attend support groups and read current literature.	DON'T be manipulative. Be direct with feelings and expectations.
DO realize eating disorders are hardly ever just about food.	DON'T try to control the person's behavior, as it can intensify the problem.



DO realize that lying is a result of shame and a part of the eating disorder; your loved one may deeply regret not being honest.	DON'T talk about what he or she is eating without their permission
DO express gratitude for each other.	DON'T impose rules except those that are necessary for the individual's or family's safety and well-being. Avoid power struggles.
DO model normal eating behavior.	DON'T blame yourself, feel guilty or dwell on causes.
DO realize that during and after mealtimes can be especially stressful; it can help to discuss what went well and what was challenging.	DON'T tell someone with anorexia who has gained weight he or she looks better.
DO take care of yourself. You need rest and rejuvenation.	DON'T expect yourself to be a perfect parent, partner, family member or friend.
DO separate your loved one's eating disorder from your loved one.	DON'T treat your loved one differently when eating meals and around food.

Source: [Eating Recovery Center](#)



Family Relapse Prevention Plan

- What tells me my loved one is well?
- What are warning signs my loved one is struggling?
- In what ways can I support or intervene when they are struggling?
- Who can we reach out to for support for my loved one?
- Who can I depend on for support for myself?



- How do I take care of myself so I can better take care of my loved one?
- What can I do for strength when I am feeling hopelessness or burnout?
- What changes can we make in the home to promote and support recovery?
- What are my loved one's strengths or values that will serve them in their recovery?
- What are my strengths or values that will help me in supporting my loved one's recovery?



Frequently Asked Questions

- **How do I talk to my child about their behaviors?**
 - While we encourage being mindful of how we communicate, we don't want to fall into the trap of avoiding difficult conversations entirely. Bringing objective observations with curiosity to your child can help shine light on where the ED is trying to hide and help begin to reduce shame by addressing concerns lovingly. Let them know what you are observing without judgment, and ask open questions (what, when, why, how). Reassure them you are there to support them, and if you are unsure how in any moment, that you will help them find the support they need. Family sessions can be a great way to get feedback and work through communication with your child about their illness and behaviors.
- **What can the treatment team disclose to me about my child's treatment?**
 - The family is a key part of a child's recovery, and the child will benefit from family involvement in treatment. That being



said, in therapy, your child has privacy rights. When reviewing HIPAA at the start of treatment, a point discussed is that disclosure will take place if there is intended harm to the client or someone else. The ED itself is harmful and the team will determine how to maintain child's trust while including parents in important information about their child's wellbeing. We encourage you to talk to your child's clinician about how to collaborate on your child's care.

- **What causes an eating disorder?**

- There is no one cause for an eating disorder. We can understand many biological, personality, and environmental factors that contribute to the onset of an eating disorder, which your child will be encouraged to do in treatment. We want to build understanding and reduce shame around experiences and self in order to learn more about their needs and find new, sustainable ways of coping.

- **Will my child always struggle with food?**

- They don't have to. While everyone's recovery journey looks different, a commonality they share is that they are not linear. In treatment your child will be working on their relationship



with food and body, and like any relationship, it can change, develop, encounter new challenges, and grow with you.

- **Is full recovery possible?**

- Yes, full recovery is possible! That's not to say there will never be self-doubt or hard days, but with commitment and willingness you can remain in recovery and live a full, vibrant life with a healed relationship with food and body.

