Eating Disorder Diagnostics for Mental Health Professionals

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Young, white, rich, and female?

Myth #1

Myth#1: White, young, female, rich

- Ages 12-25 are high risk, there’s been a surge of middle-age onset or pregnancy onset (later life ED’s)
- Most diagnosed are female, it is estimated that 1/3 of ED’s are male
- Common in LGBTQ community
- ED’s occur across demographies, including every religious group, SES, age group, and race.
Only skinny people have “serious” eating disorders.

Myth #2

Myth #2 “thin enough”

- 80% of serious eating disorders are normative or above normative weight
- Atypical anorexia
- Psychological consequences
- Higher rates of SI

Eating disorders are a lifestyle choice/about vanity.

Myth #3
Myth #3

- Eating disorders are created/caused by multiple factors
- Some eating disorders have no body image dysmorphia or disturbances
- Most eating disorders are co-morbid with severe mental health issues (the one’s you’ll see present for therapy); MDD, GAD, OCD, self-harm, and suicidality, etc.
- They are not a choice. And even if they were, imagine what context must be present for one to “choose” to go through the pain/against biology and have disordered eating.

What other myths are there about eating disorders?

(What are your thoughts?)

Eating Disorder Diagnostics

How do we diagnose?
Important Considerations

- Changes and improvements from DSM IV to V
- The changing face of eating disorders / culture
- “Rule in” vs. “rule out”

DSM IV to V

- “Significant weight loss” vs. less than 85% of healthy weight. (Atypical anorexia nervosa)
- Reducing the required frequency of binge episodes from two to one episode per week for 3 months
- Binge eating disorder is no longer provisional and is an accepted subgroup
- ARFID was introduced
- Less EDNOS diagnosis (switched to OSFED)

Changing face of eating disorders

- Muscular dysmorphic, changing body ideals
- Eating disorders as a spectrum
- Drugs misused change over time (not just laxatives, diuretics)
- Transgender / LGBTQ+ connections to eating disordered behaviors/body dysmorphia
- Dia-bulimia
- Most overlooked populations include men, older women, minorities, and the mentally challenged (desire for thinness can grow in the mildly disabled, ASD, etc.)
Rule in vs. rule out

- Avoid first ruling out all possible psychiatric or medical causes of symptoms
- Delaying diagnosis can increase severity, cause iatrogenic morbidity (or illness caused by medications used to treat eating behavior related medical issues vs. stemming from a more biological cause)
- A thorough ED assessment, psychiatric history and mental status examination will help with understanding psychological features related to the medical presentation (don’t overly rely on self-report when possible)

Major Diagnosis

- Anorexia Nervosa (Purging or Restrictive Type, and Atypical (not in DSM 5))
- Bulimia Nervosa (including Diabulimia, Exercise Bulimia)
- ARFID
- Binge Eating Disorder
- Night Eating Syndrome
- DSFED

Anorexia Nervosa (AN)

- Substantial and medically significant voluntary weight loss by dieting, overexercising, laxative/diuretic abuse.
- Duration of at least 3 months
- Intense fear of fatness — relentless drive for thinness (without breaks)
- An overevaluation of the benefits of thinness/shape change for self-esteem
- Frequently body image distortion, denial of low weight
- Signs of medical starvation: abnormal hormone functioning, loss of muscle mass, amenorrhea and loss of sex drive frequent, but not required
- Subtypes: (1) AN-R: Classic food restriction; no binge-purge; may include overexercising and (2) AN-BP: significant weight loss plus recurrent BP behaviors with compensation
Bulimia Nervosa (BN)

- Binge eating at least once a week for at least 3 months. Binges = rapid amounts of food eaten in a less than 2 hour time frame, perception of loss of control
- Regret, guilt, or shame after binges – medical discomfort, fear of becoming fat
- Inappropriate compensation for perceived overeating by purging. Forms of purging include vomiting, misuse of laxatives or diuretics, compulsive exercise, increased fasting
- Shared overevaluation of benefits of thinness for self-esteem and mood regulation
- (1) Purging subtype 80% or (2) Other compensation - i.e. fasting, excessive exercise 20%
- Not weight associated

Binge-eating Disorder (BED)

- Binge Eating at least once a week for 3 months or longer.
- Binge eating expanded definition to huge caloric intake in less than 2 hours time period to subjectively smaller amounts or constant grazing that leads to medical discomfort, stomach pain, or significant psychological distress.
- No compensatory behaviors to “undo” binging behaviors.
- Sidenote: Patients are often older (30-40s), frequently medically obese (but not weight based), equally prevalent in males/females

Avoidant/Restrictive Food Intake Disorder

- A disturbance in feeding behaviors (often in children or infants) not otherwise explained by lack of food, cultural norms, or a diagnosed psychiatric or medical disorder that would better explain the weight loss or lack of appropriate weight gain.
- Not associated with a distorted body image or drive for thinness
- May manifest as a lack of interest in food or an abnormal rejection of food due to it’s sensory properties
- Sidenote: PEAS (Picky Eating Adult Support) consideration
- *If it brings psychological distress, medical concerns, or increases isolation*
Other Specified Feeding & Eating Disorders (Catch-all)

- Atypical anorexia (1) Weight above or within "normal range," (2) Subclinical anorexia (about 8% of failures to conceive in women may be due to being 4.5-6.5 pounds below the weight of normal gonadotropic functioning).
- Bulimia Nervosa Syndrome; less frequent, exam times or after drinking bouts
- Purging Disorder
- Diabulimia, manipulation or deficient insulin use to "dump" glucose / lose weight
- Night Eating Syndrome: repeated episodes of overeating at night after awakening from sleep, variable remembrance/skewness not otherwise explained by medical/psychiatric disorder or medication.
- Orthorexia: over-rigidity and restriction with "healthy eating" causing disturbances with work, relationships, increased occupation with controlling food, and social flexibility

Common co-morbidities

- Mood disorders: (40-70%) depression, bipolar type II, dysthymia (persistent depressive disorder)
- Anxiety disorders
- Obsessive compulsive behaviors or issues of "under-control" or "over-control"
- Alcohol and/or other substance abuse (esp. amphetamines)
- Personality disorders or vulnerable traits (trauma-reference)
- Traits in AN: sensitive, perfectionistic, persevering, self-critical
- Traits in BN: impulsivity, unstable moods, dramatic behaviors, emot. intensity
- Traits in BED: high harm avoidance, low self directedness, difficulties with ER, low self-esteem

Differential Diagnosis

- Depression or anxiety related weight loss/lack of eating, grieving weight loss
- Sensory issues present in ASD
- Behavioral sensitization: previous choking episode
- Paranoid delusions: fear of poisoning in food
- Medical concerns not coinciding with psychological features or non-compliance with treatment to regain weight (Gastritis, food intolerances, medical issues related to digestion, Cancer, etc.)
- Insulin dependent Diabetes Mellitus
- Cystic Fibrosis
Development of Eating Disorders

- Begin as strategies to deal with problems in psychosocial functioning, emotion regulation/suppression, or goals in living
- "Ego syntonic" when AN is not considered to be a source of suffering, and in fact can feel "powerful" or anxiety relieving vs. "Ego-dystonic" nature of BN which can feel distressing, out of control, or shameful.
- The "CAKE"

The "Cake"

- Genetics
- Family of origin issues and intergenerational transmission of maladaptive coping, ways of being, trauma, personality dimensions, and mental health concerns (Unhealthy relationship dynamics)
- Issues of over or under control (and lack of regulation or over-regulation)
- Culture, social media, and friends
- Low self worth/self-esteem
- Trauma
- Perfectionism and shame with complex emotions
Assessment & “Honest Lies”

How do we assess for ED’s? What if our clients tell “honest lies”?

SCOFF Assessment & EAT-26

The 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 3-month period?
4. Do you believe yourself to be FAT when others say you are thin?
5. Would you say that FOOD dominates your life?

Count 1 point for every yes. A score of 2+ indicates a likely case of an ED and need for further assessment.

*I add in the question, do you ever misuse diuretics, laxatives, insulin or make yourself vomit?*

How this “shows” up in therapy

– Usually people will not present to therapy for their eating disorder behaviors (often they present for anxiety, stress management, relational problems, suicidality, depression, OCD, or underplay eating issues)
– “honest lies” and the necessity of labs
– Better to gather more information so you can provide it for treatment facilities and higher levels of care if needed and get coverage by insurance companies
– Logistics of brain issues presenting in therapy as depression, brain fog, not remembering sessions.
– Watch for undiagnosed “auto-immune” issues or rationalization of diets
Clues to Uncovering EDs

How do we catch honest lies?

Clues for hidden AN

- Unexplained weight loss, failure to gain weight in teens
- Secondary loss of period
- Membership in weight-focused groups: ballet, wrestling, modeling, gymnastics, cross country, etc.
- Preoccupation with need for additional weight loss/shape change despite obvious thinness or masculinity
- Frequent mirror gazing
- Frequent food or weight loss talk - negative comparison of self to thinner peers
- Feeling cold, lanugo, unexplained hair loss

Clues for a “vulnerable” temperament

- Being highly detail-oriented
- Having trouble letting go of mistakes
- Avoiding risks
- Not liking new things or experiences
- Having a high sensitivity to feeling threatened
- Not easily impressed by rewards or compliments
- Planning everything
Clues for hidden BN

- Unexplained low potassium
- Family report of patient vomiting, finding boxes of laxatives/diuretics, patient frequently takes showers after meals/goes to bathroom
- Swollen or tender parotid glands
- Loss of dental enamel on lingual surface, large number of cavities
- Gastro reflux, esophageal erosions in young persons
- Yo-yo weight patterns
- Unexplained loss of large amounts of food, money spent on food, driving around to get food, going to different shops/grocery stores

Clues for hidden BED

- Continued unexplained steady weight gain or sudden rapid weight gain
- Shame or guilt in discussing eating patterns
- Targeting different shops, stores, restaurants
- Hopelessness/helplessness about weight
- Potentially obesity
A Team Approach

Who is part of the ED team?

- Dietitian
- Medical Doctor
- Psychiatric Med Provider
- School system or work system
- Family system
- Occupational Therapist

Higher Levels of Care

What are the higher levels of care for EDs?
Higher Levels of Care

- General outpatient with a team
- Level 1
- IOP (Intensive Outpatient Programs)
- PHP (Partial Hospitalization Programs)
- Residential (over-night without acute medical access)
- Inpatient (over-night with some medical access 24/7)
- Acute Hospitalization (hospital-like with acute care access 24/7)

Determining Higher Levels of Care

- Assess for eating disorder behavior frequency and impact on lifestyle factors
- Medical necessity and labs (how is their brain & body functioning?)
- Suicidality and self-harm
- Lack of hope, perspective, or treatment resistance
- Non-compliance to treatment or meal plans
- Truancy from work, school, normal activities to engage in ED behaviors

Key Indicators for Inpatient Hospitalization

- Below 85% of expected body weight or BMI below 18.0.
- Severe resistance to and/or low motivation for change.
- Long duration of eating disorder.
- Purging multiple times daily.
- Lack of access to outpatient treatment.
- Low familial and social support for change.
- Amenorrhea.
- Acute or multiple comorbid psychiatric disorders.
Key Indicators for Inpatient Hospitalization (Ct’d)

- Concurrent alcohol or substance abuse.
- Strong risk or intent for suicide.
- Serious concurrent medical problems.
- Electrolyte imbalance.
- Abnormal vital signs such as pulse, blood pressure, or body temperature.
- Rapid rate of weight loss.

Assessment Tools

- EAT-26, SCOFF
- Medical Examination/Schema
- Mental Health Assessment
- Nutrition Assessment
- Medical Labs

Eating Disorder Behaviors as “adaptive”

And the trauma connection
ED – Trauma Connection, Trauma Defined

“Trauma is (ALSO) what happens inside of us as a result of traumatic events. It is a loss of connection to oneself and to the present moment.” - Dr. Gabor Mate

“Trauma is about the body becoming immobilized, feeling helpless or numb. Often traumatized people either don’t feel their body at all, or they feel it all the time.” - Dr. Bessel Van Der Kolk

“Trauma is a term often used to mean overwhelming experience, however, I’d also include neglect as a trauma to the developing brain.” - Dr. Dan Siegel

Some of the adaptive functions:

- The body as protection
- Returning to childhood/fear of growing up
- Control/mastery over the body “issues of over-control”
- A sense of identity & rules
- Restriction as penance or “cleansing” (sometimes religious shame ties)
- Feeling of empowerment, “this is where I get my power”
- Safe way to rebel; “My eating disorder is mine”
- Avoidance of intimacy/relationships or re-traumatization

Major issues to address

- The body as being “safe” internally/externally, trusting the body (the body is on your side)
- Shame – working towards shame resilience & healthy expectations/goals
- Reconnecting with the self, trusting it
- Reconnecting with others, building trust in healthy relationships and the world “the world as working towards my good”
- Finding sense of power in other things (re-framing the body/beauty as power being anti your values/inner self)
CBT for Eating Disorders

- Identifying and challenging cognitive distortions and problematic beliefs (Black & white thinking, catastrophizing, etc.)
- Assessing fears and the “If this, then what might happen?” and working towards getting to more secondary emotions and deeply rooted belief systems
- Challenging irrational or negative belief systems, re-integrating into a client’s belief system
- Helping client’s develop skills of awareness for catching negative thoughts/beliefs in-the-moment and self challenge them “second thought”
- Criticism: 13 inch drop to the heart (subconscious, family roles, or embodied resistance)

IFS for Eating Disorders

- Our internal system has different parts that interact in sequences and styles that are similar to the ways people interact.
- All parts are welcome, befriending our parts.
- Self as the C’s (competent, curious, compassionate, calm, creative, connected)
- it’s you in flow, it’s the “observing self”, may be thwarted by parts in extreme roles
- Parts take over when it’s underdeveloped in childhood/during trauma or when it does not trust the self
- Exiles (complex, painful emotions), Managers (look good in daily life), Firefighters (reactive and work to put out fires when triggered exiles come out)
Narrative and Eating Disorders

- What meaning have I made of my parts or different events?
- Re-writing the meaning we assigned to different events in our lives and meanings we created with a non-fully developed brain (i.e. my parent’s divorce is my fault)
- Understanding and connecting to the good meanings of certain events in our lives and our ways of responding to it (silver linings, meaning making of the eating disorder as necessary for growth internally or in family system, help others who struggle with mental health, etc.)
- Focus on the intentions, dreams, and values that have guided a person’s life

Building Trust & Shame Resilience

- Learning values of trust, B.R.A.V.I.N.G. (Boundaries, Reliability, Accountability, Vault, Integrity, Non-judgment, Generosity)
- Building trust in ourselves and others
- Learning about shame vs. healthy guilt

DBT & RO-DBT

- Both use dialectical philosophy and behavioral principles (skills training)
- DBT for issues of “under control” (impulsivity, over-dramatic gestures, erratic behaviors, overly flexible/changing, disorganized etc.) seen more so in Bulimia
- RO-DBT for issues of “over control” (high inhibition, follow their own rules, overly rigid, isolating/lonely, perfectionistic) seen in both AN and BDD
- In RO-DBT, emphasis is on self-empower/self questioning and increasing openness/flexibility vs. self-control in DBT
- In RO-DBT, social signaling is important for both the client to learn and the instructor/therapist to embody
RO-DBT Areas of Competency

Receptivity and Openness — RO-DBT helps individuals become more receptive to feedback; feedback and constructive criticism can be difficult for perfectionists to acknowledge; those with a high sense of control find feedback to be quite threatening. Yet, we cannot learn and grow unless we are open to feedback. Also, most people do not like those they perceive as close-minded or “know it all’s.”

Flexibility — RO-DBT helps those with overcontrol develop a sense of flexibility — a key to living a full life. Life itself requires adaptability because our behavior in one situation might not be appropriate in another situation; we certainly can’t control everything — and trying to do so will inevitably lead to internal strife.

Intimacy and Connectedness — RO-DBT teaches emotional recognition and emotional expression — these are important skills for people who are overcontrolled; these skills help us facilitate healthy and rewarding relationships.

Strategic Therapy

- Putting the ED out of a job by changing the role/function of a behavior
- Prescribing the symptom (you will plan your binge for this amount of time on [this day])
- Must be used wisely, after really understanding the dynamics of a client’s ED and must take into account the medical side of things
- Helping family systems to shift the ways they are engaging with the client and ED (i.e. accepting/not giving it attention vs. trying to control, getting angry, etc.)
Family Therapy

- Helping family members work on the system’s health together.
- Helping family members understand the role of the eating disorder in the family system and the purpose it serves (i.e., keeps parents close by having something to work on/talk about together)
- Must be “empowering” vs. “shaming” approach
- Working on family boundaries or flexibility in overly rigid family systems
- Importance of family members being differentiated and interdependent vs. enmeshed or avoidant

Bottom-up Therapy

- Somatic Experiencing
- EMDR
- Yoga
- Mindfulness skills & meditation
- Hypnosis
- Brain Spotting
- Body mapping

Exposure & Group Therapy

- Exposing client’s to fear foods, fearful situations, hard conversations and conflict with family members in family therapy, and eating with the client.
- Sometimes this is done with resourcing and/or in a group setting. This is usually more accessible in higher levels of care.
- Group therapy can provide allies, hope, and opportunities for client’s to support and gain social skills while externalizing the ED as they see it in others.
- Group therapy can be process-oriented, sharing meals, family group, art therapy, or yoga/movement groups.
Other common therapies used

- Acceptance and Commitment Therapy
- Motivational Interviewing
- Art & expressive therapies
- The Maudsley Method

Treatment goals & planning

What are the transdiagnostic treatment goals?

- Correction of medical concerns, distinguishing between immediate medical needs and long-term concerns (e.g., digestion issues/malnourishment vs. low bone mass, decreased brain mass, amenorrhea despite weight gain)
- Reaching "set point" weights (subjective), normal hormone regulation, satiety patterns, and gonadotropin functioning
- Less obsession or unhealthy thoughts/preoccupation with food/body/weight
- Therapy for co-morbid and underlying psychological/trauma causes of ED
- Family support/psychoeducation, development of differentiation/healthy relational skills
- Relapse prevention
- Increase resilience/flexibility and distress tolerance
- Slowly introduce mindfulness, proprioception, integration, stress management
Treatment Planning

- Tailored to the specific needs and manifestations of the eating disorder; reaching set point weights, etc.
- Use of efficacious treatment modalities depending on the traits, co-morbid dx's, and family system dynamics
- Assessing for appropriate levels of care to avoid the "revolving door" or increase in symptom severity
- Consideration of certain weight restoration/cognitive restoration before utilizing other treatment modalities
- Working with a team in moderate+ cases and "staying in your lane" in your role with the treatment team (unless in an area underserved, seek training when possible - email me for resources)
- Ensuring to include treatment plan for "relapse prevention" – i.e. families eating together

Treatment Planning (A general template)

1. Phase 1: Assessment & team building *throughout process checking in about specific ED behaviors, severity, and oscillating (going back to other phases as needed)*
   a. Assess for medical/physical needs (usually in conjunction with physician)
   b. Treatment planning for weight restoration (if needed)
   c. Encourage Family Involvement (when possible) – provide psychoeducation and identify role of ED in family system
   d. Build rapport with client and create treatment team as needed
2. Phase 2: Challenging beliefs/re-writing the story and skill building
   a. Identify cognitive distortions, stories, and belief around self worth, body image, food, and eating behaviors

TP Continued...

- Work to reframe using neuro and developmental science to "re-write" story; potential use of IFS parts work or Narrative therapies
- Developing skills and working on issues of "OC" or "UC"
  1. Develop skills for anxiety and mood

Phase 3: Exposure therapies, Relational work, and Trauma/Roots work
- Incorporate more meal time / food and anxiety-based exposure catered to client’s specific distortions and phobias, encourage family support when applicable
- Trauma, Grief, and Expression Work
  1. Re-writing stories – processing ideas, rules, and beliefs that got "Stuck" during trauma (empowerment, shame resilience approaches)
b. Work on helping clients express repressed emotions and learn how to “feel and deal” with complex emotions or “exiles” — may utilize IFS techniques, mindfulness, and body / nervous system regulation techniques

Family & Relational Work
1. Help clients and family system develop healthy, “emotionally safe” relationships, boundaries, and ways of communicating — encourage safe emotional expression and differentiation (increase sense of self)

Body Work
1. Utilize body interventions (including SE, yoga) to help with nervous system regulation, interoception, and creating a different, collaborative relationship to the body

Treatment Planning

1. Assess for treatment goals
2. Client will make progress toward weight gain, maintenance, or following nutrition plan as outlined by dietitian.
Brief Nutritional Logistics

We are biochemical beings.

Nutritional Logistics

- A body that is lacking nutrients is more depressed, anxious, and has worse mental health outcomes
- The binge – restriction cycle that reinforces itself
- Ruining metabolisms and reverse dieting (what keeps people stuck)
- The discomfort of re-feeding with AN, BN, and BED
- Loss of period
- Blood-sugar regulation
- Impact of diuretics and Diabulimia
- Healthy weight ranges and flexibility with body weight
- Night feeding and sleep cycle dysregulation

Awareness, Prevention, and Culture

"I'm asking you to be anti-culture."
Awareness

- Include in your assessments with all clients in intake paperwork, ask them directly. (SCOFF questionnaire)
- Become involved in local/state organizations that provide awareness of this disorder.
- Be an advocate for disordered eating and “diet culture” with clients who are not diagnosable.
- Join organizations or donate to those that support lobbying, ED prevention, funding treatment, research, etc. (NEDA, eatingdisorderhope.com, AED, Manna Fund)
- Talk about it!

Prevention

- Body confidence and self-esteem classes/groups for kids going through puberty
- Decreasing diet/body talk (discussed more in the next slide)
- Catching symptoms early (don’t wait until they are “sick enough”)
- Educating parents on modeling healthy eating and body image behaviors
- Working on family systems and young people’s mental health in general
- Teaching trust, boundaries, and a healthy sense of self to young kids (and their parents)

Culture

- Diet culture doesn’t have to be normal.
- Image obsession is one of the biggest setbacks in our culture (especially for women) – objectification theory, women’s movement, “so much more than hot” (Ted talk: Beauty Sickness)
- Stop complimenting your friends on how they look or telling little girls they are pretty
- Reflect this in how you live, how you change the conversation, your social media (embody this for others)
- Stop hating on your body or obsessing over diet culture
Further Reading

- *Eating in the Light of the Moon* by Dr. Anita Johnston
- *Women, Food, and God* by Geneen Roth
- *Eating Disorder Source Book* by Carolyn Costin
- *Dance of Anger* by Harriet Lerner
- *10 Gifts of Imperfection* by Brené Brown
- *RO-DBT Skills Manual* by Thomas Lynch & associates
- *IFS Skills Training Manual* by Richard Schwartz

Local & Online Resources

- NEDA, National Eating Disorder Association, [www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org)
- Soma Therapy (dietitian, medication management, therapy): LaVeta Jarrett, Jenny Helms, Jennifer Voth, Paula Miller, Mary Neubrt, Sidney Funk
- L'Oreal Bentz, Dr. Kristin Goodheart, Beth McGilley, Dr. Jennifer Harshberger
- Eating Recovery Center online groups
- WSU Pediatric Feeding Group

Questions?

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References & Resources


REFERENCES & RESOURCES


Online Resources

Eating Disorder Information Websites:

- National Eating Disorders Information Hotline: Provides comprehensive information on the facts of eating disorders, treatment plans, and education on prevent against developing eating disorders. The site also has links to other resources and services for concerned individuals.

- Anorexia Nervosa: Awareness and Recovery: Offers comprehensive information on anorexia nervosa, including symptoms, risk factors, and treatment options. The site also provides resources for concerned individuals.

- www.betterhelp.com: Provides a platform for finding a qualified mental health professional for support and guidance in dealing with eating disorders.

- www.eatingdisorderhelp.com: Provides a comprehensive guide to understanding and managing eating disorders, including information on treatment options and personal stories.

- www.eatingdisorders.org: Offers resources and support for individuals and families affected by eating disorders, including information on treatment options and support groups.

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Online Resources Ct’d

Central Eating Disorder HelpLine: 1-800-992-0220
NEDSP offers a comprehensive guide to eating disorders and a list of telephone numbers and web sites to help address eating disorders. The site has informative narratives on common eating disorders, and other information. The site is an excellent resource for parents, teens, and educators. It is a great place to start if you have questions about eating disorders.

Eating Disorder Helpline: 1-800-931-2237
The Eating Disorder Helpline is a national organization that provides support and information about eating disorders. They are available to help anyone who needs it. The site also has links to resources, including support groups, treatment options, and websites for further information.

Online Resources Ct’d

Eating Disorders Coalition: 1-800-992-0220
The National Eating Disorders Coalition (NEDC) is a non-profit organization dedicated to raising awareness and increasing access to knowledgeable, compassionate, and effective care for eating disorders. The NEDC promotes a society where people can access care for eating disorders without barriers and where they can find the support they need to recover. The site offers information and resources on eating disorders, including links to other organizations and resources.

Eating Disorders Information Center: 1-800-992-0220
EDIC is a national organization dedicated to raising awareness about eating disorders. They provide information on the signs, symptoms, and treatment options for eating disorders. The site also offers resources for those who are concerned about themselves or someone else.

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Online Resources Ct’d

**Eating Disorder Forums and Communities**

1. **Anonymous Eating Disorder Forum**: This forum gives members the opportunity to discuss eating disorders, treatment options, and recovery. Members can post questions, share experiences, and connect with others who are also dealing with eating disorders.

2. **Support Eating Disorder Forum**: This forum is designed for those who are struggling with eating disorders, providing a safe and supportive environment for sharing experiences, seeking advice, and receiving encouragement.

3. **Bulimia’s Anonymous**: A private forum specifically for those who have bulimia, offering a place to share experiences, support, and resources.

4. **Christian Eating Disorder Forum**: This forum is aimed at providing a community for those who are dealing with eating disorders, focusing on a Christian perspective.

5. **Support Eating Disorder**: A forum for those who are struggling with eating disorders, providing a platform for support, guidance, and community.

6. **Binge Eating Disorder**: A forum for those who are dealing with binge eating, offering a community for support, discussion, and recovery.

7. **Eating Disorder Recovery Center**: A community for those who are recovering from eating disorders, offering support, resources, and a safe space to share experiences.

8. **Eating Disorder Information Center**: A comprehensive resource for those dealing with eating disorders, providing information, support, and resources.

9. **Beating Bulimia**: A forum for those who are struggling with bulimia, offering support, advice, and resources.

10. **Eating Disorder Support**: A community for those who are dealing with eating disorders, providing support, resources, and a safe space to share experiences.

11. **Eating Disorder Anonymous**: A private forum for those who are dealing with eating disorders, offering a safe space to share experiences and seek support.

12. **Eating Disorder Anonymous Board**: A private forum for those who are dealing with eating disorders, offering a safe space to share experiences and seek support.

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