1. What are some of the non-physical symptoms that they may have? such as mood disturbances?

   Look at my slide "Personality Vulnerabilities" for detail on mood disturbances. Those with EDs are prone to clinical perfectionism and control issues as well.

2. Do you think the concept and increased use of intermittent fasting has impacted individuals who have an eating disorder?

   Many are using this as a tool to manage their weight and many have reported many health benefits. How would you diagnose someone who uses this as a tool to manage their weight as it could look like restricting eating and reducing their overall calorie intake.

3. There is a difference between intentional vs unintentional restricting, correct? I think about myself. I'm so busy all day I lost track of time and miss meals.

   Does the restriction, intentional, or not, lead to loss of social, occupational, cognitive functioning or bingeing/loss of weight? If so, it is still an eating disorder.

4. What about AFRID,PICA, and orthorexia can you give some symptomology for these or some intake questions for these?

   Very in-depth criteria for all, but essentially: ARFID is related to food intake and can be based on sensory issues, motor issues, and feeding physicality issues. ARFID is "extremely picking eating" without body image or weight issues so you'd want to ask about their body and self image. Orthorexia is the disorder of "perfect" eating so asking if they are afraid of foods that are not completely and totally healthy and nutritious, or if food has to "look" perfect, pretty, or perfectly presented. PICA is eating non-food substances so asking if they eat anything non-food (paper, ink, hair, glass) is diagnostic.

5. Do you have any suggestions for helping an 8 year old boy with ARFID?

   I would not treat an ARFID client and refer them to a specialist who can work on sensorimotor/feeding therapy.

6. Will you at some point touch on what the literature says may be the etiology of BDD specifically or eating d/o in general?

   "Being young, female, and dieting" are the three greatest risk factors.

7. Is there a certification program for CBT-E? How would we access that program?

   I did ICP's Center for the Study of Anorexia and Bulimia 2 year training program and I recommend it highly! https://icpnyc.org/csab/2-year-training-program/

8. Do you address origin of control issues in tx and how to regain control over other aspects of life?

Yes with traditional psychotherapy which I use in my sessions as well. As mentioned I take an integrated approach whereby I don't follow the manual verbatim, therefore there is room to discuss the origin of control issues, childhood, self-image, and self-esteem, family history, etc.

9. What about patients with substance use challenges?

   Consider what is the primary and secondary concern. See it as a game of "wack-a-mole" and work from the primary down to the secondary issue. Typically, if someone has severe substance use and severe, ED I would not treat at the outpatient level. I would refer them to a higher level of care.

10. any reason that you know for high rates in orthodox population?

    In my trainings and conversations with Orthodox Jewish women, primarily, it stems from a cultural norm of "thinness" and "beauty" as well as the resume process of matchmaking that daughters go through. Their resumes have their BMI's on them which is a pain point for many adolescents in fear that they won't be matched with a good partner. More research is needed.

11. What is your experience with eating disorders in individuals with co-occurring serious mental illness (i.e schizophrenia or bipolar)? Any considerations?

    I unfortunately don't have a ton of experience with schizophrenia/ED crossover but Bipolar disorders and ED's are intercorrelated. Eradicating the eating disorder is always helpful as it decreases the emotional lability and dysregulation consistent with mood disorders.

12. For clients that are in the early stages of realizing their eating disorders is there a best practice to start with treatment and discussion, and how might that be different from clients that have had an eating disorder for years with other forms of MH struggles?

    Motivational interviewing is helpful for understanding their motivations for wanting to change relationships with eating and their bodies. As always, motivation is the best predictor for change. I also think the "How much do you think about food/body/weight?" intake question is very helpful. People who are realizing they struggle with food/weight are often shocked to learn most of us non-ED sufferers only think about it 10-15% per day.

13. Also is there a helpful tool to get clients to provide more detail about their eating disorder if they are often being vague? Thank you!

    Yes. You can use the EDE-Q.

14. Have you had success in getting insurance companies to cover treatment specific to eating disorder diagnoses or only under other diagnosis such as depression?

    Yes companies do often take the ED diagnoses.

15. How do you work with patients who have an eating disorder and are in recovery from substance/alcohol use?

    A multi-modal approach. Typically clients will be in treatment for their eating disorders and also, adjunctly, doing substance abuse treatment whether that be in a 12-step, a harm-reduction program, a mentorship, having a sponsor or case worker, etc.

16. Do you recommend a 12 step approach in addition?

    Yes if it helps the client.

17. How do you navigate a client who is obsese but avoids discussing eating and feels ADHD, anxiety and depression is her primary concern. How can we initiate discussion without making her feel "insulted" which is what happens frequently?

    I think this is a loaded question that I would need more info on. How do you know she has an eating disorder simply because of her size? Is there a doctor mandating that she lose weight for health reasons? Is this your primary concern rather than hers? I would follow her lead rather than cast your ideas about her treatment on to her. If there is a doctor's involvement saying that her health is an issue and she must lose weight, can you focus on positive protective factors such as eating nutritious meals, increasing mobility and movement, practicing positive self care strategies, yoga, etc. to build rapport? Focus less on her weight/size in your conversations about her health. Also look into the Health at Every Size movement.

    https://haescommunity.com to help support this client compassionately.

18. I'm a caseworker, not a therapist. When talking with parents about selecting a therapist for their child struggling with an eating disorder what are the most important things to consider? Is it important to see a therapist who specializes in eating disorders or who has some kind of specialized training?

    Yes. An experienced eating disorder specialist is important. IAEDP.com is our professional membership association and you can search for ED therapists in your area.

19. What do you say to clients who say they're not hungry during the day? and is it ok to try to get client to start with low carb meals due to extreme reluctance to eat regularly?

    Yes. Start where the client is. However, if there is extreme restriction to the point where their health is at risk (so that either their intake is minimal, their BMI is extremely low, they are reporting lightheadedness/fainting, or a doctor is concerned) then it would be important to refer them to a higher level of care like a intensive outpatient or partial hospitalization.

20. How do you approach weight loss conversations in a healthy way?

    Very good question. I discuss weight loss as I would any change with clients: when the client brings it up as a concern for them. Be careful to not place your own judgments or

ideas about weight on a client. When it is brought up, I help clients by exploring why they want to lose weight, and the intention behind it. Is there a medical reason? Is it a societal pressure? Is it a self-image issue? Then we go from there.

21. What approach would you take with a client who reports that they are working with a nutritionist to manage a medical diagnosis such as Polycystic Ovarian Syndrome and have been instructed to eliminate gluten from their diet? Great question.

    Collaborate with that dietitian. Inform then that you are observing signs of an eating disorder. Try to help client find a happy medium between recovery and health needs. Work together to have client not deprive themselves (there are great gluten free options these days!).

22. Can anyone get an eating disorder? If its about the family you grew up, then why only one family member gets it etc. ????

    Anyone can get an eating disorder but there is often a genetic predisposition to the development of a diagnosable eating disorder. Many of my clients often have a family member with an ED.

23. What advice do you offer to a parent of a youth that is struggling with mental health, gender dysphoria and beginning to show signs of eating disorders due to weight gain from psych meds.

    Good question. Work with the psychiatrist to make sure meds are right. Work with the family to understand gender dysphoria, asking the client how they want to be supported and helping the client articulate that to the family, and also encourage them to "add" in healthy habits at home: i.e. family dinner together, cooking healthy meals, add in positive/neutral conversations about food and body rather than negative ones. Focus on the addition of healthy family practices and not negative such as deprivation, dieting, etc. I think this is a good family for separate family therapy & psychoed since this would be a lot to do all yourself.

24. As a care manager for a Health Home I have a client who overeats because his parents deprive him from snacks and only allows him to eat vegetables as snacks. How do I go about helping the client overcome his bad eating habits?

    Start with the parents. Helping them understand that they are setting him up for overeating by restricting his food intake. Psychoeducation around what is appropriate for the client in terms of snacks and meals (i.e. fruit and vegetables are not a substantial snack but an apple with peanut butter and granola bar is). Referring them to a registered dietitian who can work with them as a family.