A Word from the Editor

The summer 2013 issue marks my last as editor of Perspectives. For the past 6 years, I’ve had the privilege of discussing, editing, and reviewing an incredible array of creative essays on treatment, research and advocacy in our field. I remain amazed by the energy and passion of the professionals, patients, and families in our community and thank you all for having given me this opportunity.

Dr. Marjorie C. Feinson, Professional Development Specialist for The Renfrew Center Foundation, will take over the editor’s role starting with the winter 2014 issue. She brings a wealth of clinical and academic experience to Renfrew having been a university professor and researcher for the past 30 years with a special focus on women’s mental health. Dr. Feinson will continue our efforts in providing a thought-provoking, stimulating professional journal.

Doug Bunnell, Ph.D.

An Introduction to Avoidant-Restrictive Food Intake Disorder (ARFID)

Jessica B. Lerman, BA and Evelyn Attia, M.D.

The classification of a disease is only useful if it serves to clarify clinical diagnosis and guide diagnosis-specific therapy. Such is the premise and intent of the Diagnostic and Statistical Manual of Mental Disorders (DSM). However, as is the case with all disease classifications, newer data derived from epidemiological, classification, and treatment studies mandate periodic revision and updating. In addition, new consensus perspectives emerge that provide for more precision and rigor of disease criteria, removing ambiguities of language and gaps in knowledge.

With this background in mind, the DSM’s fourth edition (DSM-IV) has recently undergone revision and a fifth edition (DSM-5) has been published. Several changes have been made to the category of eating disorder diagnoses. Specifically, in addition to the familiar clinical conditions of anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED), a new label has been introduced – Avoidant-Restrictive Food Intake Disorder (ARFID). While new in name, ARFID actually describes the
clinical group that was previously included in the diagnosis “Feeding Disorder of Infancy or Early Childhood” (FD). FD was included in DSM-IV, but was rarely used by clinicians and not studied by researchers. As a result, there is little information about the characteristics, course and outcome of individuals with this condition. In addition to attending to AN, BN and BED, the Eating Disorders Work Group for DSM-5 was charged with considering FD, as well as two other diagnoses – pica and rumination disorder – formerly listed in the category “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence.” These disorders are grouped together in DSM-5 with AN, BN and BED in a general category labeled “Feeding and Eating Disorders.” Pica and Rummation Disorder have been left essentially unchanged in the new manual, but ARFID was created in an attempt to make the previous FD category more useful.

The original FD diagnosis required that affected individuals demonstrate: 1) persistent failure to eat adequately with a significant failure to gain weight or a significant weight loss for over a period of one month; 2) that the eating disturbance be unrelated to gastrointestinal conditions or other general medical diagnoses (e.g., esophageal reflux); 3) that the eating pattern not be defined by another mental disorder (e.g., Rumination Disorder) or by the lack of available food; and, 4) that the onset of the eating pattern occur before age 6 years (American Psychiatric Association, 1994).

ARFID is an expanded category that replaces the DSM-IV diagnosis of FD. ARFID may include children, adolescents and adults presenting with an inability to eat for a range of reasons. These may include those related to the physical properties of particular foods or the feared consequences of eating specific types of food other than its effects on body weight and shape. ARFID shares some diagnostic similarities with AN, including restrictive intake leading to severe weight loss; however, ARFID differs from AN in the reported or observed motivations underlying the behavioral disturbance. This newly defined category encompasses three general categories of avoidant or restrictive eating behavior associated with low weight or other evidence of nutritional compromise: 1) Lack of interest in eating; 2) avoidance based on sensory characteristics of food, including appearance, smell, taste and texture; and, 3) Fear of the consequences of eating, e.g., functional dysphagia or fear of swallowing (Bryant-Waugh, Markham, Kreipe and Walsh 2010).

**Case Example: Avery is a 12-year-old girl who has always been petite and above the 25th percentile for both height and weight on the growth chart, but is now trending below the 10th percentile for weight. Her struggles around food started at age 10 when she began refusing to eat for fear of vomiting. Although Avery is a pleasant girl and has a modest social life, she has recently stopped socializing completely, coming home immediately after school to make her stomach feel calmer. Her habitual eating pattern consists of small quantities of food ingested very slowly. Changing the content and texture of the food does not ameliorate Avery’s eating pattern. She manipulates her food on the plate and becomes very temperamental when told to finish her food. Recently, Avery has developed a fear of eating in public, refusing to eat meals during the school day. She expresses no fear of gaining weight due to shape or weight concerns. In fact, she was only made aware of her low weight after a visit to the pediatrician. When educated about the dangers of her low weight, she immediately became tearful and expressed a desire to gain weight.

This patient, who restricts her caloric intake due to her fear of food-associated emesis, meets criteria for ARFID according to DSM-5. Anorexia nervosa will need to be considered in the differential diagnosis for this patient; however, because her behaviors are not associated with body image or weight control issues, fear of gaining weight or a refusal to acknowledge her low body weight, a diagnosis of AN can be ruled out.

According to the DSM-5, an individual meets criteria for ARFID if there is an eating or feeding disturbance manifested by a persistent failure to meet appropriate nutritional and/or energy needs associated with one or more of the following: 1) significant weight loss (or failure to gain weight or faltering growth in children); 2) significant nutritional deficiency; 3) dependence on enteral feeding or oral nutritional supplements; and, 4) marked interference with psychosocial functioning. The second criterion requires that there is no evidence that lack of available food or an associated culturally sanctioned practice is sufficient to account alone for the disorder. The third criterion requires that the eating disturbance not be exclusively dependent on a disturbance in perception of one’s body weight or shape, such as occurs in AN or BN. The fourth criterion is that the eating disturbance is not due to a concurrent medical condition or another mental disorder, and that when an eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the other condition or disorder and warrants additional clinical attention (Kreipe and Palomaki 2012).

The diagnostic changes in DSM-5 serve to clarify the language and extend the usefulness for feeding and eating disorders of infancy or early childhood. The main feature of ARFID is the avoidance or restriction of food intake without body weight or shape concerns, leading to clinically significant consequences. In some individuals the food avoidance or restriction may be based on specific food characteristics such as color, texture, temperature, taste or smell. Individuals with heightened sensory sensitivities, such as those with autism spectrum disorders may manifest greater likelihood of developing ARFID. Food avoidance or restriction may also be associated with a negative association to food following, or in anticipation of, an aversive experience such as vomiting or choking. Individuals with identified anxiety disorders, including specific phobias may manifest a greater likelihood of developing ARFID.

ARFID is associated with a number of other clinical features including the physiological effects of nutritional deficiencies and/or semi-starvation, notably hypometabolic signs such as...
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hypothesis or bradycardia. In children with ARFID, growth may be delayed or stunted. Differential diagnosis may be difficult for ARFID; medical conditions causing food aversion and weight loss (e.g., gastrointestinal conditions, occult malignancies) must be considered. It is important for clinicians to evaluate a number of medical (e.g., gastrointestinal reflux) or co-morbid psychiatric conditions (e.g., depression) that may affect food intake. For ARFID to be considered, the eating disturbance would not be expected to resolve with the treatment of the underlying condition and would need to be severe enough to warrant specialized management. If a medical condition is present and associated with the development of ARFID, the disturbance of food intake would likely continue following the resolution of the medical problem.

Since ARFID is a new diagnostic entity, there is little empirical evidence supporting specific treatment recommendations. Nevertheless, behavioral management and nutritional support are commonly used for the restrictive food intake patterns characteristic of this disorder. Since body shape and weight concern are not present in ARFID, clinicians should expect individuals with ARFID to identify different motivations for the restrictive eating than those generally present in AN or BN. In younger patients, relational issues may play a role (Davies et al., 2006) and for some, temperament or developmental problems may contribute. Treatment should focus on behavioral management of restrictive eating, and for some, the treatment of the underlying disorder (e.g., treatment of a swallowing or vomiting phobia) may need to be included in the management of an individual with ARFID.

It will be important to systematically collect data about individuals with ARFID in order to better understand the clinical presentations, course and prognosis of individuals who fall into this new category of illness.

REFERENCES

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The DAD Initiative
A Clarion Call To Educate, Empower And Encourage Dads To Become More Engaged In All Aspects Of Their Loved One’s Eating Disorder Journey
DONALD A. BLACKWELL, ESQ.

If someone had told me in the Fall of 2006, as I stood at the top of our South Florida driveway watching my 18-year-old daughter Ashley head off to the University of Southern California to begin her freshman year, that in the Spring of 2013 I would be writing a piece for Perspectives inspired by our family’s journey through the insidious and highly complex maze that is the world of eating disorders, I would’ve looked at them like they were from another planet! After all, at the time, I’d never even heard of eating disorders, save for having a vague recollection that one had played a role in the death of Karen Carpenter. Moreover, by all objective measures, Ashley seemed to be an unlikely candidate to follow in Ms. Carpenter’s tragic footsteps. She was a National Merit Scholarship Finalist, an AP Scholar of Distinction and a 4-time All-State choralist, who had traveled around the world entertaining audiences in their native tongues. She had been in two motion pictures and numerous plays, was an accomplished equestrian, appeared to be fiercely independent and was a prolific and award-winning writer of short stories and poetry. She also was the co-founder of a local theater company, who wrote and produced original plays, and the recipient of USC’s prestigious Presidential Scholarship.
By all outward appearances, Ashley seemed to have the world on a string.

And then one day, before the ink had dried on the 4.0 GPA she earned in her first semester of studies, Ashley stopped eating and her (and our family’s) worlds turned upside down. Even if I wanted to, it would be impossible within the confines of this article to accurately describe the blur of in and out-patient treatment facilities, hospital emergency rooms and visits to psychologists, psychiatrists, doctors, nutritionists and life coaches that defined the next 4½ years of our lives. We canvassed the United States in search of answers, hope and healing, while simultaneously trying to juggle work responsibilities, the needs of Ashley’s older brother, and the seemingly never-ending and emotionally-charged battles with insurance companies. It would be harder still for me to explain how any of us survived to talk about it. The important thing is that, thankfully, we did.

Fast forward to October, 2012, where, on the heels of the publication of my new book, “Dear Ashley . . .”—A Father’s Reflections and Letters to His Daughter on Life, Love and Hope, I had the privilege to present at NEDA’s 2012 Annual Conference in St. Petersburg, Florida. I had hoped to be speaking to an audience of dads, particularly since my presentation, Navigating in Uncharted Waters—One Dad’s Practical Suggestions for Supporting Your Loved One in All Phases of Their Eating Disorder Journey, was designed specifically for their benefit. There was only one problem: It turned out that, in a “sold-out” population of 600 conference registrants, only 1 was a non-NEDA-affiliated dad! To make matters worse, several of the moms who attended my presentation approached me afterwards and shared that their current or former husbands not only weren’t supportive of their daughters’ recovery efforts, they were further complicating the situation by their insensitive and hurtful comments.

I shed a lot of tears on the long drive back to Miami that afternoon. Some fell because I realized that if I’m to be completely honest with myself, I was once one of those uninformed dads. Still others fell for the countless number of daughters (and sons) who’ve had to battle their eating disorders without the benefit of knowing that their dads are firmly, unconditionally and non-judgmentally in their corner. I quickly decided something needed to be done about that and the “something” I came up with is “The Dad Initiative — Committed To Healing, United in Hope” (“The Initiative”).

The Initiative is predicated on my personal experiences and beliefs, many of which are substantiated by what little research and commentary exists on the subject of dads, daughters and eating disorders (Agras, Hammer & McNicholas, 2007; Costin, 1996; Maine, 1991; Meeker, 2006) namely that:

• Healthy recovery from an eating disorder should involve the entire family.
• There are few bonds on Earth stronger than the love between a father and his daughter.
• There are few things more important to a daughter or more critical to her healthy development than her father’s attention, affection and approval.
• Most dads are silently thirsting for a closer relationship with and a better understanding of their daughters.
• As a rule, dads are pre-wired to fix rather than feel. They are likely to be skeptical about traditional therapy models.
• The level of vulnerability and emotional intimacy required to connect fathers and daughters in ways that meet a daughter’s “dad needs” is not intuitive to men (i.e., it does not always come naturally to a dad).
• Dads have a significant reserve of “positive intention” that they are eager but often not entirely certain how to express to their daughters, particularly as daughters begin the complex transformation into young womanhood.
• Many fathers lack appropriate modeling of empathy from their own experiences with their fathers. Even the most myopic, black-or-white thinking or stubborn of dads can be taught to be a “New Father” — I know, because I once was one of those “black-or-white” dads!

• The rewards associated with being more vulnerable, emotionally intimate and sensitive about the father/daughter relationship are well worth the effort it takes to get there.
• Where eating disorders and disordered eating behaviors are concerned, a father’s willingness to participate in his daughter’s recovery on a more visible and intimate level may be the most important gift he can ever give his daughter, his family and, ultimately, himself.

The Goals of ‘The Initiative’ are Threefold:

1. Educate: Dads need to be taught, using sound empirical data and anecdotal evidence, that eating disorders are real and life threatening. Only then can we hope to dispel the misguided notions that often underlie dismissive and hurtful comments such as “it’s just a phase she’s going through;”, “it’s nothing more than a selfish ploy for more attention;”, “it’s a bunch of psycho-babble;” and/or “it’s a choice that just as easily can be ‘re-made.’” Simply put, fathers (as well as mothers, siblings, and friends) need to learn to acknowledge and validate their loved one’s eating disorder struggles with the same urgency and concern they unquestionably and unhesitatingly would muster if their loved one was afflicted with a more “objectively verifiable” life-threatening medical condition. As one friend recently suggested, to react as if there were an “intruder with bad intentions lurking at their loved one’s bedroom window.”

2. Empower: Dads need to understand that by becoming more fully engaged they have the power to make a positive difference in their loved one’s eating disorder treatment and recovery. They also need to realize the harmful impact lack of involvement or, worse yet, hyper-critical, uninformed and/or counter-productive behaviors and comments can have in the care and recovery process. They then need to be equipped with well-defined/concrete tools and strategies (e.g., detailed “Do’s and Don’ts” lists, etc.), so that they can clearly understand how to be an effective and loving contributor to their loved one’s recovery efforts. In addition,
they need insight on how to support their significant others (spouses, etc.), who likely are already shouldering most of the day-to-day support responsibilities.

3. Encourage: Dads need to be encouraged to participate in all of the front line activities that are central to their loved one’s treatment and recovery journey. These include active participation in group, family and individual psychotherapy sessions that are part of the comprehensive treatment plan. To facilitate fathers’ participation, practitioners and educators need to design a communications plan/network that supports and respects dads’ work obligations and makes creative use of available technologies to help facilitate their in-person and/or online participation in that process. They also need to develop and utilize “session plans” that are thoughtful, prospective in nature and focused on father/daughter relationship-building, rather than on fault-finding, finger-pointing, shame, guilt and other “certain-to-drive-dads-away” topics.

A Step-By-Step Strategy For Achieving Those Goals

The first step in securing that support is to create an awareness of and to solicit support for The Initiative from individual and institutional treatment professionals, as well as organizations that promote eating disorders education. It is essential that we develop a grass roots base of support among those working in the field. There are several means available for creating that awareness and support. Direct e-mail campaign, for instance, could announce The Initiative, identifying its goals and providing a simple, easy-to-follow game plan for achieving those goals; webinars, conference presentations, and articles in professional publications would be important channels of information.

The next step in the process is to establish an inter-disciplinary panel or committee of specialists to collaborate on a global strategy designed to assist local practitioners at all levels of eating disorder treatment expertise. This group would develop:

- Recommendations for attracting, rather than alienating, dads. Many dads find the language and values of therapy inherently unfamiliar and discomforting and many are openly skeptical about the foundations of psychotherapy. It is essential to make it clear that effective therapy is a means of relationship building and NOT a retrospective fault-finding mission.
- Recommended “reading lists” that provide dads with an easy-to-digest but no less comprehensive overview of eating disorders, including empirical data designed to: teach dads that eating disorders are real and life threatening illnesses. Despite growing awareness about these diseases, common misconceptions and perceptions about the nature of the disorders persist.
- Standardized tools and strategies, including detailed lists of “Do’s and Don’ts” that dads can clearly understand and apply to become more effective participants in treatment. These tools should also include specifics about how dads can properly support their daughter’s recovery efforts.
- “Suggested Session Plans” designed to assist group leaders and clinicians in conducting healthy and productive father/daughter sessions that are forward-looking and which afford opportunities for mutual growth and healing.
- Strategies for using modern technology to ensure a dad’s ability to participate/and be involved even when being physically present is not possible, including Skype, Google+ “Hang-Out,” teleconferencing and conference calls.

A Sample “Suggested Session Plan”

One of the most meaningful and powerful therapy sessions I ever attended with my daughter involved her reading a “Letter to Dad” that she had written prior to the session at her therapist’s suggestion. The letter was an effort by Ashley first to express her love for me and then attempt to explain, in her own words, the nature of her illness and the extent to which it had (and was) consuming her life. The letter led to a series of heartfelt and very emotional exchanges and embraces that had a profound and lasting impact on both of us – and the therapist barely had to say a word.

That session and my lifelong love of writing in general convinced me that letter-writing (and reading) can be a powerful tool in developing, enhancing and/or rebuilding the intimate father/daughter relationship. This is the sort of closeness that The Initiative is intended to promote. For that reason, one of the “Suggested Session Plans” could include a series of 4 one-hour weekly sessions between a father and his daughter during which the dad would be asked to write and share 4 letters, in the following order – one per session:

“A Profession of Love” – This letter should be relatively “easy” for most dads to write. In it, the dad need simply tell his daughter that he loves her unconditionally and that he has since the day she was born.

“A Request for Understanding” – This letter likely to be the most difficult to write. Daughters tend to put their dads on the highest of pedestals. They want nothing more than to make their dads proud of them. Many are fearful of disappointing their dads, of falling short of what they perceive to be their dad’s expectations and standards. In this letter, the dad needs to acknowledge his humanity. As obvious as it may be to him and to everyone else in his world, his daughter needs to hear her dad recognize that he is imperfect, that he’s made mistakes and that he likely will continue to make them, despite his best efforts and intentions. If the circumstances warrant, the dad might also use this letter to ask for his daughter’s understanding and forgiveness, particularly if there is a past wound in need of special healing.

“Words of Affirmation and Encouragement” – This is an important letter. In it, the dad needs to let his daughter know that he is proud of her. He needs to allow her, perhaps for the first time, to see herself through his loving, non-judgmental eyes. In their
reflection, he needs to “show her” the many attributes he sees in her that make her special (e.g., her kindness, her creativity, her courage, her determination, her love of animals, her sensitivity, her loyalty, etc.) – and then offer words of affirmation and encouragement.

“A Commitment for the Future” – Finally, the dad needs to make it clear to his daughter, whether he is living under the same roof or not, that he’s not going anywhere where she is concerned – that he is fully committed to her and that he will continue to be there for her. In short, he needs to let her know that she can count on her dad for unconditional support. Dads can’t just assume that their daughters know things like this. In fact, in writing each of these letters, it is critical that the authoring dad not make any assumptions about what his daughter “already knows.” It’s what she needs to know that matters here.

I’m confident this exercise alone will change the father/daughter landscape and serve as a catalyst for continued dad involvement.

My hope is, as we work to build The Initiative, that we stay focused on the following markers of success:

• Greater dad involvement in their daughter’s ED treatment and recovery.
• Stronger, more intimate relationships between dads and their daughters.
• Adding an important (but currently underutilized) resource to the treatment and recovery dynamic – dads.
• A heightened level of awareness on the part of dads with respect to the seriousness of eating disorders and the urgent need to address all aspects of the disease (i.e., education, legislative, financial, insurance, etc.).
• A higher rate of long-term recovery and relapse prevention, which, in turn, translates into saved lives, fewer long-term medical complications and a long-term savings for families in regard to finances, time and, most importantly, life.

CONCLUSION

Women, including mothers and clinicians, have long played a critical nurturing role in the treatment and recovery of those suffering from eating disorders and to their substantial credit they continue to do so – often at considerable personal sacrifice. However, I believe that dads also are desirous and fully capable of contributing to their daughter’s recovery on a level well beyond simply providing support. I believe that by validating their daughter’s struggles and becoming more actively and visibly involved in the treatment and recovery process, dads can meaningfully contribute to their daughter’s healing. However, those objectives will only become a reality if clinicians and other treatment specialists around the country embrace the critical role of dads and take affirmative steps to ensure that dads become more visible and active participants in the process. Both moms and dads have distinct roles in, treatment and recovery of those suffering from eating disorders. With proper education, encouragement and guidance, I’m convinced dads and moms can better partner in providing a level of acceptance and belief that has a power unlike any other to facilitate their daughter’s self-empowerment and readiness to change.

REFERENCES


Neurophysiological Management of Arousal: Eating Disorders & Neurofeedback Training
MARVIN H. BERMAN PH.D., CBT, BCN, & CHRISTOPHER DIMALCARO, B.S.

The strategic and dynamic approaches to the treatment of eating disorders is now beginning to incorporate the neurophysiological aspects of behavior in constructing more effective treatment models. This occurs as eating disorder theorists evolve away from reliance on psychodynamic, structural, and strategic family systems etiological constructs toward more biopsychophysiological constructs, i.e., the management of arousal. Biofeedback, as a application methodology in the field of behavioral medicine, is now being seen as having a substantive contribution to make in thinking about treatment of many psychosomatic disorders, of which ED can be considered an example. Biofeedback is defined as:

“a process that enables an individual to learn how to change physiological activity for the purposes of improving health and performance. Precise instruments measure physiological activity such as brainwaves, heart function, breathing, muscle activity, and skin temperature. These instruments rapidly and accurately ‘feed back’ information to the user. The presentation of this information — often in conjunction with changes in thinking, emotions, and behavior — supports desired physiological changes. Over time, these changes can endure without continued use of an instrument.” (ISNR, 2008, www.isnr.org)

Neurofeedback training (NFT) has its foundations in peripheral biofeedback, which has been a staple of behavioral medicine for the past 100 years. It takes into account behavioral, cognitive, and subjective aspects as well as brain activity in helping people to increase awareness of and then modify internal states of arousal. The characteristic that distinguishes NFT from other forms of biofeedback is a focus on the central nervous system and the brain. Like other forms of biofeedback, NFT uses monitoring devices, such as non-invasive sensor arrays attached to the scalp and earlobes, for reference and grounding purposes. NFT’s mechanism of action, at the neuronal level, involves the modulation of excitatory and inhibitory patterns of specific neuronal assemblies and pathways based upon the details of the sensor placement and the feedback algorithms used, thereby increasing flexibility and self-regulation of relaxation and activation patterns. (ISNR website, www.isnr.org)

The underlying process supporting this idea of substantive neural reorganization has been referred to as neuroplasticity. This is accomplished through the use of monitoring devices to provide moment-to-moment information to an individual on the state of their physiological functioning. The technique is a non-invasive approach to operant conditioning of the electrical activity emanating from large groupings of cortical neurons. This is most often accomplished using the electrical signals that can be used to present a variety of feedback stimuli that provides moment-to-moment information to an individual on the state of their physiological functioning (Collura, 1993). The technique is engaging and interesting to most people and, when properly applied, has no negative side effects, potential for embarrassment or physical discomfort.

NFT commonly involves connecting the person to an EEG recording device and having them watch a computer screen wherein the volume and brightness of the auditory and visual stimuli are controlled by the person’s maintenance of specific patterns of EEG activity. The brain training protocols are derived from the Quantitative EEG (QEEG) assessment conducted at the beginning of treatment (Thatcher, 2010). The operant conditioning only provides positive feedback, there is no failure condition. The feedback shape the response from a given baseline to incrementally higher levels of success. Problems of brain self-regulation fall into three general areas: instability (which is the case in epilepsy and other conditions), under arousal, and over arousal. Training Beta (15-38hz) activity is often selected to treat manifestations of under arousal such as depression, poor attention and focus, and frequent sleep disruption. Symptoms of over arousal, such as anxiety and difficulty falling asleep, commonly respond to training in a frequency just lower than Beta, called the sensory motor rhythm or SMR (12-15hz). Alpha (8-12hz) training is useful for some individuals with anxiety because of its calming effects. Deep relaxation training with a specialized program of alpha/theta brain wave feedback has been used to successfully treat a variety of addictions. (Peniston & Kulkosky, 1991)

NEUROFEEDBACK AND TREATMENT OF EATING DISORDERS (ED)
Abnormalities in EEG activity are evident in people struggling with eating disorders and these patterns of dysregulation are shown to only partially normalize with refeeding or weight gain (Bradley, et al., 1997). EEG functional abnormalities in the prefrontal, cingulate, and temporal regions respond differently to stimuli (Jäuregui-Lobera I, 2011) and appear to correlate with decreased cognitive and interpersonal skills that can interfere with ED recovery maintenance.

A two-part study conducted to determine the effectiveness of NFT on treatment outcomes of eating disorder patients showed statistically relevant changes in Beck Depression Inventory (BDI), Eating Disorders Inventory (EDI) and neuroticism scores as well as a
decreased need for medication (Smith, et al., 2003). NFT has been shown to address other common complaints in early recovery such as insomnia (Hammer et al., 2011), drug cravings (Trudeau, 2000), mental cloudiness and the inability to concentrate, all of which are often viewed as relapse triggers (O’Connell, et al., 2008).

Sleep disturbance among people struggling with AN is a frequently reported clinical feature and is often related to nutritional status rather than emotional disturbance. (Jääregui-Lobera, 2012). The alpha frequency band was diminished in amplitude among AN and BN subjects compared with controls. This pattern of diminished capacity to produce sufficient activity at lower frequencies indicates loss of balance in arousal management. The brain is engaging in purposeful responses to incoming stimulation and not successfully inhibiting or quieting the system. In short, hunger keeps you awake and anxiously thinking about how to get more calories. The perseverative nature of rigid preoccupation with food and body responses to consumption are common in patients with ED and maybe sequelae of this imbalance of neurophysiological arousal. Tammela (2010), in a study of Finnish women with binge eating disorder, found decreased inhibition of Beta activity in the QEEG recordings suggesting dysfunctional responses to food related stimuli.

While traditional NFT protocols utilize one or two separate EEG recording channels to conduct neurofeedback training, new approaches are incorporating 4, 8, 24 or more independent signal sources. The new protocols also measure significantly lower bands and provide instantaneous comparisons to normative databases and 3D models that more precisely indicate the dysregulated signals’ likely point of origin in the brain (Thatcher, 2010). The common application of simultaneous multi-channel recording permits normative comparisons of the person’s EEG rhythms utilizing one of a number of EEG databases. The database used in our clinical practice is based on NeuroGuide software and the Neurometrics database developed at NYU’s Dept. of Psychiatry (Prichep & John, 1988). This approach allows for monitoring and reinforcement of a larger number of variables in real-time and has been demonstrated to reveal aspects of brain function important to understanding a variety of neurologically-based disorders. The most advanced of these approaches is LORETA z-score neurofeedback training where training is focused on the current sources in the brain using inverse mathematical solutions (Thatcher, 2012). Early reports indicate that the LORETA-based neurofeedback is producing positive results in fewer sessions with a variety of clinical subpopulations. As of yet, however, no studies of ED using LORETA neurofeedback have been reported.

QEEG measures are used to both direct real-time neurofeedback training in our clinical practice and for optimizing psychiatric medication selection (Debattista et al., 2010). The neurofeedback training using instantaneous z-score feedback is the most recent advance in QEEG-based neurofeedback methods. Debattista and colleagues (2010, p. 135) concluded that “referenced EEG (rEEG) is a neurometric-based tool that might help bring objective data to the decision of drug choice instead of using the trial-and-error that characterizes the current pharmacotherapy of resistant depression.” A controlled study by Hatch (2010) used QEEG to assess differences among patients with AN and BN. Results of the comparisons of subjects with AN and normal controls indicated specific deficits in response times in those EEG bands (Theta and Alpha) associated with relaxed attention and the capacity to self soothe. One can also view the results in terms of the person’s available resources for differentiated response to incoming stimulation. The slowed response time decreases the amount of cognitive resources that can be brought to bear to evaluate a given input. The loss of capacity for making finer cognitive and sensory discriminations can be considered a functional characteristic, i.e., the observed loss of flexibility in behavioral and emotional responses, in this clinical population.

The researchers concluded that eating disorders are related to altered mechanisms of cortical neural synchronization: “There is likely a core, generic disturbance in AN in the early “automatic” neural processing of emotion irrespective of weight or nutritional status (Hatch, 2010, p.267).” The use of event-related potentials (ERPs), i.e., CNS-mediated reactions to novel audio or visual stimuli, to evaluate subjects’ cognitive responses to emotionally charged images can be used therapeutically by developing operant conditioning protocols to increase reaction times by normalizing the relevant dysregulated EEG activity.

Further analysis of EEG activity in ED patients may also reveal neurophysiological conditions including subclinical seizure (spiking) activity. In these cases, the use of anti-seizure medications has been shown to normalize EEG activity and reduce compulsive eating behavior. (Rau, Struve & Green, 1979) The importance of probing for previous head traumas, including administration of general anesthesia, can’t be overemphasized as these can significantly contribute to the development of obsessive-compulsive behaviors as compensatory to the traumatic brain injury (TBI) (Berthier, et al., 2001). QEEG assessment and neurofeedback training has been shown to remediate a number of TBI symptoms (Thornton & Carmody, 2009) and therefore can help remediate ED symptoms associated with TBIs.

More research is needed to more accurately identify the EEG biomarkers for specific EDs however, according to the most recent review of electroencephalography in eating disorders, Jääregui-Lobera notes a “…complementarity seems to exist between EEG and neuroimaging studies in terms of the study of overall functions, which are the result of an interaction among the different brain areas as well as the connections between them. In fact, eating disorders might reflect some disturbances of a system of interconnecting pathways or circuits in the brain.” (Jääregui-Lobera, 2011, p.11) These brain systems and networks are now being identified by techniques like
the QEEG and LORETA and are serving to refine existing operant conditioning-based therapeutic interventions for the entire spectrum of CNS-mediated neuropsychiatric conditions. These refinements in assessment are being leveraged by clinicians to improve treatment outcomes both in shortening treatment length (cost) and in actual symptom improvement for a larger percentage of clients. We have found that with the improved ease of NFT implementation, training can be conducted remotely via the internet, again greatly reducing treatment cost with no decrement in efficacy. The client learns to apply the electrodes, guided by the therapist watching via SKYPE and the training session is conducted by the therapist using remote control software to operate the client’s computer. Clients are also then able to conduct sessions on their own which again drives down cost and enhances training outcomes by increased frequency of sessions and thus sharpening the learning curve.

**SUMMARY**

Neurofeedback training now appears to represent a viable, safe, non-drug, cost effective alternative approach to modifying the neurophysiological activity in the brain that contributes to the specific cognitive processing, emotional and behavioral dysregulation of those struggling with eating disorders. Additional study is indicated to further refine the neurophysiological biomarkers and training design algorithms to optimize their integration within existing in-patient and outpatient therapeutic ED treatment programs.

**FURTHER RESOURCES**

Electroencephalography in eating disorders
- [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261648/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261648/)

**REFERENCES**


Sexual orientation has been identified as a specific risk factor in the development of eating disorders among men (Russell & Keel, 2002; Siever, 1994). Some studies indicate that between 20 percent (Andersen, 1999) and 42 percent (Carlat, Camargo & Herzog, 1997) of eating disordered males are gay or bisexual. When considering that 6 percent of the general male population is gay (Seidman & Reider, 1994), there appears to be evidence that gay males are disproportionately represented in the eating disordered male population. In addition, more than 15 percent of gay and bisexual males have struggled or are struggling with full syndrome or subclinical eating disorders (Feldman & Meyer, 2007). This clinical population, although relatively new with respect to research, deserves more attention from both a clinical and research perspective.

**THEORETICAL FRAMEWORKS FOR UNDERSTANDING SEXUAL ORIENTATION AND THE DEVELOPMENT OF EATING DISORDERS**

As researchers have investigated the role sexual orientation plays in the development of eating disorders, different theoretical frameworks have emerged to elucidate why gay men may struggle with a diverse set of pressures. This article highlights several of these main perspectives for understanding disordered eating in the gay community.

**Sociocultural perspective: Media influence**

Societal pressures and ideals have been shown to be powerful in decreasing body satisfaction in women (Thompson, et al., 1999). Additionally, media images have been a powerful predictor of a decrease in body satisfaction (Henderson-King, Henderson-King, & Hoffman, 2001). Leit, Pope, and Gray (2001) found that the ideal male body, as evidenced by BMI (body mass index) and FFMI (fat-free mass index) in Playgirl magazines from 1973-1997, has become increasingly muscular. Thus, men are surrounded by media images
portraying an increasingly unattainable body ideal.

Gay men may struggle with different pressures concerning media influence. Recently, researchers have attempted to understand the role of media influence on gay men’s body image and disordered eating behaviors. Carper, Negy, & Tantleff-Dunn (2010) found that gay men may have an increased vulnerability to media influence that might contribute to higher rates of eating disorders and body dissatisfaction within this group. Flip through the advertisements and images in magazines that cater to gay males and you will see “perfectly” sculpted (if not airbrushed) chests, arms, and chiseled abdominal muscles—the ever so sought after “six-pack.”

**Sociocultural perspective: Gay cultural influence**

In a journal article titled, “Out of the Closet and into the Gym: Gay Men and Body Image in Melbourne, Australia”, Duncan (2007) points out that the emphasis on physical appearance and body shape is blatantly evident in gay male culture. He goes on to describe “the scene” in which this is most observable, namely the “social networks and spaces that constitute gay social life” (Duncan, 2007 page 331). Ideal images among gay culture tend to be hyper-focused on a muscular body that is virtually free of fat, hairless, and often based on a Caucasian standard of beauty. Duncan (2007) conducted a qualitative study seeking an understanding of just how cultural ideals in the gay community affect gay men. After interviewing gay men of different ages and backgrounds, the nuanced nature of dealing with these idealized images emerged. Participants describe feeling marginalized in many aspects of their lives. One astutely pointed out that because of this feeling of marginalization, he wanted to strive to meet the ideal of his community. Another participant emphasized fitness and a muscular physique so as to not be identified as gay. The perspectives offered by these interviews illustrate how individuals are differentially impacted by ideal images in the gay community.

In a study by Tiggemann, Martinis and Kirkbride (2007), both gay and straight males identified the ideal male body as being both thin and muscular, with gay males desiring to be thinner and more muscular than their straight counterparts. Attempting to acquire muscle mass while remaining thin presents gay males with a rather difficult physical task, one that if not achieved could engender a negative reaction to one’s body and feelings of not measuring up to the gay ideal. This perceived failure, and the accompanying emotions, could be the tipping point for some in the gay community to develop an eating disorder.

The role of peers and relationship status and the pursuit of thinness in the gay community

Researchers have attempted to explore the reasons why gay men may place more emphasis on appearance than their heterosexual counterparts (Siever, 1994). One hypothesis is that the desire to attract other men is a primary motivator for emphasizing appearance. Studies suggest that men in general place more importance on appearance when selecting partners (Tiggemann, Martinis, & Kirkbride, 2007). Hosper and Jansen (2005) found that eating disorder behaviors in both gay and straight males were strongly linked to body dissatisfaction, with body dissatisfaction in gay males being strongly influenced by the opinions of their gay peers.

While single men may feel significant pressure to attain a certain ideal, perhaps men in relationships feel less concerned with appearance as they have secured a partner. Brown and Keel (2012) found that relationship status actually moderated the effect on disordered eating for men who were 30-40 years old. The moderation occurred only for drive for thinness and dieting frequency and not for bulimia. This finding supports previous literature that suggests men who are trying to attract partners (single men) may be at a higher risk for developing disordered eating than men who are in committed relationships. These findings seem important to keep in mind when working with gay men, as they are seeking partners who may feel physical appearance and attractiveness is crucial in a potential partner.

**Past experiences as risk factors**

When working with gay and bisexual males, it is important to consider certain past experiences that may be contributing to the development of eating pathology. Childhood sexual abuse appears to be a prevalent issue with the sexual minority male population. A study by Feldman and Meyer (2007) found that 53 percent of those men who identify as bisexual and 31 percent of those who identify as gay have a history of childhood sexual abuse. This same study also found a correlation between childhood sexual abuse and the development of eating disorders with gay and bisexual males. Clinicians working with this population should consider the possibility of past sexual trauma and how the eating disorder may be used as a way to manage intense negative feelings resulting from the sexual abuse.

Wiseman and Moradi (2010) found that, in sexual minority men, both childhood harassment for gender non-conformity and sexual objectification experiences were linked to eating disorders through high levels of body surveillance and body shame. As these authors explain, having been teased in childhood “for not being athletic or masculine enough” can lead to the individual closely monitoring his body (body surveillance) resulting in body shame and an increased risk for the development of an eating disorder (Wiseman & Moradi, 2010, p.156). A similar path exists for sexual objectification experiences where the individual receives inappropriate or unwanted sexualized comments, touches or gestures. As the authors illustrate, although an individual may initially respond favorably to being seen as sexually desirable, he may become over-focused on his body if his need to be sexually attractive is a primary source of self-esteem. He may be vulnerable to feelings of shame about his body and physical appearance if he fails to garner the same sexualized attention from others in the future. Shame and body dissatisfaction can markedly increase the risk for the development of eating disordered thoughts, feelings, and behaviors.
Other Considerations for Clinicians

When working with a gay man who is struggling with an eating disorder or body image issues, it behooves the treating clinician to be aware of other sexual orientation-related issues the gay client may be struggling with that could have an impact on the development of an eating disorder. These issues help create a context in which eating disordered behaviors occur and deserve attention from the treating clinician and the research community.

Internalized homophobia and shame

A study by Allen & Oleson (1999) found a “pronounced relationship between internalized homophobia and internalized shame,” suggesting that shame could be “the principle pathogenic factor in internalized homophobia” in gay men (Allen & Oleson, 1999, p.39). This study also verified the negative impact internalized homophobia has on the self-esteem of gay men (Allen & Oleson, 1999).

It is important for clinicians who work with gay males to recognize the pervasiveness of homophobic messages directed at gay men from the larger community—governments, faith organizations, corporations—and from their more intimate community of family and friends. When treating an eating disordered gay male, assessing for an internalization of these homophobic messages will help the clinician illuminate any shame and self-esteem issues the client may be experiencing and how the eating disorder is used as a coping mechanism to deal with the subsequent identity issues and strong negative emotions.

Coming out and gay identity development

Vivienne Cass’ (1979) theory on gay identity development serves as an excellent model of how gay men come to terms with their sexual identity. Cass describes six primary stages that gay men go through as they come out to themselves and others. The gay man’s identity struggle first begins with confusion and progress through other stages that involve identity comparison, tolerance, acceptance, pride, with the hope of eventual identity synthesis. Knowing where the eating disordered sexual minority client is in his development as a gay male will help the clinician identify the appropriate development tasks he may be struggling with and the possible functions the eating disorder may be serving the client at a particular developmental stage.

Feldman and Meyer (2007) found that younger gay males (18-29) are at a higher risk for developing eating disorders. This is important to know if you are a clinician who works with gay males in a college or university setting. For many gay males, the college years are the first time they feel safe to begin exploring their sexuality. During this new exploration they are also exposing themselves, maybe for the first time, to the different aspects of the gay socioculture (discussed above) that can possibly lead to body dissatisfaction and eating disorders at a time when they are entering the first stages of their gay identity development.

AIDS/HIV Status

This can be a tricky issue for clinicians, since the client may not have revealed his HIV status. However, if the positive status is known, then clinicians should consider the impact the disease, especially AIDS, and the medications used may have on the client’s body and any body image issues that may arise as a result.

CONCLUDING REMARKS

Knowing the various specific eating disorder risk factors present within the gay community and the more global issues which gay males experience is imperative in providing effective treatment. However, effective treatment must also be ethical treatment. When an eating disordered gay male enters your office, he brings with him much more than just issues associated with eating or exercising or body image. First and foremost, he is a gay male who needs to be accepted for who he is. He needs to feel safe to explore issues that include food and body image. He also needs to feel safe to explore issues that may, at times, be less about the eating disorder and more about his sexual orientation, a topic that can engender various reactions from clinicians. These reactions, regardless of what they may be, I believe, need to be honestly explored without judgment. For us to be ethical providers of care, we must know our own values and also our own limitations. We must provide a place for the gay client to feel valued.

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Until we are all free, none of us are free.

Emma Lazarus

As a psychotherapist who has specialized in body image issues and eating disorders for nearly 17 years, I have often felt the frustration that accompanies supporting clients in claiming their recovery while living in a culture that is actively working to undermine their progress. Our clients face a daily struggle to build or rebuild a community and find their voice in the face of issues of weight and size discrimination and the impossible beauty ideals.
As clinicians, we spend a great deal of time and energy helping our clients develop the skills and tools that they need to survive, then thrive, and maintain their recovery. We may prescribe food and feelings journals, support and therapy groups, and encourage them to rebuild their relationships to food and their bodies, to family and friends, all so that they are associating with people who are a positive influence on them. It is maddening to realize that all of these efforts are counteracted by media and cultural messages that shake their sense of self and their trust in their own bodies.

Recent writings have offered up a holistic view of what recovery can look like (Costin & Schubert, 2011) (Liu, 2011) (Cash & Smolak, 2012). In addition to the goal of attuned eating and an increased commitment to self-care, recovery means that a client has a new sense of well-being, which includes a “sense of purpose, empowerment, and meaning” (Liu, 2011). One day I realized that if one of my clients had a family member who was as single-minded about sabotaging their recovery (as are the media and advertising messages they hear every day), I would do whatever I could to make sure that my client’s exposure to this voice was limited or eliminated. And it was with this realization that I knew that in order to effectively do my work, I needed to blend my commitment to social justice with my clinical work. I have found that activism can fill that need for purpose and empowerment and provide our clients with a powerful antidote to the fear, isolation, and silence that often accompany eating disorders.

In addition to my private practice, I also work in the field of college public health at the University of Michigan where I founded and advise a group of student activists focused on body image and eating disorders. It was in this role that I first encountered the metaphor of “working upstream.” The idea is that when we are providing treatment and other interventions, we are working downstream, metaphorically standing on the edge of a rushing river, pulling people out of the water. At some point in this process, however, it is necessary to broaden our view and become curious about what is happening upstream that puts people at risk and tosses them into the river in the first place. When we acknowledge that eating disorders are not just a symptom of individual pathology but rather evidence of larger system of cultural bias towards a body ideal, therapeutic interventions aimed only at the individual client seem like an incomplete solution to a pervasive problem. Those in recovery from an eating disorder often look around and find little cultural support for their new way of thinking and being. We try to guide them through their experiences of weight, body shape, and eating in the midst of a culture that is obsessed with these issues. Despite our efforts, our clients are constantly being pulled closer to the banks of the river.

**DEFINING ED ACTIVISM**

Activism can be defined as the behavior of advocating for some social or political cause (for instance, protecting the environment, marriage equality, or in this case, eating disorders and body image issues) through a wide range of strategies and means (Corning and Myers, 2002). The options for eating disorder activism range from broad institutionalized acts such as starting a petition to more grassroots acts like protesting a product or media campaign. This definition is broad enough to encompass many different contents of activism and means of being an activist while at the same time focusing on the basic goal of improving society through political behavior. We found that activism was associated with higher psychological wellbeing, at least for conventional as opposed to high-risk activist behaviors, and that activists were more likely to flourish than were non-activists. (Musick & Wilson, 2008)

Typically, eating disorder activism has been seen as a tool of primary prevention, the idea being that we can work to head off the development of eating disorders by targeting the harmful messages that are aimed at vulnerable populations. However, less has been written about using it as a tool in recovery itself. In this case, the involvement in the process is, in itself, the desired outcome (Tartakovsky, 2012) (Maran, 2009).

The therapeutic power of activism has been studied in an array of venues and the findings show that activism has a positive impact on a multitude of factors, including mood, self-esteem, chronic pain, and PTSD (Arnstein, Vidal, Wells-Federman, Morgan, & Caudill, 2002) (Keyes, 2002) (Klar & Kasser, 2009) (Arnstein, 2010). Activism can serve as a powerful antidote to the feelings of powerlessness, hopelessness, and silence that accompany eating disorders. Activism is also one important way that people committed to prevention can model and facilitate respect and empowerment.

**ASSESSING CLIENT READINESS FOR ACTIVISM**

It is important to realize that not every client will be ready to engage in activism and we need to take care to gauge the appropriateness of prescribing social change work. When you are thinking about encouraging a client to engage in activism, it is important to assess their readiness. Someone who is early in the process may not have the extra energy to give, or they may not be ready to hear the messages themselves, let alone be in a position to be an outspoken ally. Their own personal recovery should remain their top priority and we should not ask them to engage in behavior that will be triggering or that could take the focus off of their own journey. For example, Jenna, a 19-year-old woman in treatment for anorexia, expressed an interest in joining the outreach component of the student group that I advise. It is not uncommon for group members to have their own history with eating and body image issues. In fact, their own experience is often what attracts them to the group’s work and it is part of what makes them such fierce advocates. I knew that Jenna was still working closely with her clinical team, had not yet reached her goal weight and still internalized the thin-ideal. I validated her wish to get involved and give back and expressed my concern with her being on the front lines delivering a message that she herself did not yet believe or embody. I knew from experience that her wish to be ready to be a part of the group and her actual level of readiness were not aligned
and her premature participation could jeopardize her progress and potentially harm our message to the rest of campus. However, I knew that her initiative to get involved came from a place inside her that wanted what the group had to offer and I wanted to honor that. I invited her to work with me individually as a volunteer in my office. Later in the year, after she had more time in recovery, we transitioned her into a more visible role in the group, and the other group members now see her as a mentor and leader.

The earliest actions that a budding activist may feel ready for are those that are more personal and private. Once clients have built some confidence and have grown more comfortable with their activist identity, they can choose to begin to engage in broader initiatives, activities, and campaigns that can impact social change on a larger scale. They can share their story publicly, or lobby government representatives to work for policy change in regards to insurance coverage for eating disorder treatment. It is important to make the point that not every client will be comfortable with the more visible and political level of work. There are, however, many other activities that can provide clients with opportunities for empowerment, healing, and transformation. If we think about opportunities for activist engagement on a continuum, we can help clients identify opportunities for engagement that fit their level of readiness and confidence, as well as their own personal communication styles. For example, a client may not feel ready to speak at a rally or other public forum, but they might feel ready to plan the rally behind the scenes or write a letter to the manufacturer of a specific product that engages in harmful advertising.

For example, Shirley Wang, a 17-year-old blogger at Proud2Bme.com recently lead the charge to remove the BMI calculator published in the magazine, Seventeen. Shirley, a young woman in recovery from anorexia, was angered that the magazine seemed to be going against its own “body peace pledge” by printing a chart that claimed that a BMI of 14.8 was in the healthy range for an 18-year-old. As she puts it quite succinctly on her blog: “Does that sound F*#ed up to anyone else, or is it just me?”

Activism can also be a useful tool to help empower parents. For example, a mother who lost her daughter to complications from ipecac abuse recently partnered with Families Empowered and Supporting Treatment of Eating Disorders (FE.A.S.T) and initiated a letter-writing and petition campaign via social media. The campaign was directed at the writers and producers of the television show, Glee, where one of the main characters on the show recommended that a young girl use ipecac as a weight loss method. The writers called upon the television network, FOX, to re-edit this scene or write in appropriate information about ipecac into the series.

**THE THERAPIST AS ACTIVIST:**
In addition to encouraging our clients to get involved in eating disorder activism, we can challenge ourselves to join them in the fight and work alongside them for change. I think there is a great deal of opportunity for these two tracks to converge in powerful and transformative ways.

It can be liberating for a client to hear that their struggles are not caused by his or her personal failings. Developing an awareness of how media messages and other social forces may have contributed to their pursuit of a physical ideal can help reduce feelings of shame and powerlessness. In this vein, a properly timed suggestion that a patient can speak out and push back against these messages can be an important part of a therapeutic strategy (Kupers, 1993). In session, we can brainstorm ways that we can work to change the systems that oppress and harm our clients. We can encourage our clients to think about the messages that they encounter on a daily basis. Sometimes, as in the case of a patient with an eating disorder, they have grown to mistrust their own voice and opinions and surrender the right to set healthy boundaries. When we invite our client’s strong feelings and advocate for their expression we are presented with the opportunity to serve as a model of someone who will not be silenced in the face of the stifling media messages and societal pressures, and also as someone who does not believe the despairing patient lacks agency in the real world (Kupers, 1993).

For many clinicians, the transition from therapist to activist is an uneasy one. Many struggle with the concept of neutrality and believe it is not appropriate for them as professionals to act aggressively as advocates or agitators—as if clinicians were expected to maintain a neutral stance in regard to social concerns. I argue that there can be no neutral stance in the face of social inequity; that inaction in the face of further disenfranchisement is a symptom of the mental conditions that bring clients to treatment. Terry Kupers (1993) also asserts that:

“while the lack of activism on the part of providers results not only from a vague notion about therapeutic neutrality, it can also stem from a serious case of burnout. In fact there is a parallel between the passivity and inaction of the providers and the consumers of public mental health services, the common denominator being a deep sense of powerlessness and despair.”

This feeling of burnout can be caused or compounded by the fact that we too are experiencing the pernicious and pervasive toxic messaging and it is easy to feel like our energies and efforts are barely making a dent. Activism can also be a tool for empowerment and renewal for the clinician.

To get started, clinicians and other ED professionals can approach their own involvement on a continuum. Here are some simple places to begin:

1. Take a look at the messages that exist in your office and your waiting room. Do you subscribe to health and beauty magazines or other material that promotes a beauty ideal or is splashed with photo-shopped images? Make a commitment to remove these items and then consider going one step further. Invite your clients to “speak out” in your waiting area. Post a sign letting them know you have made a commitment to creating a safe space. Let them know that if there are any remaining messages that they find offensive, they can rip out the pages, or grab a sharpie and “talk back.”
2. Work to reduce the stigma of having an eating disorder. A recent study on the University of Michigan campus revealed that the fear of being stigmatized was a strong deterrent to seeking help and a major contributor to the silence that surrounds eating disorders. Challenge yourself to speak out when you see biased, inaccurate, or sensationalized portrayals of body and weight issues or eating disorders in the media. Protest, coupled with praise and acknowledgement for companies that promote positive, realistic images of people helps to educate businesses and media outlets about ways that they can contribute to prevention efforts.

3. Join ED activist networks and learn how you can add your voice to others’ AGA and other groups have been successful in protesting and facilitating the removal of advertisements such as the Hershey Chocolate “You can never be too rich or too thin” campaign. Marilyn Wann, a member of the Association for Size Diversity and Health (ASDAH) initiated an amazing campaign called “I STAND against weight bullying” in response to billboards that targeted and shamed overweight children. The National Eating Disorders Association (NEDA) and the Binge Eating Disorders Association (BEDA) both have active advocacy arms that you can get involved with and add your voice to the conversation.

CONCLUSION

A client’s recovery is strengthened when they learn that they can actively resist the barrage of messages that tell them that they need to change themselves to fit some unrealistic and unhealthy images or ideals. We need to make a commitment to actively engage, confront, and critique the messages that we see, hear, and read (and think!). We need to challenge ourselves and others when we make or hear statements about size and the perceived imperfections in ours’ and others’ bodies. We need to seek help if necessary so that we get support as we learn how to confront these messages. In our vision of what it means to be an ally, we need to make sure that we are taking strides to create an inclusive community around body diversity.

I believe that body image dissatisfaction and eating disorders are social justice issues. Billions of dollars are being spent every year advertising weight loss methods, surgeries, and other to products to guarantee that we do not feel good about who we are and what we look like. It is estimated that we experience as many as 1500 ads per day (Maine, 2011). Right now, someone is sitting in a boardroom coming up with a strategy to get us to hate ourselves tomorrow and they are banking (literally!) on the fact that they will be successful. They know that as long as we are worried about our bodies we are not working together to make the change we need to see in the world. Imagine all the energy that we could funnel into other areas of our lives. Imagine what it could be like if we were able to harness this energy to join together to protest injustice and discrimination. In other words, we could change the world.

REFERENCES


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