


**INVISIBLE SEVERITY:  
TREATING EATING DISORDERS IN  
HIGH FUNCTIONING COLLEGE  
STUDENTS**

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**LEARNING OBJECTIVES**



Identify	Identify key features of high-functioning presentations of eating disorders in college-aged and emerging adult clients, including patterns of "invisible" severity that are frequently overlooked.
Apply	Apply a transdiagnostic framework to assessment and treatment planning for eating disorders, with attention to emotion regulation, identity development, and value-aligned decision-making.
Implement	Implement intervention strategies that move beyond insight development alone and reduce inadvertent reinforcement of eating disorder symptoms in well-intended clinical work.

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**A NOTE ON TODAY'S  
PRESENTATION**



This is a BIG topic to cover!

- We will cover a lot AND there will be so much more to do

Limitations in research in the eating disorder field

- Diagnostic overlap and fluidity
- Sampling bias
- Measurement limitations; self report
- Limited longitudinal data
- Intervention and treatment gaps
- Stigma
- Funding

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# COMPLEXITY ON CAMPUS

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# THE PERFECT STORM FOR COLLEGE STUDENTS



- Transitions/change can trigger on EDs
- Age of onset for EDs is usually teens & early adulthood
- Age of onset for many mental health disorders is early adulthood
- Difficulty with individuating & separating from the family
- Social Media & comparison
- Weight stigma & anti-fat biases
- College athletics
- Binge drinking culture
- Exploring identity
- Romantic relationships & dating

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# STATS



- Between 10 and 20% of women and 4 to 10% of men in college experience an eating disorder
- Only about 20% or fewer of the students who screened positive for an eating disorder reported receiving treatment
- Eating disorder risk among US college students increased substantially by 13 percentage points from 2013 to 2020/2021.

National Eating Disorders Association

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**Functioning ≠ Wellness**

High-functioning individuals with eating disorders often appear successful, composed, and in control, while privately experiencing significant distress and impairment. Functioning can mask severity.

**What “High-Functioning” Looks Like**

- Strong academic or career performance
- Reliable, organized, achievement-oriented
  - Socially engaged, often well-liked
- Seen as disciplined, motivated, “on top of things”

**External competence vs. internal struggle**

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**Eating Disorders Thrive in High-Functioning Contexts**

**Reinforcement of Traits**

- Perfectionism → praised as excellence
- Rigidity → seen as discipline
- Self-control → admired in academics, athletics, careers

Core eating disorder traits are socially rewarded

**Developmental Factors: Identity & Autonomy**

- Emerging adulthood involves:
  - Identity exploration
  - Increased independence
- Eating disorder behaviors can feel:
  - Like control
  - Like identity (“this is who I am”)

Symptoms can be ego-syntonic and harder to question.

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**Environmental Reinforcement on Campus**

- Irregular schedules (classes, studying, social life) disrupt eating patterns
- Dining halls, food insecurity, access
- Alcohol use can mask or complicate eating patterns
- Lack of supervision

The environment can both trigger and sustain symptoms.

**Societal Reinforcement**

- Cultural idealization of control and discipline
- Productivity culture & moralization of self denial
- Wellness culture as a socially acceptable mask
- Social comparison & digital reinforcement

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## MEDICAL STABILITY MYTH



"Medically stable" often means **no immediate crisis, not absence of risk**. This label frequently creates false reassurance and delays intervention

### "Normal" Labs Don't Mean Normal Functioning

- Standard labs can remain within range despite significant behaviors:
- The body compensates—until it suddenly can't
- Labs are a *lagging indicator*. By the time abnormalities appear, the disorder may be more entrenched or dangerous

### Weight Is NOT an indicator of severity

- Many students fall within or above "normal" BMI ranges
- Significant malnutrition can occur at any weight
- Weight suppression (being below one's natural set point) increases risk even if BMI looks "healthy"
- **Clinical trap:** Providers may miss diagnoses like Atypical Anorexia Nervosa because the student doesn't appear underweight

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## MEDICAL STABILITY MYTH



### Physiological Adaptation Masks Instability

The body adapts to prolonged under fueling:

- Lowered heart rate (bradycardia)
- Hormonal suppression (e.g., menstrual disruption)
- Reduced metabolic rate
- Altered electrolyte balance (sometimes still within range)

**Key point:** These adaptations are *signs of stress*, not stability

### Subclinical Signs Are Often Missed

Students may present with:

- Fatigue, dizziness, brain fog
- GI distress (bloating, constipation)
- Sleep disruption
- Increased anxiety or irritability
- Menstrual changes

These are often attributed to:

- "College stress"
- Anxiety/depression
- Poor sleep habits

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## THE DANGEROUS REALITY



### Eating Disorders have a high rate of mortality

- Medical Complications
- Suicidality

### Eating Disorders hide in plain sight

- You cannot "tell" if someone has an eating disorder by looking at them
- Normalization of behaviors such as dieting and exercising in our culture
- Denial, secrecy, lying, and shame accompany eating disorders
- Misinformation and stereotypes about:
  - The seriousness of the disorders
  - Who is affected



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## THE DANGEROUS REALITY



- Medical Complications
- Orthostatic vitals
- Cardiac arrhythmia, bradycardia
- Shortness of breath
- Dental Erosion
- Cold intolerance
- Osteoporosis/Osteopenia
- GI Issues (constipation, bloating, diarrhea)
- GERD
- Amenorrhea, abnormal menses
- Parotid gland enlargement
- Hormonal changes
- Gastroparesis
- Impaired immune system
- Abnormal lab values (potassium, sodium, magnesium, phosphorus)
- Seizures
- High blood pressure
- Fainting episodes, lightheaded, dizziness
- Perforated esophagus
- Blood in urine, stool, vomit
- Weight fluctuations, weight loss/gain

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## THE DANGEROUS REALITY



### **Underline** Suicide is the **second-leading cause of death among US college students**

- High-functioning students are not less suicidal—they are often **more concealed, more self-critical, and more capable of acting without detection**
- Discrepancy between external functioning and internal distress
- Conditional self worth and identity
- Profound loneliness can exist despite outward connection
- Suicidal thoughts may emerge as an *escape from perceived failure or inadequacy*
- Capability for suicide – high executive functioning and high ability to conceal intent

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## CLINICAL CHALLENGES



“High-functioning” clients often present with competence, insight, and stability on the surface, while the eating disorder remains ego-syntonic, reinforced, and deeply embedded.

### **Underline** Therapeutic Alliance Can Be Complex

- Clients may be:
  - Highly agreeable or compliant verbally
  - Privately resistant behaviorally
- Desire to “be a good client”
- **Clinical challenge:** Pseudo-alliance (appears strong but lacks depth or honesty)

### **Underline** Secrecy Is More Sophisticated

- Greater ability to:
  - Hide behaviors
  - Provide socially acceptable explanations
- Less likely to trigger concern from others
- **Clinical challenge:** Incomplete or distorted clinical picture. Balancing autonomy with clinical risk

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## CLINICAL CHALLENGES



### High Insight Can Mask Low Readiness

- Clients articulate patterns well:
  - "I know why I do this"
- Insight may not translate into behavioral change
- **Clinical challenge:** Risk of overvaluing insight as progress
- **Implication:** Focus on behavior change and experiential work, not just cognitive understanding

### Cognitive Rigidity and Perfectionism

- Black-and-white thinking
- Rule-governed behavior around food/exercise
- Fear of making mistakes
- **Clinical challenge:** Clients may try to "do recovery perfectly"
- **Implication:** Emphasize flexibility, process over outcomes, and tolerating imperfection

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## CLINICAL CHALLENGES



### Emotional Avoidance Is Subtle but Entrenched

- Use of control, structure, or numbing instead of overt dysregulation
- Emotions may be intellectualized rather than experienced
- **Clinical challenge:** Limited emotional processing despite verbal fluency
- **Implication:** Integrate experiential, somatic, and emotion-focused interventions

### Delayed Consequences Increase Entrenchment

- Lack of immediate negative consequences
- Reinforcement over time strengthens neural and behavioral patterns
- **Clinical challenge:** Less urgency for change
- **Implication:** Highlight long-term costs and patterns, not just immediate impact

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## TRADITIONAL APPROACHES MAY NOT WORK



High functioning clients may already have insight into

- Patterns
- Function
- Triggers
- Medical complications

High functioning clients may already have

- Therapeutic language
- Exposure to therapy and/or techniques



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**TRADITIONAL ASSESSMENT & SCREENING TOOLS**

**MAY NOT CAPTURE THIS POPULATION**

- EDI-3 Eating Disorder Inventory
- EDE-Q Eating Disorder Examination Questionnaire
- EDDS Eating Disorder Diagnostic Scale
- SCOFF Eating Disorder Questionnaire



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**A TRANSDIAGNOSTIC APPROACH**

Unify proven treatment principles to treat the same shared underlying problems that drive different emotional disorders



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**TREATING THE WHOLE PERSON: A TRANSDIAGNOSTIC APPROACH**




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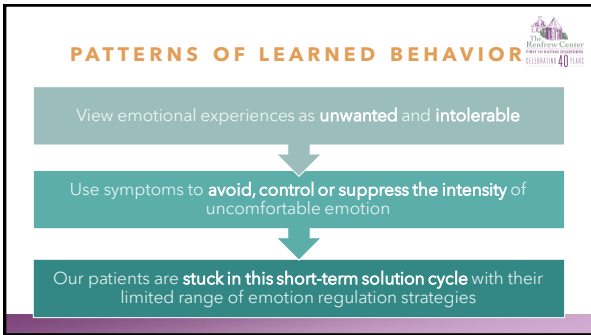
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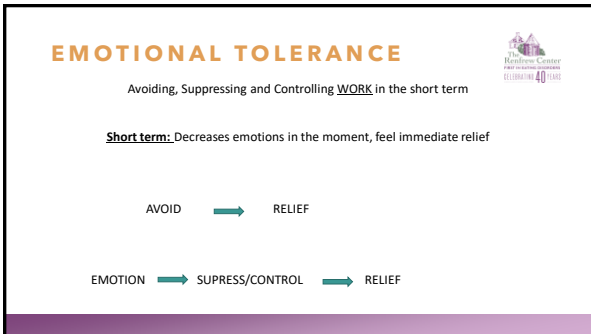
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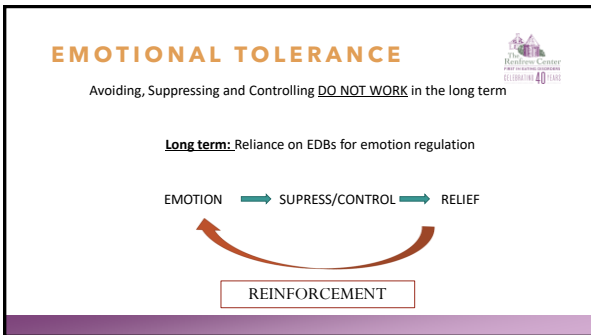
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## A TRANSDIAGNOSTIC APPROACH

High performance functions similarly to eating disorder behaviors

- Avoid negative affect
- Relief from negative affect

High functioning may not be an identity but a way of managing emotion – especially emotions about self



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## SCREENING & ASSESSMENT CONSIDERATIONS



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## ASSESSMENT CONSIDERATIONS

High functioning college students may present for:

- Anxiety
- Headaches
- GI issues
- Insomnia
- Inattention
- Relationship issues
- Stress



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## ASSESSMENT CONSIDERATIONS

**There is no single "look" to eating disorders**

The highest-risk students are often those least likely to be flagged

- **Underdiagnosis is common**  
→ Especially in:
  - Men
  - Students of color
  - Higher-weight students
  - LGBTQ+ students
- **Risk = intersectional**  
The most vulnerable students often sit at *multiple intersections*

**High Functioning & At Risk**

- Highly competitive universities
  - Athletes
  - Greek Life
- International & First Gen students
- Health & Pre-Professional Tracks
- Pre-med/Bio/Chem/Nursing/Dental
- Engineering/Computer Science
  - Business
- Pre-Law/Political Science
  - Performing Arts
  - Psychology

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## ASSESSMENT CONSIDERATIONS

- Screen everyone and anyone who presents for help
- Apparent "health" behaviors should not be used to rule out ED risk
- Screening for eating disorders is not 'done' at assessment
  - Assessing the relationship with food is ongoing
    - Gather information ongoing – listen for what is said and not said
  - We don't know what we don't know – especially about food and eating patterns
  - Building trust is vital to gaining access to information about food and body
- Addressing eating patterns and the relationship with food can be foundational work with anyone presenting for help – especially college students and emerging adults

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Criteria	Outpatient	IOP	PHP	Residential	Inpatient
<b>Medical stability</b>	Stable	Stable	Stable	Stable	Unstable
<b>Suicidality</b>	Low	Low	Low-moderate	Moderate	High risk
<b>BMI</b>	>85% IBW	>80% IBW	>75% IBW	~75% IBW	<75% IBW
<b>Motivation</b>	High	Moderate	Variable	Low	Very low
<b>Support system</b>	Strong	Moderate	Variable	Weak	Absent

**LEVEL OF CARE DECISION FACTORS**

ADAPTED FROM APA AND AED CRITERIA

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# TRANSDIAGNOSTIC INTERVENTIONS: ADAPTATIONS FOR HIGH FUNCTIONING CLIENTS



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## THE THERAPEUTIC RELATIONSHIP

**The most vital component of any therapeutic work**

Considerations for the therapeutic relationship with high functioning clients

- Respect the high functioning identity without unintentionally reinforcing it
  - Praise the person not the behavior: resilience vs success
  - Non performative stance
  - Avoid praising insight as progress or change
  - Respect capability while acknowledging cost
  - Avoid challenging or framing high functioning as avoidance too early

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## THE THERAPEUTIC RELATIONSHIP

<p><b><u>Collaborative &amp; Transparent</u></b></p> <ul style="list-style-type: none"> <li>• Explain what you are doing and why – as you are doing it</li> <li>• Share roadmap of treatment</li> <li>• Invite feedback</li> <li>• "Shoulder to Shoulder" approach</li> <li>• "Other side of the table" approach</li> </ul>	<p><b><u>Model Authenticity and Congruency</u></b></p> <ul style="list-style-type: none"> <li>• Clinician as an opportunity to witness balance between competency and humanness in action</li> <li>• Create safety to make mistakes, be vulnerable, be playful/silly</li> <li>• Asks more personally from clinicians to "be" the work while concurrently "doing" the work in session</li> </ul>
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## MEET THEM WHERE THEY ARE

Sequencing of interventions matters!

- Match their cognitive style
- Provide education: nutritional, medical and emotional
- Normalize ambivalence
- Explore and examine values and identity



THEN move to emotion exposure and distress tolerance



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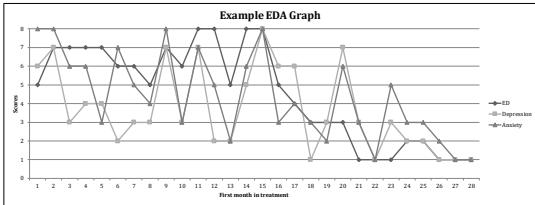
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## EDA: DAILY EATING DISORDER, DEPRESSION, AND ANXIETY FORM



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## UNIFIED STRATEGIES: DECISIONAL BALANCE



CONS (Reasons to stay the same)	PROS (Reasons to change)
Praise and attention from others	Physical appearance is compromised-always look tired, pale skin, swollen
Makes me feel productive	Would like to be social and go out with friends
I'm comforted by food. It's the only pleasure I have	I am unable to feel good, positive emotions
Boosts self-esteem	I want to be able to think about something else besides weight, food, calories, numbers
I like the way my body looks	My partner is worried about me
It's an excuse to get out of things	I want my personality back
Gives me routine and structure	I'm tired of hiding my body
Been doing it for so long, it's part of me	

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Message  
Today 16:56

**hey**  
Read 16:56

## COGNITIVE FLEXIBILITY

**Automatic appraisals:** Interpret information received as evidence to support core beliefs


**Reappraisals:** Asking yourself what else could be possible?

Intervention Example:

Have the client select images or videos from social media accounts or text message via his/her/their phone

Have the client identify automatic appraisals from the image/video/text

Have the client identify additional appraisals or interpretations



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## EATING DISORDERS ARE EMOTIONAL DISORDERS

Behavioral attempts to influence, change, or control painful emotional states

Function to regulate affect/provide momentary relief from aversive emotions

Therefore, recovery requires **experiential challenge** (doing things that have been habitually avoided) and reducing avoidance strategies

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## "THE ARC" OF AN EMOTIONAL EXPERIENCE

Date/Time	Situation or Trigger	Physical Sensations	Thoughts Physical Sensations	Behaviors/ Urges	What happens next?
	A		<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid #2E8B57; border-radius: 50%; padding: 5px; background-color: #2E8B57; color: white;">R</div> <div style="border: 1px solid #2E8B57; border-radius: 50%; padding: 5px; background-color: #2E8B57; color: white;">Thoughts</div> </div>		<b>Short C Long</b>

The 3-Component Model



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## VALUE-ALIGNED DECISION MAKING



### Short Term

- Temporary relief
- **Not aligned with values**

- Eating disorder behaviors
- Isolation
- Shutting down
- Reinforce core beliefs

### Long Term

- Uncomfortable in the short term
- **Aligned with values**

- Emotion regulation
- Self compassion
- Connection promoting behaviors
- Vulnerability

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### list of values

Accountability	Adventure	Artistic	Autonomy	Balance	Belonging	Bravery	Clear	Compassion	Confidence	Control	Cooperation	Courage	Curiosity	Flexibility	Forgiveness	Freedom	Generosity	Gratitude	Healthy	Honesty	Humor	Independence	Integrity	Kindness	Knowledge	Leadership	Learning	Logic	Love	Low-key	Modesty	Neatness	Order	Organization	Optimism	Openness	Peace	Perseverance	Playfulness	Power	Practicality	Respect	Responsibility	Resourcefulness	Reverence	Self-reliance	Seriousness	Social	Stability	Tradition	Trust	Unconventional	Uphold	Warmth	Wisdom	Wit	Youthfulness
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### Core Values

Adventure	Adventure	Authenticity	Balance	Belonging	Bravery	Clear	Compassion	Confidence	Control	Cooperation	Courage	Curiosity	Flexibility	Forgiveness	Freedom	Generosity	Gratitude	Healthy	Honesty	Humor	Independence	Integrity	Kindness	Knowledge	Leadership	Learning	Logic	Love	Low-key	Modesty	Neatness	Order	Organization	Optimism	Openness	Peace	Perseverance	Playfulness	Power	Practicality	Respect	Responsibility	Resourcefulness	Reverence	Self-reliance	Seriousness	Social	Stability	Tradition	Trust	Unconventional	Uphold	Warmth	Wisdom	Wit	Youthfulness
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Write your notes

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VALUES & EATING DISORDERS



But what if I value:

- Being thin?
- Being disciplined?
- Having control?
- Having willpower?
- My health?
- Belonging?
- Approval?



What if having an eating disorder is a part of my values?

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EATING DISORDERS, IDENTITY, SOCIAL ACCEPTANCE



Identity

- Eating disorders can become deeply intertwined with sense of self
- Diagnosis and symptom presentation can become descriptors of the individual
  - AN: Controlled, disciplined
  - BN: Out of control, impulsive
  - BED: Gluttonous, lack of will power
  - ARFID: Picky, child-like

Social Acceptance

- Human instinct and drive towards connection and acceptance from others
- Normalization ED behaviors and glorification of thinness
  - ED as a tool for social acceptance

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VALUES & EATING DISORDERS



- **Eating disorders are values-hijackers.** They often masquerade as values ("discipline," "health," "control"), but actually narrow life and pull you away from what truly matters—relationships, joy, purpose, and freedom.
- **Values help separate you from the ED.** When you clarify what you care about, it becomes easier to notice: *Is this choice aligned with my values—or with the eating disorder's rules?*
- **They support recovery even when motivation is low.** You don't have to want recovery every day. Values let you choose recovery-aligned actions because they move you toward the life you want, not because you feel ready or confident.
- **They shift the focus away from weight and appearance.** Values re-center recovery on quality of life—how you want to show up, what you want your energy to go toward, and what you don't want the eating disorder to keep stealing.

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# MOOD INDUCTION

- **Method:** using songs, images, film clips, and so on to invoke a powerful emotion
- **Purpose:**
  - Observe differences in level of comfort & discomfort
  - Notice when & what we do to escape those emotions
  - **Learn it is possible for the emotion to decrease in intensity on its own**




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# MOOD INDUCTION CONSIDERATIONS



- Variability in stimuli
- Gauge of intensity
  - Still picture alone
  - Still picture + music
  - Video
- Your own level of discomfort



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# MOOD INDUCTION RECORDING FORM



Stimuli (e.g., video clip, song, image)	Primary emotional response	Intensity (0-10)	Secondary emotional response	Intensity (0-10)
	Emotions: Thoughts: Physical Sensations: Behaviors/Impulses:		Emotions: Thoughts: Physical Sensations: Behaviors/Impulses:	

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**WHAT IS AN INTEROCEPTIVE EXPOSURE?**

Exercise designed to build tolerance of uncomfortable physical sensations

Blount, J., Anderson, L., & Anderson, C. (2015). Integration of interoceptive awareness training into treatment. *Clinical Psychology: Science & Practice*, 22(2), 194-200.

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**ED-SPECIFIC INTEROCEPTIVE EXERCISES**

Sensation/Symptom to be induced	Interoceptive exercise
Fullness, bloating, gastric functions	Gulping water or Pushing abdominal muscles out
Mechanoreception/tactile discomfort	Tight clothing or Tightening belt
Intense awareness of skin/body parts	Wet clothing
Feeling of body weight sinking into seat	Sit on very soft surface (pillows, bean bag)
Feeling of body, legs, buttocks "spread"	Sit on hard, flat surface

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**INTEROCEPTIVE EXPOSURE: STEP-BY-STEP**

Explanation    Anticipatory Anx    IE Exercise    Symptom Intensity    Distress

Using SUDs (0-10), rate client's level of anticipatory anxiety for the exercise

What do you feel in your body? How intense is that feeling? (0-10)

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## WHAT IF?

If the exercise is not producing the anticipated sensation or response, it is important to be curious and explore the following possibilities?

- Has tolerance already developed?
- Lack of similarity with personal experience of distress/intense emotionality?
- **Well-practiced in avoidance/disconnecting?**

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## ANCILLARY TREATMENTS

**Why These Work for High-Functioning Students**

**Ancillary therapies help by:**

- Interrupting over-intellectualization
- Engaging the body and emotions
- Creating *corrective experiences*, not just conversations
- Playing with perfectionism

**Common Pitfalls**

- Introducing too early → can feel vague or unsafe
- Not framing the purpose → high-functioning clients may dismiss as "fluffy"
- Moving too fast into body-based work (especially with EDs or trauma)

Somatic Therapy	Art Therapy
Psychodrama	Movement/Dance Therapy
Expressive Writing/Narrative Therapy	Music Therapy



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## INVISIBLE SUPPORT

The family system is often overlooked and underutilized in the treatment of college students and emerging adults

While parents are not always a part of daily life, many young adults are still dependents



- Financial

Emerging adults may be less likely to ask for help and reach out for support

- Developmental expectations

High functioning adults may be less likely to ask for help and reach out for support

- Identity
- Vulnerability

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## COMPLEX FAMILY PRESENTATIONS

Family members do not believe in mental health	Family members have active mental health symptoms	Family members actively engage in eating disorder behaviors
Family members hold beliefs consistent with weight stigma/bias/discrimination	Family members do not accept or acknowledge trauma history	Family members have participated in the experience of trauma
Family members do not accept or acknowledge identity or orientation	Family members are absent	Family members are over-involved



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## SPECIAL CONSIDERATIONS FOR CLINICIANS

In the absence of 'healthy' relational figures, the therapeutic relationship becomes even more vital

The Clinician and Therapeutic Relationship may have to serve as:

- The 'good enough parent'
- An attachment figure
- A bridge to building new or deepening existing relationships

Requiring Clinicians to be capable of:

- Consistency
- Unconditional positive regard
- Relational repair
- Boundaries



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When the rights of women and LGBTQ+ individuals are being threatened, gun violence is a weekly occurrence, and the state of democracy is being threatened but you got to go to work and pretend everything is ok.



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## CLINICIANS ARE OFTEN HIGH FUNCTIONING TOO



- Increased risk of transference and over-identifying
- Risk of assuming stability based on insight and competence
- Risk of under evaluating risk and urgency
- Risk of avoiding difficult/uncomfortable conversations
- Risk of keeping clients in lower levels of care
- Risk of not contacting family members / supports

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## CLINICIANS ARE HUMANS TOO

If we are uncomfortable with the emotion that a patient or situation is evoking, we may respond out of the desire to stop/avoid/manage our own emotions.

Are your clinical decisions and actions fueled by your need to change your emotional experience?

What emotions are you uncomfortable experiencing?

- Personally?
- Professionally?



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## INCREASING CLINICIAN AWARENESS

Date/Time	Situation or Trigger	Physical Sensations	Thoughts	Behaviors/ Urges	What happens next?
	A		Thoughts Physical Sensations		Short C Long

The 3-Component Model



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## INCREASING CLINICIAN AWARENESS



**Antecedents for Clinicians**

- Internal factors
- Environmental factors
- Systemic factors
- Historical

**Short vs Long Term for Clinicians**

**Short Term**

- Temporary relief

**Long Term**

- Uncomfortable in the short term
- Aligned with values

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## CARE FOR CLINICIANS - REMINDERS!



**Practice What We Preach As ED Professionals:**

- Nourish our bodies
- Drink water
- Go to the doctor
- Movement

**Personal Connection**

- Reciprocal relationships
- Authentic relationships
- THERAPY

**Professional Connection**

- Networking: Group and 1:1
- Trainings
- Consultation Groups
- Supervision

**You are the most valuable resource you provide your clients**

- Your humanness
- Your presence
- Your compassion
- Your ability to hold space
- Your unconditional care

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## QUESTIONS ? THOUGHTS ?

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## CONTACT INFORMATION



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For more information about The Renfrew Center's programs and services, please call **1-800-RENFREW (736-3739)** or visit [www.renfrewcenter.com](http://www.renfrewcenter.com).

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