iaedp™ Foundation

Atlanta Chapter

International Association of
Eating Disorder Professionals

Eating Disorders Information
&
Community Resource Guide

2020

Our mission is to promote a high level of professionalism among practitioners who treat individuals with eating disorders by promoting ethical and professional standards, offering education and training in the field, certifying those who have met prescribed requirements, promoting professional awareness of eating disorders and assisting in prevention efforts.

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A Message from Our President

Lauren Greenway, LPC, CPCS

Greetings!

Thank you for your interest in quality treatment of eating disorders.

The Atlanta Chapter of The International Association of Eating Disorders Professionals (iaedp) is a local non-profit chapter of the iaedp Foundation, which was established in 1985 to promote a high level of professionalism among eating disorder treatment providers.

Our Atlanta mission is to ***educate and connect healthcare professionals in the treatment of eating disorders***. We are excited to share this Community Resource Guide with you, in service of this mission!

This Community Resource Guide was developed by eating disorder experts on our chapter board in an effort to provide important and relevant information to treatment providers. Oftentimes, providers are at a loss of how to provide resources to those affected by eating disorders and we want to help in that endeavor. The Resource Guide provides reputable referral resources in the Atlanta area for individuals and families who are affected by eating disorders. It contains information about eating disorders and their treatment, local resources including chapter members, Certified Eating Disorders Specialists and free support groups, as well as a list of our generous sponsors who provide the means for us to achieve our goals.

We recognize that collaboration among treatment professionals is a key factor to treatment success and to ED prevention. Therefore, we encourage you to use this Community Resource Guide to connect and dialogue with professionals across healthcare disciplines.

We invite you to learn with us at our continuing education workshops and to connect with us at our networking events. Please visit our website at **www.atlantaiaedp.com** and our Facebook page: iaedp Atlanta Chapter to learn more. Please feel free to reach out to me or any iaedp Atlanta board member with questions or email us at **atlantaiaedp@gmail.com**.

We look forward to hearing from you!

Warm Regards,

Lauren Greenway, LPC, CPCS
President, iaedp Atlanta Chapter

A Message from Our Medical Liaison

Anna Tanner, MD, FAAP, FSAHM, CEDS

Greetings,

Physicians are uniquely positioned to help patients with eating disorders, yet very few have received significant training on how to do so. Most medical providers will encounter a patient with one of these illnesses. This Community Resource Guide offers providers information about managing the medical complications of this very ill population.

Eating disorders are extremely prevalent, affecting an estimated 10-12 million Americans. In addition, they are one of the most lethal psychiatric illnesses. Contrary to many stereotypes, eating disorders can affect patients at any age, males as well as females, and minority populations.

In all of the eating disorders, the medical complications are primarily due to the behaviors associated with that particular eating disorder. Thus, in patients with Anorexia Nervosa, the medical complications are primarily related to the effects of starvation on the whole body. In Bulimia Nervosa, the medical complications are primarily due to the method and frequency of purging. In patients with Binge Eating Disorder, medical complications are most often secondary to the obesity that accompanies this condition over time.

Within this guide are brief descriptions of eating disorders, a quick screening tool to be used when an eating disorder is suspected, and suggestions for the initial medical evaluation. In addition, Refeeding Syndrome is reviewed, a potentially lethal complication seen in some patients with very significant weight loss.

Most importantly, patients who present with medical symptoms that stem from eating disorder behaviors will not get well until the underlying eating disorder is correctly identified and treated. Since eating disorders are mental illnesses with medical complications, these patients need a multi-disciplinary team with experience treating eating disorders. Physicians can be an important part of this team. All patients with eating disorders will require psychotherapy, and most patients will need to work with a dietician and a psychiatrist. Many will need to attend group therapy and some will even require hospitalization at a center specializing in eating disorders.

The level of care required for each patient is determined by the severity of eating disorder thoughts and behaviors and the acuity of the medical illness. Both psychiatric and medical needs must be assessed and addressed for a successful outcome. This guide lists treatment professionals here in Atlanta with extensive training and experience in treating eating disorders and leading treatment facilities that sponsor our chapter.

We hope you find this resource guide useful, and please never hesitate to reach out to any of the iaedp members listed for further support and advice.

Thank you for joining us in our efforts!

Anna B. Tanner, MD, FAAP, FSAHM, CEDS Medical Liaison

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OVERVIEW OF EATING DISORDERS (ED)

WHAT ARE EATING DISORDERS?

Eating disorders have serious psychological, emotional, behavioral and medical problems. They involve extreme feelings, thoughts, and behaviors surrounding eating, food and body image. Eating disorders have serious consequences for physical and mental health, and they are potentially life-threatening. They impact millions of people in the United States.

WHO DEVELOPS AN EATING DISORDER?

The majority of people who struggle with eating disorders are teenage girls and young adult women. However, people of every age, race, gender and socio-economic status develop eating disorders as well.

Eating disorders do not discriminate.

- Individuals with anxiety, depression, low self-esteem and trauma and unhealthy coping mechanisms are at high risk of developing eating disorders.
- Eating disorders are more prevalent among girls and women.
- Millions of boys and men develop eating disorders.
- Prevalence is similar among all races in the United States.
- LGBTQ individuals are at particular high risk due to the cultural pressures they face.
- Adults in their 40s, 50s, 60s and even 70s struggle with eating disorders.

WARNING SIGNS

If you notice some of these warning signs, seek professional help immediately. The earlier a person with an eating disorder seeks treatment, the better the prognosis.

Prompt treatment significantly improves the chances of full recovery.

Warning Signs of Anorexia Nervosa	Warning Signs of Bulimia Nervosa	Warning Signs of Binge Eating Disorder
Significant weight loss	Large amounts of food disappearing	Significant weight gain
Preoccupation with weight, food, dieting and body image	Going to the bathroom after meals and noticing signs of vomiting	Eating large quantities of food in short periods of time
Refusing to eat certain foods	Presence of laxative packages	Eating until uncomfortably full
Commenting about feeling “fat”	Excessive exercising	Digestive problems
Avoiding meals and situations involving food	Unusual swelling of the cheeks or jaw area and dental problems	Feeling out of control of eating behaviors
Excessive exercising	Calluses on the back of the hands	Secretive eating
Irritability	Being self-critical and feeling guilty	Skipping meals and bingeing later
Being self-critical	Feeling overwhelmed and anxious	Feelings of shame, self-loathing and depression
Feeling “not good enough”	Preoccupation with dieting and body image	Eating before going out to eat
		Feeling overwhelmed and anxious
		Fear of feeling hungry

EATING DISORDERS TREATMENT

Eating disorders impact every aspect of well-being. **Emotionally**, suffering involves being chronically flooded by overwhelming feelings of shame, terror, self-loathing, hopelessness, rage and despair. These feelings are occasionally so unbearable that the individual chooses to die. **Psychologically**, individuals say they feel "crazy", because their logical mind is constantly bombarded by irrational thoughts and persistent obsessive thinking about food and body size. **Socially**, relationships are damaged due to avoidance of social activities that involve food, secretiveness, isolating, and the fears and frustrations of loved ones. **Medically**, health can be significantly compromised, sometimes causing irreversible damage and even death. **Spiritually**, faith is often shattered causing a loss of hope, joy, love of life, self-esteem and a sense of meaning. Eating disorders are all encompassing and complicated psychological diagnoses; therefore, getting appropriate treatment is critical for healing and recovery.

The first step in treatment is to obtain a comprehensive eating disorders assessment from a well-trained, experienced psychotherapist. The therapist should thoroughly evaluate all aspects of well-being as well as correlate the reported symptoms with the various eating disorder diagnostic criteria. By completing the comprehensive assessment, the therapist will understand the progression, severity, and duration of the problems; a diagnosis can then be assigned, if appropriate. A medical evaluation by a physician must also be completed to determine how and to what degree the eating disorder has impacted physical health. These findings are shared by the physician with the therapist. Once this is completed, the therapist can determine what level of care is needed and make an appropriate treatment recommendation based on the psychological assessment and medical findings.

There are several levels of care ranging from one or two hours of treatment per week to inpatient hospitalization. Individuals may move from one level of care to another depending on needs and progress. Outpatient care is recommended after hospitalization for continued healing and recovery. The following edited guidelines from the National Eating Disorders Association (NEDA - www.nationaleatingdisorders.org) describe the various levels of care and appropriate symptoms.

Outpatient Care: The patient is treated in individual psychotherapy at an outpatient therapist's office weekly or as frequently as the therapist determines is needed. In addition to psychotherapy, the therapist will help the patient form an outpatient treatment team that collaborates with the therapist. This team may include another psychotherapist who is providing group, couples or family psychotherapy, a psychiatrist, a dietician and a medical doctor.

- Medically stable and no need for daily medical monitoring
- Psychiatrically stable and able to function in everyday social, educational or work settings
- Making progress in recovery
- Healthy enough to be unsupervised the majority of the time

Intensive Outpatient Program (IOP): The patient is treated at a treatment center several times per week for a few hours at a time. This often involves process groups and some meal support. Typically, the patient is also seeing a therapist weekly as well as other professionals such as a psychiatrist, a dietician and a medical doctor.

- Medically stable and no need for daily medical monitoring
- Psychiatrically stable and able to function in everyday social, educational or work settings
- Making progress in recovery
- Stable enough to leave the treatment program at the end of each day

Partial Hospitalization Program (PHP): The patient is treated at a treatment center 5-7 days per week for most of the day. Group, individual and family therapy, and meal support are part of this treatment. A dietician, a therapist, a psychiatrist and a medical doctor are part of the treatment team.

- Medically stable
- Function is impaired but without an immediate risk
- Daily medical and mental status assessments needed
- Unable to participate in normal social, educational or work settings
- Engaging in daily eating disorder behaviors such as bingeing, purging, and restricting

Residential Treatment: The patient is treated at a treatment facility 24 hours a day, 7 days a week. Group, individual and family therapy, and meal support are part of this treatment. A dietician, a therapist, a psychiatrist, and a medical doctor are part of the treatment team.

- Psychiatrically impaired
- Unable to make progress at Outpatient, IOP or PHP levels of care

Inpatient Treatment Program (INP): The patient is treated on a medical support unit. This level of support provides medical stability, group therapy, individual and family sessions, as well as, meal support. A dietician, a therapist, a psychiatrist and a medical doctor are part of the treatment team.

- Unstable or depressed vital signs
- Laboratory results indicate acute health risk
- May have complications due to coexisting conditions such as diabetes
- Psychiatrically unstable and/or suicidal

Adjunctive Therapies: Outpatient treatment may include the following adjunctive therapies:

- Dialectical Behavior Therapy
- Yoga and Mindfulness Based Stress Reduction Therapy
- Art and Music Therapy
- Self-Esteem and Body Image Workshops

Free Support Groups: Support groups reduce shame, provide social connections and improve self-worth.

- ANAD: Anorexia Nervosa and Associated Disorders is a support group for patients and their families.
- EDA: Eating Disorder Anonymous is a 12-step support group, based on the principles of Alcoholics Anonymous.
- FED: Family and Friends of those with Eating Disorders is a support group for those in relationships with people who have eating disorders.
- For the days, times and locations of free community support groups see pages 29 to 31.

DIAGNOSITIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM) CLASSIFICATION SYSTEM FOR MENTAL ILLNESS

- The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), is the standard psychiatric reference used in the United States.
- The patient's symptoms and behaviors are compared with an established list of diagnostic criteria.
- The DSM is periodically reviewed and revised to reflect both social and scientific changes in the understanding of mental illness.
- The DSM-5, published in 2013, represents a "major overhaul" in format and content from the 4th edition (DSM-IV), published more than 20 years ago.
- Changes were made both within individual disorders and across the manual's organization to reflect the spectrum of clinical symptoms as they evolve over a life-span.

EATING DISORDER CLASSIFICATIONS IN DSM-5

- All disorders related to eating are grouped together in the ***Chapter on Feeding and Eating Disorders*.**
- Diagnostic criteria for the disorders most likely to begin in infancy are listed first; although age is no longer a defining feature of any of the disorders.
- All eating disorders display these characteristics:
    1. Disturbance of eating or eating-related behavior
    2. The behavior(s) result in the altered consumption or absorption of food
    3. Cause significant impairment in physical health or psychosocial functioning
- The classification scheme is "mutually exclusive" so that only one of the diagnoses can be assigned during a single episode. The exception is Pica, which can be diagnosed concurrently with another ED.

EATING DISORDERS LISTED IN THE CHAPTER ON FEEDING AND EATING

Pica: Specify if in remission

Rumination Disorder (RD): Specify if in remission

Avoidant/restrictive Food Intake disorder (ARFID): Specify if in remission

Anorexia Nervosa (AN)

- Specify if Restricting type or Binge-eating type
- Specify if in Partial remission or Full remission
- Specify current severity as Mild, Moderate, Severe, or Extreme

Bulimia Nervosa (BN)

- Specify if in Partial remission or Full remission
- Specify current severity as Mild, Moderate, Severe, or Extreme

Binge-Eating Disorder (BED):

- Specify if in Partial remission or Full remission
- Specify current severity as Mild, Moderate, Severe, or Extreme

Other Specified Feeding or Eating Disorders: Symptoms are characteristic of a feeding and eating disorder, cause significant distress or impairment in functioning but do not meet criteria for a specific ED.

- The reason full criteria are not met must be specified. Example: "bulimia nervosa of low frequency"
- See "Fact Sheet" on page 15 for more examples.

Other Unspecified Feeding or Eating Disorders: Symptoms are characteristic of a feeding and eating disorder, cause significant distress or impairment in functioning but do not meet criteria for a specific ED.

- Insufficient information is available for a "specified" diagnosis.
- Must document the "reason" for insufficient information, such as "Emergency Room Setting"

ANOREXIA NERVOSA (AN) FACT SHEET

ABOUT ANOREXIA NERVOSA (AN)

- Between 0.5–1% of American women suffer from AN with onset in early to mid-adolescence.
- Approximately 90-95% of AN sufferers are girls and women; the female-to-male ratio is 10:1.
- AN is the most common psychiatric diagnosis for adolescent girls.
- AN has the highest death rates of any mental health condition**.** Between 5-20% of individuals struggling with anorexia will die. The probability of death increases with the duration of the condition.

DEFINING CHARACTERISTICS OF AN

1. Restricted energy intake - unable to maintain a healthy weight or considerable and rapid weight loss
2. A fear of gaining weight - even when malnourished, starved or underweight
3. Distorted body image - see themselves as normal weight when they are really dangerously underweight
4. Subtypes:
   a. Restricting: Counting calories, skipping meals, restricting food groups, rigid thinking about food, obsessive thoughts and rules
   b. Binge Eating/Purging: Severe restriction of food quantity and engages in binge eating and/or purging
5. Severity Level: BMI in kg/m^2

   Mild: BMI >17 **Moderate**: BMI 16 – 16.99 **Severe**: BMI 15 – 15.99 **Extreme:** BMI <15

PHYSICAL SIGNS in addition to the defining characteristics:

- Loss or disturbance of menstruation in women/ decreased libido in men and women
- Fainting or dizziness; very slow heart rate
- Feeling cold most of the time
- Feeling bloated, constipated, and/or developing intolerance to certain foods
- Feeling tired and not sleeping well; Lethargy and low energy
- Fine hair (Lanugo) appearing on face and body
- Yellowing of skin due to high intake of vegetables (hypercarotenemia)

PSYCHOLOGICAL SIGNS

- Preoccupation with eating food, body shape, and weight
- Feeling anxious and/or irritable around meal times
- Self-esteem is highly dependent on their perception of their body shape and weight
- Intense fear of gaining weight, distorted body image and dissatisfaction with body image
- Unable to maintain a normal body weight for their age and height
- Depression and anxiety
- Reduced capacity for thinking and increased difficulty concentrating; all-or-nothing thinking
- Low self-esteem and perfectionism
- Increased sensitivity to comments relating to food, weight, body shape and/or exercise

BEHAVIORAL SIGNS

- Dieting behavior & radical changes in food preferences with obsessive rituals around food preparation and eating
- Deliberate misuse of laxatives, appetite suppressants, enemas or diuretics
- Repetitive or obsessive behaviors relating to body shape and weight (frequent body checking and weighing)
- Withdrawing from family and friends; avoiding meals with other people and eating in private
- Compulsive or excessive exercising
- Preoccupation with preparing food for others, recipes, and nutrition
- Self-harm, substance abuse, or suicide attempts

BULIMIA NERVOSA (BN) FACT SHEET

ABOUT BULIMIA NERVOSA (BN)

- BN affects 1-2% of adolescent and young adult women.
- Approximately 80-90% of BN patients are female.
- People struggling with BN usually appear to be of average body weight.
- Those struggling with BN recognize that their behaviors are unusual and dangerous to their health.
- BN is frequently associated with symptoms of depression and changes in social adjustment.
- Risk of death from suicide or medical complications is markedly increased for eating disorders.

DEFINING CHARACTERISTICS OF BN

1. Binge-Eating - Eating a very large amount of food within a relatively short period of time; Feeling a sense of loss of control while eating
2. Inappropriate Compensatory Behavior (purging)
3. Vomiting, misusing laxatives or diuretics, fasting, excessive exercise, use of any drugs (illicit, prescription and/or over the counter) inappropriately for weight control
4. Frequency of binge-eating/purging behavior is at least one time per week for 3 months
5. Self-Evaluation is unduly influenced by body shape or weight
6. Severity Level: Based on the frequency of inappropriate compensatory behaviors per week:

   Mild: 1 to 3 **Moderate**: 4 to 7 **Severe**: 8 to 13 **Extreme:** 14 or more

PHYSICAL SIGNS in addition to the defining characteristics:

- Frequent changes in weight (loss or gain)
- Signs of damage due to vomiting including swelling around the cheeks or jaw, calluses on knuckles, damage to teeth and bad breath
- Feeling bloated, constipated or developing intolerances to food
- Loss of or disturbance of menstrual periods in girls and women
- Fainting or dizziness
- Feeling tired and sleep disturbances

PSYCHOLOGICAL SIGNS

- Preoccupation with eating, food, body shape and weight
- Sensitivity to comments relating to food, weight, body shape and/or exercise
- Low self-esteem, feelings of shame, self-loathing or guilt, particularly after eating
- Having a distorted body image and extreme body dissatisfaction
- Obsession with food and need for control
- Depression, anxiety or irritability

BEHAVIORAL SIGNS

- Evidence of binge eating and purging as listed in “defining characteristics”
- Those with diabetes mellitus may omit or diminish insulin to reduce metabolism of food
- Frequent trips to the bathroom during or shortly after meals which could be evidence of vomiting or laxative use
- Secretive or erratic behavior around food; eating in private and avoiding meals with other people
- Dieting and/or repetitive or obsessive behaviors relating to body shape and weight
- Self-harm, substance abuse or suicide attempts

BINGE-EATING DISORDER (BED) FACT SHEET

ABOUT BINGE-EATING DISORDER (BED)

- The prevalence of BED is estimated to be approximately 1-5% of the general population.
- Binge-eating disorder affects women slightly more often than men; ratio of 60% women and 40% men.
- BED is equally distributed among females from all racial and ethnic groups.
- People who struggle with BED can be of normal weight or heavier than average weight.
- Most obese individuals do not engage in binge-eating.
- Compared with weight-matched obese individuals without BED, those with BED: consumed more calories, had more functional impairment, lower quality of life, more subjective distress and greater psychiatric comorbidity.
- Cross-over from BED to another ED is uncommon.
- Dysfunctional dieting often follows the onset of BED (as opposed to BN where dysfunctional dieting precedes BN).

DEFINING CHARACTERISTICS OF BINGE-EATING DISORDER (BED)

1. Recurrent episodes of binge-eating are characterized by consuming a very large amount of food within a relatively short period of time (2 hours), and feeling a sense of loss of control over eating.
2. The binge-eating episodes are associated with at least 3 of the following:
   a. Eating much more rapidly than usual
   b. Eating until feeling uncomfortably full
   c. Eating large amounts of food when not feeling physically hungry
   d. Eating alone because of embarrassment due to large amount of food being consumed
   e. Feeling disgusted, depressed or very guilty afterward
3. Binge-eating occurs on average, at least 1 time per week for 3 months
4. Severity level: The number of binge-eating episodes per week:
   Mild: 1 to 3 **Moderate**: 4 to 7 **Severe**: 8 to 13 **Extreme**: 14 or more
5. Partial Remission: Binge-eating episodes occur on average less than 1 episode per week for a sustained period
6. Full Remission: No criteria have been met for a sustained period

PHYSICAL SIGNS

- Feeling tired and not sleeping well
- Feeling bloated, constipated or developing intolerances to food

PSYCHOLOGICAL SIGNS

- Preoccupation with eating, food, body shape and weight
- Extreme body dissatisfaction and shame about their appearance
- People struggling with BED often express distress, shame and guilt over their eating behaviors
- Low self-esteem
- Depression, anxiety or irritability

BEHAVIORAL SIGNS

- Evidence of binge-eating (e.g. disappearance or hoarding of food)
- Secretive behavior relating to food (e.g. hiding food and food wrappers around the house)
- Increased isolation and withdrawal from activities previously enjoyed
- Erratic behavior (e.g. shoplifting food or spending large amounts of money on food)
- Self-harm, substance abuse or suicide attempts

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID) FACT SHEET

ABOUT AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID)

- ARFID replaces and extends the DSM-IV diagnosis of Feeding Disorder of Infancy and Early Childhood.
- Prevalence rates for ARFID range from 8% to 14% in an eating disorder treatment setting.
- ARFID can be diagnosed in children, adolescents and adults.
- Individuals with ARFID can have other psychiatric disorders such as anxiety disorders, OCD, autism spectrum disorder, ADHD and intellectual disability.
- Although ARFID is generally more common in females, males with ARFID have a higher incidence of autism spectrum disorder.

DEFINING CHARACTERISTICS OF ARFID

1. Persistent pattern of disordered eating or feeding can be characterized by:
   a. Lack of interest in food or poor appetite
   b. Fears about negative consequences of eating (e.g., vomiting, choking, allergic reaction)
   c. Selective or picky eating, often based on sensory characteristics of food (smell, texture, color of food, taste)
2. The pattern of disordered eating is also accompanied by at least one of the following:
   a. Significant weight loss or failure to gain weight/grow as expected
   b. Nutritional deficiency (e.g., anemia)
   c. Dependence on nutritional supplements or tube feeding
   d. Significant interference with psychosocial functioning
3. The disturbance is not related to body image distortion or fear of weight gain

PHYSICAL, PSYCHOLOGICAL & BEHAVIORAL SIGNS

- Restricted or reduced intake accompanied by frequent somatic complaints (e.g., pertaining to bodily symptoms and discomfort) with no apparent cause
- Lack of appetite or interest in food
- Expressed fears of choking or vomiting associated with reduced intake or refusal to eat meals or snacks
- Inability or reluctance to eat in front of others (e.g., at school, at a friend's house, in a restaurant)
- Picky eating that is unresolved by late childhood
- Limited range of preferred foods becomes narrower over time (e.g., picky eating that progressively worsens)

HEALTH CONSEQUENCES

- Increased risk for "failure-to-thrive" (not meeting expected standards of growth) due to inadequate nutritional intake. Many individuals with ARFID have stunted growth or have fallen off their growth curves for weight and height.
- Nutritional deficiencies (e.g., anemia or iron deficiency) and malnutrition which may be characterized by fatigue, weakness, brittle nails, dry hair/hair loss, difficulty concentrating and reduction in bone density.
- Weight loss or severe underweight.

PICA FACT SHEET

ABOUT PICA

- Pica involves eating nonnutritive, nonfood substances in sufficient quantity to warrant clinical attention; examples include chalk, paper, dirt, glass, plastic, soap, feces and so on.
- The word "*nonfood*" was added to the DSM-5 to exclude "diet" products with minimal nutritional value.
- This behavior is considered "*age-inappropriate*" in children older than 2 years old to exclude normal mouthing of objects by infants.
- The behavior usually begins by the age of two, and remits during adolescence or the correction of the underlying problem (iron or mineral deficiency).
- Risk factors include neglect, lack of supervision and developmental delays.

DEFINING CHARACTERISTICS OF PICA

1. Persistent and compulsive eating of nonnutritive, nonfood substances for a period of at least 1 month.
2. Eating behavior is inappropriate to the developmental level of the individual; not part of a culturally supported or socially normative practice.
3. If occurring with another disorder, it is severe enough to warrant independent clinical attention.

SYMPTOMS & HEALTH CONSEQUENCES OF PICA

- Abdominal pain with potential for intestinal obstruction. Note: a tightly packed collection of indigestible substances is called a *bezoar* and often require surgical removal.
- Infections such as toxoplasmosis and toxocariasis from ingestion of feces or soil
- Significant malnourishment may occur in extreme cases
- Pica has been associated with deficiencies in vitamins or minerals (iron, zinc). Pagophagia (ice-craving) is a symptom of iron deficiency.
- Pregnant woman can develop pica associated with the ingestion of chalk or ice.

DIFFERENTIAL DIAGNOSIS

- **Anorexia Nervosa**: If the consumption of the nonnutritive, nonfood substance is primarily used as a means of weight control (consuming tissue paper), anorexia should be listed as the primary diagnosis.
- **Factitious Disorder**: Individuals may ingest foreign objects to falsify physical symptoms.
- **Nonsuicidal self-injury**: Individual may ingest harmful items (pins, glass, knives) in the context of maladaptive behavior patterns, often associated with personality disorders.

CO-OCCURRING DISORDERS

- Autism spectrum disorder, schizophrenia, and intellectual disabilities
- Obsessive-compulsive disorders, especially trichotillomania (hair-pulling disorder) or excoriation (skin picking disorder) if the hair or skin is ingested

MORE INFORMATION

- The term pica is derived from the magpie, a black and white bird in the *genus* Pica. Magpies appear to be eating mud (although they do not) in the process of making nests.
- Across many cultures and going back as far as 4,000 years ago, humans have chewed and swallowed clay, possibly due to the putative detoxifying effects of clay and micronutrients absorbed from clay.
- Prior to the ban on lead based paint in 1978, children in low-income housing developed high rates of lead poisoning due to ingestion of lead paint chips. The pica was associated with iron deficiency anemia.

RUMINATION DISORDER FACT SHEET

ABOUT RUMINATION DISORDER

- Rumination disorder is the persistent regurgitation of food.
- The partially digested food is brought up into the mouth without nausea, involuntary retching, or disgust, and then is re-chewed, re-swallowed or spit out.
- Frequent regurgitation is defined as several times per week but typically occurs daily.
- Infants: Associated with straining and arching of the back while making sucking movements with their tongue.
- Infants, older individuals with intellectual disability or neurodevelopmental disorders: The rumination behavior is thought to have a self-soothing or self-stimulating function, similar to repetitive behaviors such as head banging.
- Older children, adolescents, adults with the disorder tend to be secretive out of embarrassment. They will disguise the behavior by putting their hand over their mouth and coughing, or restrict their intake because of social undesirability of regurgitation.

DEFINING CHARACTERISTICS OF RUMINATION DISORDER

1. Repeated regurgitation and re-chewing of food for a period of at least 1 month following a period of normal functioning
2. Behavior is not due to an associated gastrointestinal or other general medical condition (such as esophageal reflux)
3. Behavior does not occur exclusively during the course of another ED such as AN, BN, BED or ARFID
4. If occurring with another mental disorder such as mental retardation or a pervasive developmental disorder, it is severe enough to warrant independent clinical attention.

ONSET - INCIDENCE

- **Infants**: Age of onset is between 3 and 12 months; the behavior typically remits spontaneously; significant malnutrition can occur, especially if food is expelled, with mortality rates as high as 25%.
- **Older Children, adolescents and adults**: In the absence of intellectual disability, the incidence in the older children, adolescents and adults is rare.

SYMPTOMS

- Failure-to-thrive
- Malnutrition
- Bad breath
- Weight loss
- Stomach diseases
- Aspiration pneumonia
- Choking

DIFFERENTIAL DIAGNOSIS

- Gastrointestinal disorders (pyloric stenosis, gastroesophageal reflux) or other medical conditions associated with regurgitation

OTHER SPECIFIED FEEDING OR EATING DISORDERS (OSFED) FACT SHEET

USE THIS DIAGNOSIS WHEN

- Presenting symptoms are characteristic of a feeding or eating disorder but do not meet full criteria for any specific feeding or eating disorders
- Clinician documents the reason the presentation does not meet full criteria. For example, other specified eating or feeding disorder; bulimia nervosa of low frequency

EXAMPLES OF OTHER SPECIFIED FEEDING OR EATING DISORDERS

- **Atypical AN:** Significant weight loss occurs over a short period of time and has no medical cause, but the individual's weight is within or above the normal range; all other criteria for AN are met.
- **BN (of low frequency or limited duration):** All of the criteria for BN are met, except that the binge-eating and inappropriate compensatory behavior occurs, on average, less than once a week and/or for less than 3 months.
- **BED (of low frequency and/or limited duration)**: All of the criteria for BED are met, except that the binge-eating occurs, on average, less than once a week and/or less than 3 months.
- **Purging disorder**: Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting, misuse of laxatives, diuretics, or other medications, and excessive exercise) in the absence of binge-eating.
- **Night eating syndrome**: Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumptions after the evening meal. There is awareness and recall of the eating, and the night-eating is not better explained by changes in the individual's sleep-wake cycle or by local social norms; not due to the effect of medication.

UNSPECIFIED FEEDING OR EATING DISORDERS

USE THIS DIAGNOSIS WHEN

- Presenting symptoms are characteristic of a feeding or eating disorder but do not meet full criteria for any specific feeding or eating disorders
- If there is insufficient information to make a more specific diagnosis, document the situation. For example, other unspecified eating or feeding disorder; Emergency room setting

MEDICAL EVALUATION & COMPLICATIONS OF PATIENTS WITH EATING DISORDERS

Eating disorders affect up to 5% of women but often go unrecognized in medical settings. Minorities, men and older individuals are even more likely to elude detection. Why? Because medical professionals, like most people, tend to stereotype the appearance of a person with an eating disorder and fail to recognize eating disordered symptoms in individuals with a normal weight. Also, psychological characteristics such as lack of self-awareness, denial, secrecy and shame make self-reporting unlikely. Those with eating disorders are likely to seek treatment for physical symptoms without revealing the emotional turmoil that fuels their peculiar relationship with food. Despite these obstacles, physicians are uniquely positioned to identify patients at high risk of developing eating disorders or those in the beginning stages of the disease process. Early detection and intervention is crucial because it can significantly improve the likelihood of full recovery. Within this guide are brief descriptions of eating disorders, a quick screening tool to be used when an eating disorder is suspected, suggestions for the initial medical evaluation and a reminder of those patients most likely to be a risk for Refeeding Syndrome.

SUMMARY OF ESSENTIAL FACTS ABOUT EATING DISORDERS

- They are prevalent – millions suffer secretly
- They are serious medical and psychiatric illnesses – not a choice OR self-inflicted illness
- They are lethal – with the highest mortality rate of all psychiatric disorders
- They have no stereotypical look – a person does not need to "look like they have an eating disorder" to be very ill
- They are secretive – so ask questions
- They do not have to become life-long struggles; full recovery is possible with early detection

COMMON PRESENTING SYMPTOMS

- Excessive concern over weight with reluctance to being weighed
- Inappropriate dieting
- Pattern of weight loss or weight gain
- Amenorrhea
- Failure to achieve appropriate increases in height or weight in a growing child
- Check the **fact sheet** in the prior section for specific symptoms of each disorder.

INITIAL MEDICAL ASSESSMENT

→ **History** – Initial risk assessment should include the following:

1. The types, timing and pattern of eating disorder behaviors (restriction, vomiting, laxatives, exercise, withholding insulin, and so on)
2. The duration of past and recent eating disorder behavior (usually the longer the duration, the more damage is possible)
3. The severity of expression of the behavior (vomiting 10 times a day is more severe than twice a day, but using a toothbrush to do so may be more serious)

→ **Screening** The **SCOFF** Questionnaire is a 5-question screening tool designed to clarify suspicion that an eating disorder may exist. An answer of 'yes' to two or more questions warrants further assessment.

S: Do you make yourself **S**ick because you feel uncomfortably full?
C: Do you worry because you have lost **C**ontrol over how much you eat?
O: Have you recently lost **O**ne stone (about 15 pounds) in a 3-month period?
F: Do you believe yourself to be **F**at when others say you are thin?
F: Would you say **F**ood dominates your life?

- ✓ When screening for Bulimia and BED, two additional questions have been added:
  1. Are you satisfied with your eating patterns?
  2. Do you ever eat in secret?

→ **Suggestions for asking about weight and dietary habits**

1. Weight: *What would you like to weigh*?
   A desired maximum weight below BMI 19 suggests anorexia.
2. Dietary Habits: *Tell me what you eat at each meal on a typical day.*
   For both AN and BN, the typical day consists of skipped meals, limited food choices, food choices low in fat; binges are secretive and involve high calorie foods with a sense of loss of control over eating, and patients are unlikely to reveal a binge due to secrecy and shame.

→ **Obtain Objective Data**

- ✓ Height, weight, BMI
- ✓ Oral temperature
- ✓ Orthostatic vital signs

→ **Laboratory evaluation for all patients**

- ✓ Complete blood count (CBC)
- ✓ Comprehensive metabolic panel (CMP), phosphorous, calcium and magnesium
- ✓ Urinalysis
- ✓ Thyroid Function Tests

→ **Laboratory evaluation for select patient conditions**

→ **If significant or suspected self-induced emesis**:
- ✓ Amylase and lipase

→ **If significant weight loss, bradycardia, syncope or electrolyte abnormalities**:
- ✓ Electrocardiogram (EKG)

→ **For any male patient and all female patients with amenorrhea over 6 months**:
- ✓ Bone densitometry (DEXA)

→ **For females with amenorrhea also consider**:
- ✓ Pregnancy test (urine HCG)
- ✓ Consider luteinizing hormone (LH), follicle stimulating hormone (FSH), prolactin and estradiol

→ **If possible malignancy or inflammatory bowel disease**:
- ✓ Erythrocyte sedimentation rate (ESR)
- ✓ Consider immune globulin A and serum tissue transglutaminase (TTG)

COMMON PHYSICAL FINDINGS IN PATIENTS WITH AN EATING DISORDER

The medical complications seen are primarily due to the behaviors associated with that particular eating disorder. The following list reviews the potential organ system consequences of eating disorder behaviors.

1. Electrolyte Abnormalities

- Hypoglycemia may be starvation-related in anorexia nervosa
- Hyponatremia may result from excessive water intake, a behavior often used to suppress appetite and increase satiety, or to artificially inflate weight gain
- Hypophosphatemia may be detected on initial evaluation following weight loss, and is a dangerous complication of refeeding syndrome
- Hypokalemia can be a sign of regular self-induced vomiting, laxative abuse, or diuretic abuse

2. Gastrointestinal Symptoms

- Functional gastrointestinal disorders are common in individuals with eating disorders
- Delayed gastric emptying and slowed whole gut transit times are common in anorexia nervosa
- Gastrointestinal reflux disease (GERD), Mallory Weiss tears, bilateral parotid gland enlargement, dental caries and enamel erosion are all associated with self-induced vomiting
- Elevated transaminases can be associated with starvation and also seen during refeeding
- Rectal prolapse and hemorrhoids can be due to laxative abuse

3. Gynecologic and Obstetric Changes

- Hypothalamic amenorrhea and infertility are common with anorexia nervosa
- Pregnancy complicated by poor weight gain, intrauterine growth retardation or hyperemesis gravidarum may be seen in individuals who purge by vomiting
- Rapid postpartum weight loss due to excessive breast pumping has been reported

4. Neurological Presentation

- Syncopal episodes due to fluid restriction or diuretic or laxative abuse
- Complaints of headaches are common
- Seizures can occur due to hypoglycemia or hyponatremia
- Wernicke-Korsakoff's syndrome has been reported

5. Cardiac Symptoms

- Bradycardia with a heart rate of 50 or lower can occur with anorexia nervosa
- Orthostatic hypotension or orthostatic tachycardia
- Mitral valve prolapse associated with atrophic cardiac muscle can occur with severe starvation
- Arrhythmias secondary to electrolyte abnormalities

6. Endocrine Abnormalities

- Hypothalamic amenorrhea and infertility, as well as osteoporotic fractures are complications of anorexia nervosa
- Sick euthryoid is seen in anorexia nervosa with low T3 and rT3, TSH and T4 may also be suppressed
- Hypercortisolemia due to starvation related activation of the HPA axis is common in anorexia nervosa
- Ketoacidosis in a diabetic may reflect purging by under-dosing insulin or insulin omission in order to waste calories

7. Hematological Indicators

- Anemia, leukopenia and thrombocytopenia are common in anorexia nervosa

8. Comorbid Psychiatric Conditions

- Anxiety disorders, major depressive disorder and substance abuse are comorbid with eating disorders

9. Renal Complications

- Renal failure can occur with laxative and diuretic abuse.
- BUN may be low due to low protein intake

10. Opportunistic Infections

- Anorexic patients with severely low BMI can develop mycobacterial infections and aspergillosis

IMPORTANT FACTS TO REMEMBER

- **Rapid weight loss** due to infection or other medical conditions affect the body differently than the slow weight loss due to AN.
- **Weight loss** with AN occurs over months of limiting energy intake and/or increasing energy expenditure; this enables metabolic adaptations that affect the interpretation of biochemical and other indicators of malnutrition.
- Laboratory values may appear normal initially but can change suddenly if refeeding is too aggressive.
- The glucose load that occurs with refeeding increases insulin release which can produce shifts of phosphate and potassium into the cell.
- **Extracellular serum phosphate and potassium** then decrease quickly causing cardiac arrhythmias.
- This rapid shift in fluid and electrolytes is known as **refeeding syndrome.**

REFEEDING SYNDROME

- Potentially fatal shifts in fluids and electrolytes can occur in malnourished patients receiving enteral or parenteral refeeding.
- The hallmark symptom of refeeding syndrome is **hypophosphatemia.**
- Abnormal sodium and fluid balance, changes in glucose, protein and fat metabolism, thiamine deficiency, hypokalemia and hypomagnesaemia have also been reported.

CHARACTERISTICS OF PATIENTS AT HIGH RISK OF REFEEDING SYDROME

ANY ONE of the following:

- ✓ BMI <16
- ✓ Weight loss >15% in the previous 3-6 months
- ✓ Little or no nutritional intake for >10 days
- ✓ Low levels of potassium, phosphorous or magnesium before refeeding

ANY TWO of the following:

- ✓ BMI <18.5
- ✓ Weight loss of >10% in the previous 3-6 months
- ✓ Little or no nutritional intake for >5 days
- ✓ History of alcohol abuse or drugs including insulin, chemotherapy, antacids
- ✓ Diuretics

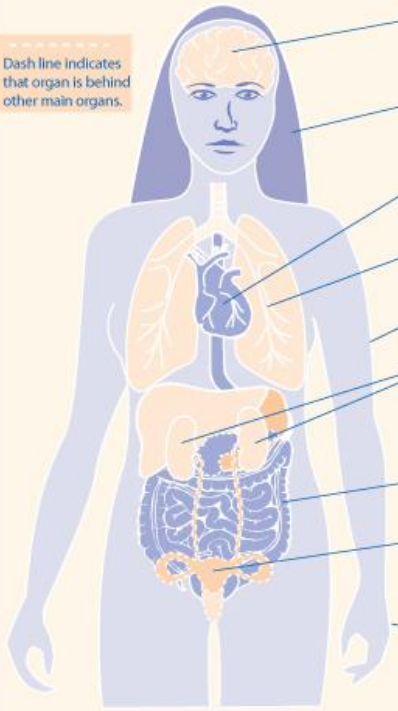
Refeeding Syndrome can be **DEADLY** and patients at risk should be admitted for medical stabilization and management of the medical complications of refeeding.

Fluid boluses should be **AVOIDED** in eating disorder patients, especially those with a low heart rate and low blood pressure, and those who are purging.

Summary of Medical Complications in Patients with Eating Disorders

- Malnutrition
- Dehydration
- Electrolyte imbalance
- Hyponatremia (related to water-loading)
- Refeeding Syndrome
- Vitamin and mineral deficiencies
- Lanugo (soft downy hair on face, back, arms)
- Edema
- Muscle atrophy
- Impaired neuromuscular function
- Amenorrhea
- Easily bruising skin
- Liver failure
- Bad circulation
- Slowed irregular heartbeat
- Arrhythmias of the heart
- Angina
- Heart attack
- Infertility
- Polycystic Ovarian Syndrome
- Problems during pregnancy
- Depression
- Lowered body temperature
- Cramps, bloating, constipation
- Diarrhea, incontinence
- Osteopenia
- Arthritis
- Dental problems - decalcification of teeth, erosion of tooth enamel, severe decay, gum disease
- TMJ Syndrome or related TMJ problems
- Orthostatic hypotension
- High blood pressure/ hypertension
- Low platelet count/thrombocytopenia
- Disruption in blood sugar levels
- Diabetes
- Ketoacidosis
- Iron deficiency/anemia
- Kidney infection/failure
- Osteoporosis
- Mallory-Weiss tear
- Gastric rupture
- Gastrointestinal bleeding
- Esophageal reflux
- Barrett's esophagus
- Cancer
- Insomnia
- Chronic Fatigue Syndrome
- Hyperactivity
- Callused or bruised fingers
- Dry skin and hair/brittle hair and nails
- Hair loss
- Peptic ulcers
- Pancreatitis
- Digestive difficulties
- Weakness/fatigue
- Seizures
- Death

Anorexia affects your whole body



Brain and Nerves
can't think right, fear of gaining weight, sad, moody, irritable, bad memory, fainting, changes in brain chemistry

Hair
hair thins and gets brittle

Heart
low blood pressure, slow heart rate, fluttering of the heart (palpitations), heart failure

Blood
anemia and other blood problems

Muscles, Joints, and Bones
weak muscles, swollen joints, bone loss, fractures, osteoporosis

Kidneys
kidney stones, kidney failure

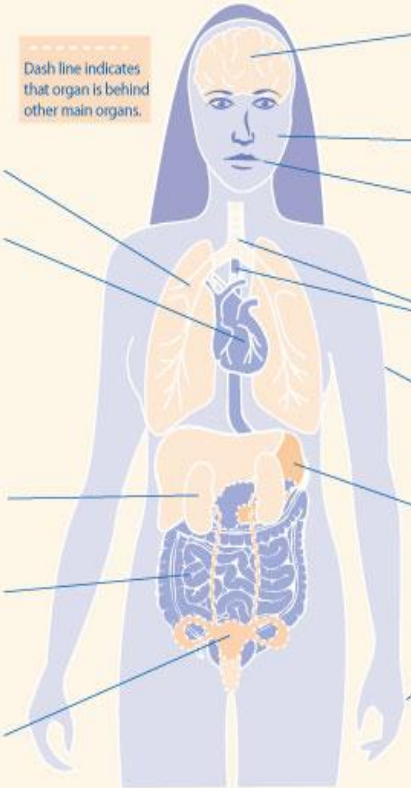
Body Fluids
low potassium, magnesium, and sodium

Intestines
constipation, bloating

Hormones
periods stop, problems growing, trouble getting pregnant. If pregnant, higher risk for miscarriage, having a C-section, baby with low birthweight, and post partum depression.

Skin
bruise easily, dry skin, growth of fine hair all over body, get cold easily, yellow skin, nails get brittle

How bulimia affects your body



Brain
depression, fear of gaining weight, anxiety, dizziness, shame, low self-esteem

Cheeks
swelling, soreness

Mouth
cavities, tooth enamel erosion, gum disease, teeth sensitive to hot and cold foods

Throat & Esophagus
sore, irritated, can tear and rupture, blood in vomit

Muscles
fatigue

Stomach
ulcers, pain, can rupture, delayed emptying

Skin
abrasion of knuckles, dry skin

Blood
anemia

Heart
irregular heart beat, heart muscle weakened, heart failure, low pulse and blood pressure

Body Fluids
dehydration, low potassium, magnesium, and sodium

Kidneys
problems from diuretic abuse

Intestines
constipation, irregular bowel movements (BMs), bloating, diarrhea, abdominal cramping

Hormones
irregular or absent period

ATLANTA CHAPTER BOARD MEMBERS
(2019-2020)

PRESIDENT: Lauren Greenway, LPC, CPCS, CEDS

Lauren is a licensed professional counselor in the state of Georgia and has a private practice in Sugar Hill. Lauren graduated from Georgia State University in 2011. She has held positions at Ridgeview Institute, MARR, and Hope Homes. Specialty areas include eating disorders, addictions, trauma, relationship issues and self-esteem issues.

SECRETARY & President-Elect: Taylor Rae Homesley, LPC, CPCS, CEDS

Taylor Rae is a Licensed Professional Counselor with a degree in Marriage and Family Therapy from Richmont Graduate University. She currently works as the Associate Clinical Director at the Veritas Collaborative GA Hospital. Taylor Rae believes in helping people see and recognize their own strength and self-worth.

TREASURER: Joy Ssebikindu, LPC

Joy graduated from Vanderbilt University her BA in Sociology and Child Development, and also her MEd in Clinical Mental Health counseling. As a Licensed Professional Counselor, she specializes in working with individuals, couples, and families who have issues with communication, family transitions including divorce, trauma, depression, anxiety, and disordered eating/eating disorders. She joined the Center for Discovery team in November of 2016 and has since become Program Director. Joy also maintains an outpatient private practice in Atlanta, GA. To date, Joy is often sought out by advocacy groups and mental health treatment centers/hospitals to consult on multi-cultural cases due to her personal and professional experience in managing issues related to diversity, inclusion and other issues related to ethnic sensitivities.

PAST PRESIDENT: Diane Hilleary, LCSW, CEDS, CEDS-S

Diane has been treating girls and women with eating disorders since 2005. She sees individuals, families and groups in her private practice in Atlanta, GA. Diane is intensively trained in Dialectical Behavior Therapy and leads DBT groups for women in recovery. She previously served as treasurer of iaedp-Atlanta and currently serves as a chapter representative to the iaedp International Board.

EDUCATION CO-CHAIRS:

Anne Marie Dine, LPC, CPCS, CEDS-S

Anne Marie works primarily with clients who have eating disorders, substance use disorders, depression, anxiety, and/or trauma in her private practice. Anne Marie has served as Primary Therapist, Clinical Director, and Director of Outpatient Services at Atlanta area treatment centers and is focused on helping clients find holistic wellness. Anne Marie is intensively trained in DBT and is a level 1 EMDR practitioner, and is certified as a CPCS to provide supervision towards licensure for aspiring therapists.

Leslie Way, MS, M. Div., NCC, APC

Leslie received her master's degree from Mercer University. Through her work with clients with eating disorders, addictions, depression, anxiety, and histories of trauma, she strives to help individuals improve their relationships with themselves, others, food, and their bodies. She works closely with clients in areas such as shame, self-compassion, gender and sexuality, communication, boundaries, spirituality, and grief. Leslie currently works as a Program Therapist at Ridgeview Institute.

HOSPITALITY CO-CHAIRS:

Arielle Crain, LAPC

Arielle completed her Master's in Community Counseling at the University of Georgia and currently sees clients at Midtown Psychotherapy Associates and Odyssey Family Counseling Center. Arielle's treatment focus includes using interpersonal process, expressive arts, CBT, and DBT interventions to treat adolescent and adult women experiencing issues related to eating disorders, body image, self-esteem, depression, anxiety, grief, trauma, and abuse. .

Hannah Stokes, LPC

Hannah completed her Master's Degree in Clinical Mental Health Counseling from Auburn University. Hannah enjoys working with children, teens, and young adults at her private practice, New Wave Counseling, in Brookhaven, GA. She uses creative and expressive therapies, Cognitive Behavioral Therapy, and Person Centered Theory to help individuals struggling with eating disorders, disordered eating, body image issues, anxiety, depression and other types of psychological issues. She is also a Licensed Be Body Positive Facilitator and enjoys incorporating this in her work when appropriate. Hannah is passionate about helping others experience a meaningful, healthy, and balanced life.

CERTIFICATION CHAIRPERSON: Jessica Baker, Ph.D, CEDS, CEDS-S

Jessica is a licensed psychologist, certified eating disorders specialist, and iaedp approved supervisor. She also serves on the certification committee for iaedp. She started the eating disorders program at MARR Women's Center before opening her private practice in 2007. She has been treating eating disorders and other mental health issues since 2001.

MEMBERSHIP CHAIRPERSON: Lisa Janik, MSRD, LD

Lisa is a Registered Dietitian currently working with individuals in a mental health treatment facility, including those with disordered eating and eating disorders. Lisa previously worked at Ridgeview Institute in the Women's Center for Trauma and Eating Disorders. Lisa is in the process of establishing a private practice focused on helping clients develop healthier relationships with food and their bodies.

MARKETING CHAIRPERSON: Cassie Gaub

Cassie began working in the field of eating disorders in 2007. She has worked in a variety of capacities including intake, admissions and outreach. She is extremely passionate about providing the best possible information and support for those exploring treatment. Cassie is a Cum Laude graduate of Montana State University – Billings, where she earned a B.S. degree in the field of Sociology and was honored by the National Dean's List for academic achievements. Cassie currently works as the clinical outreach and staff recruitment representative for Center for Discovery. When Cassie is not at work, she enjoys being outdoors, playing with her dog and also works as an

empowerment and transformation coach. Cassie is honored to be a part of the Atlanta chapter of IAEDP..

SOCIAL MEDIA CHAIRPERSON: Laura McLain, PsyD

Laura is the Site Director at The Renfrew Center of Georgia with oversight of both the clinical program and operations and has a small private practice in the Atlanta area. She has extensive experience working with eating disorders as well as diverse populations. She has had experience with individuals whose issues include trauma, addictions, personality disorders, developmental disabilities, anxiety, depression, and gender identity. Laura believes that the power to change is possible for all individuals and that patients can take manageable steps to better their lives. She has presented at several events and conferences on topics related to eating disorders and addictions, diversity and cultural contributions, and college age individuals. Laura is a member of the American Psychological Association, the Georgia Psychological Association, and the Atlanta chapter of IAEDP.

MENTORSHIP CHAIRPERSON: Tara Arnold, Ph.D, LCSW, CEDS, CEDS-S

Tara is the clinical co-director of WholeHeart Psychotherapy, a group of experts treating eating disorders, women's issues and substance use disorders. Tara is an eating disorder specialist and supervisor. In her practice she conducts individual therapy, clinical supervision, and group therapy in body image, DBT (intensively trained), interpersonal dynamics, and healing eating disorders.

MEDICAL LIAISONS:

Carrie Poline, D.O., FAPA

Dr. Carrie Poline is a double-board certified practitioner in child & adolescent and adult psychiatry specializing in eating, anxiety, mood and child behavioral disorders. Her current private practice sprouted from her tenure as Medical Director of The Atlanta Center for Eating Disorders. Dr. Poline is now the supervising psychiatrist at The Renfrew Center for Atlanta. She is an adjunct faculty member of Emory University's Department of Child & Adolescent Psychiatry where she has taught and supervised residents. Dr. Poline remains committed to the advocacy, research, education, prevention and direct care of patients struggling with eating disorders. Dr. Poline was presented with the inaugural award of "Exceptional Women in Medicine" and recognized as a "Top Docs of Atlanta" by Castle Connelly in 2017 and 2018.

Anna Tanner, MD, FAAP, FSAHM, CEDS

Dr. Anna Tanner is Vice President of Medical Services for Veritas Collaborative. She is a board-certified Pediatrician who has specialized in the care of complicated adolescent patients, in particular patients with eating disorders, for the past 20 years. Upon moving to Georgia, she started the Teen Center at Gwinnett Pediatrics and Adolescent Medicine in 2000. As she saw increasing numbers of patients and families affected by eating disorders, she became involved in local advocacy and education efforts. Dr. Tanner currently serves as an Adjunct Assistant Professor of Pediatrics for Emory University School of Medicine and as an Adjunct Clinical Assistant Professor in the Department of Psychiatry and Behavioral Science for Morehouse School of Medicine. In recognition of her work, she has been appointed as a Certified Eating Disorder Specialist by the International Association of Eating Disorder Professionals and holds the designation of Fellow in the Society of Adolescent Health and Medicine. She has been listed as a "Top Doctor" by Atlanta magazine every year from 2013 to 2018.

GALA CO-CHAIRS:

Gail Phillips, LCSW

Gail has specialized in the treatment of eating disorders for over 25 years, and she has extensive training and experience. She helps individuals with all types of eating problems, and she also treats addictions, anxiety, depression, personality disorders, and relationship problems.

Jamie Singleteary, MA

Jamie currently holds the position of Regional Outreach Manager for Monte Nido & Affiliates; this includes Oliver Pyatt Centers, Clementine, and Monte Nido Programs. Post completion of her graduate program she had the pleasure of working in a variety of mental health settings facilitating groups, presenting lectures and working with families. In her current role she serves as a liaison and resource for providers and families in the Southeast Region who need higher levels of care for their loved ones suffering from an eating disorder. Jamie is excited to be a part of such an amazing group of professionals and looks forward to making this a great year for the Atlanta IAEDP chapter.

Stephanie Cohen, RDN, LD

S**tephanie** has worked exclusively with eating disorders since 2007. Her career started at Ridgeview Institute and continued at the Renfrew Center of Georgia when it opened in 2013. Stephanie maintains a private practice and enjoys working with men, women, transgender individuals, and with individuals during pregnancy. She is currently working on her CEDRD certification.

Why Refer to a Specialist?

Certified Eating Disorders Specialists are well-trained and experienced in the treatment of eating disorders and have obtained a highly-respected certification from the International Association of Eating Disorders Professionals (iaedp).

CERTIFIED EATING DISORDER SPECIALISTS (CEDS) & CERTIFIED EATING DISORDER REGISTERED DIETITIAN (CEDRD)

iaedp-Atlanta Chapter Members

CEDS-S: Clinician is also an iaedp approved supervisor

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EATING DISORDER SUPPORT GROUPS

ANAD*:* Anorexia Nervosa and Associated Disorders is a support group designed to help individual suffering from any type of eating disorder. It is a process group and usually facilitated by a mental health professional.

EDA: Eating Disorders Anonymous is a 12-step support group.

FED: Family and Friends of those with Eating Disorders.

DAY & TIME	MEETING TYPE	LOCATION	CONTACT	OTHER
MONDAY				
12:00 – 1:00 PM	**EDA Online**	**Newcomer Meeting** Focus is on Steps 1 - 2 - 3	http://www.eatingdisordersanonymous.org/online.html	Prior 1st meeting, register with Chatzy - go to EDA website & complete registration. You will be sent a password immediately.
6:00 - 7:00 PM	**FAMILY SUPPORT GROUP**	**Ridgeview Institute** 3995 South Cobb Drive Smyrna, GA 30080 Young Adult Building East Room 4	Contact Ridgeview Institute Women's Center 770-434-4568 Ext: 4530	A free confidential support group for family and friends of individuals with eating disorders, unresolved trauma, addictions and co-occurring disorders.
6:00 - 7:00 PM	**ANAD for Adults**	**Midtown Psychotherapy** 1708 Peachtree St., NW. Suite 530, Atlanta, GA 30309	For information about **ANAD for Adults** – Contact: Alli Kuder, LMSW 404-606-1211	RSVP before 1st group for additional information and details
7:00 - 8:00 PM	**ANAD for Family & Friends**		For Info about **ANAD for Family & Friends** – Contact: Kylie Gerks, MFT	
7:00 - 8:00 PM	**ANAD for Teens** (Ages 13 - 19)		For Information about **ANAD for Teens** – Contact: Arielle Crain, NCC 704-877-0577	
7:00 - 8:00 PM	**EDA Phone Meeting**	Phone Meeting	Join by calling: 1-712-432-0385 Bridge: 797101#	Get support from people all over the country by **phone** or **Skype.**
TUESDAY				
12:30 – 1:30 PM	**EDA Online**	**12- Steps & 12-Traditions** Focused Meeting	http://www.eatingdisordersanonymous.org/online.html	Register prior to 1st meeting
1:00 – 2:00 PM	**EDA Phone Meeting**	Phone Meeting	Join by calling: 1-712-432-0385 Bridge: 797101#	Get support from people all over the country by **phone** or **Skype**
6:30 – 7:30 PM	**EDA**	4633 Shiloh Rd Cumming, GA 30040	Kristy E. kristyedenfield@gmail.com	
6:30 – 7:30 PM	**EDA**	183 Timberlake Rd Kennesaw GA	Amber S. 845-453-1456	The meeting is in a house. Knock on

		30144		door

DAY & TIME	MEETING TYPE	LOCATION	CONTACT	OTHER
WEDNESDAY				
6:00 – 7:00 PM	**ANAD**	**Century Springs East** 6100 Lake Forrest Drive, Suite 450, Atlanta, GA 30328	Joey Pulley, LPC 404-242-5612	
7:00- 8:00 PM	**ANAD Online**	**Online Support Group**	Contact Kris Pina at krispina@eatuitive.com for sign on information	Video conference
7:00 – 8:00 PM 3rd Wednesday of Every Month	**ANAD**	**11755 Pointe Place Suite A2 Roswell, GA 30076**	Contact Emily Siegel, LCSW at 678-822-7030 or msemilysiegel@gmail.com	Age 12 & older
8:00 – 9:00 PM	**EDA Online**	**Newcomer Meeting** Focus is on Steps 1 - 2 - 3	http://www.eatingdisordersanonymous.org/online.html	Register prior to 1st meeting
THURSDAY				
3:30- 4:30 PM	**EDA**	**University Village** 1085 Canton Pl NW Building 6000 Room 6137 Kennesaw GA 30144	Lee at lhyaduck@kennesaw.edu	Group does not meet during school breaks
5:00 – 6:00 PM Every Other Week **Call about date**	**ANAD**	**Ethos Counseling, LLC** 2565 Thompson Bridge Rd #207 % 360 Therapy, LLC Gainesville, Georgia	Linh Lam, LPC 678-582-8501	Jan 19, Feb 2, Feb 16, March 2, March 16, March 30; **call first**
7:00 – 8:00 PM	**ANAD**	**Care & Counseling Center of Georgia** 1814 Clairmont Rd., Decatur, GA 30033	Gayle Benator, LAPC 404-636-1457 ext. 422. or gbenator@cccgeorgia.org	Call or email prior to first meeting
8:00 – 9:00 PM	**EDA Phone Meeting**	Phone or Skype Meeting	Join by calling: 1-712-432-0385 Bridge#: 797101#	Get support from people all over the country by **phone** or **Skype.**
8:00 – 9:00 PM	**EDA Online**	**Topic Meeting** 1st Thursday: Milestone Meeting 3rd Thursday: Speaker Meeting **Other Thursday meetings Are Topic Meetings**	http://www.eatingdisordersanonymous.org/online.html	1st Thursday: Celebration of milestones in recovery. 3rd Thursday: Speaker meeting
FRIDAY				
1:00 – 2:00 PM	**EDA Online**	**Big Book Study**	http://www.eatingdisordersanonymous.org/online.html	Register prior to 1st meeting
12:30 – 2:00 PM	**FED**	**Atlanta Center for Wellness** (www.AC4W.org) 6100 Lake Forrest Dr. Suite 450, Atlanta, GA	Ephrat Lipton, LCSW ephratlipton@gmail.com (404) 202-0932 atlantacenterforwellness.com	Call before attending to verify location and time

		30328.		
8:00 – 9:00 PM	**EDA**	**Freedom Club (12-step clubhouse)** 47 North Fairground St. Marietta, GA 30060	Meeting in on the 2nd floor of the Wigley Building (above Happy Charley's). freedomclub.org	See freedomclub.org for more details & map

DAY & TIME	MEETING TYPE	LOCATION	CONTACT	OTHER
SATURDAY				
10:00 - 11:00 AM	**EDA Phone Meeting**	Phone or Skype Meeting	Join by calling: 1-712-432-0385 Bridge#: 797101#	Get support from people all over the country by **phone** or **Skype.**
10:00 - 11:00 AM	**ANAD**	**St. Luke's Presbyterian Church** 1978 Mount Vernon Rd, Atlanta, GA 30338, room 145, church parlor	Page Love, RDN, CSSD, LD 770-395-7331 pagelove@nutrifitga.com http://www.nutrifitga.com/groups	Senior High Room Room 207
10:30 - 11:30 AM	**EDA Online**	**Big Book Study**	http://www.eatingdisordersanonymous.org/online.html	Register prior to 1st meeting
11:30- 12:30 PM	**ANAD**	2993 Sandy Plains Rd #115 Marietta, GA 3066	Ann ann@livingtruecounseling.com	Email prior to 1st meeting
SUNDAY				
9:00- 10:00 AM	**EDA Phone Meeting**	Phone or Skype Meeting	www.eatingdisordersanonymous.org/phonemeetings.html	For MEN only
12:00- 1:00 PM	**ANAD Online**	Online Support Group	www.anad.org/online-support-group	Open to anyone with an ED
1:00 – 2:00 PM	**EDA Phone Meeting**	Phone or Skype Meeting	Join by calling: 1-712-432-0385 Bridge#: 797101#	Get support from people all over the country by **phone** or **Skype.**
2:00- 3:00 PM	**EDA Phone Meeting**	Phone or Skype Meeting	www.eatingdisordersanonymous.org/phonemeetings.html	
5:00 – 6:00 PM	**EDA**	**The Phoenix House-3** 3121 South Side Kennesaw GA 30101	Kris Shock 678-480-4275	
5:00 – 6:00 PM	**ABA**	**Atlanta Dream Center** 652 Angier Ave NE Atlanta GA 30308	Brittany 305-842-8552 Brittanylynn791@gmail.com	Use side entrance
8:00 – 9:00 PM	**EDA Online**	**12- Steps & 12-Traditions** Focused Meeting	ttp://www.eatingdisordersanonymous.org/online.html	Register prior to 1st meeting

EATING DISORDER MEAL SUPPORT GROUPS AND FITNESS SUPPORT GROUPS

DAY & TIME	MEETING TYPE	LOCATION	CONTACT	OTHER
VARIOUS				
Every 1st Monday of month 6:00 – 7:00 PM	**Dinner & Discipleship**	**Positive Nutrition** 3855 Shallowford Rd Suite 420 Marietta, GA 30062	Julie Brake, RDN, LD 404-326-5118 Julie@PositiveNutrition.net	1st Monday of every month (specific meeting dates listed at www.PositiveNutrition.net/events-group This is a bring your own dinner group where we discuss Biblical perspectives, particularly those that apply to nutrition
Every 3RD Monday of month 7:00 – 8:00 PM	**Intuitive Eating Support Group**	**Positive Nutrition** 3855 Shallowford Rd Suite 420 Marietta, GA 30062	Julie Brake, RDN, LD 404-326-5118 Julie@PositiveNutrition.net	3rd Monday of every month (specific meeting dates listed at www.PositiveNutrition.net/events-group This group is for discussion and support of intuitive eating
1x month Thursday Or Saturday 8:30 – 9:30 AM	**Breakfast Club with Page Love**	Restaurant changes regularly so check out **Nutrifitga.com** for schedule	Page Love, RDN, CSSD, LD at 770.395.7331 pagelove@nutrifitga.com http://www.pagelove@nutrifitga.com	Restaurant changes regularly so check out http://www.nutrifitga.com/groups for schedule
1x per month Saturday 3:00 PM	**Fit for Life**	Location changes regularly so check out Nutrifitga.com for schedule	Page Love, RDN, CSSD, LD at 770.395.7331 pagelove@nutrifitga.com http://www.nutrifitga.com	Free, gentle monthly fitness to challenges you to vary your activity routine, listen to your body, & learn how to fuel and hydrate during exercise. Examples: walks, hikes, biking, yoga, strength training. http://www.nutrifitga.com/groups
1x month Thursday OR Saturday 8:00- 9:30 PM	**Dessert Club**	Restaurant changes regularly so check out **Nutrifitga.com** for schedule	Page Love, RDN, CSSD, LD at 770.395.7331 pagelove@nutrifitga.com http://www.nutrifitga.com	Restaurant changes regularly so check out http://www.nutrifitga.com/groups for schedule
2nd & 4th Tuesday of month	**ANAD ONLINE**	**Online Support Group**	ANAD website anad.org/online-support-groups/	Open to those in recovery from an ED.

RECOMMENDED WEBSITES

IAEDP-ATLANTA CHAPTER - atlantaiaedp.com

IAEDP FOUNDATION - iaedp.com

NEDA - nationaleatingdisorders.org

ACADEMY FOR EATING DISORDERS - aedweb.org

F.E.A.S.T. - feast-ed.org

ANAD - anad.org

EDA - eatingdisordersanonymous.org

EDIN - myedin.org

MANNA - mannafund.org

GURZE BOOKS - gurzebooks.com

For our latest information, news & events please visit our:

Website: www.atlantaiaedp.com

Facebook Page: iaedp Atlanta Chapter

As a non-profit organization, iaedp is grateful to the following organizations who generously demonstrate their commitment through financial support of our organization. It is through their generosity that we are able to create educational opportunities specific to the treatment of those suffering from eating disorders.

2020 Atlanta iaedp sponsorship

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