PSYCHCEs

Clinical Strategies for Treating Adolescent Eating Disorders

Section 1: Comprehensive Overview of Eating Disorders

Introduction

Eating disorders are among the most serious and complex mental health conditions treated by psychologists today. They are characterized by persistent disturbances in eating behaviors, cognition, and emotional functioning. These conditions not only affect physical health but also intersect significantly with identity, trauma, and broader sociocultural factors. As such, a modern understanding of eating disorders requires psychologists to integrate knowledge from psychiatry, psychology, cultural studies, ethics, and medical science. This section provides a comprehensive overview of eating disorders, highlighting diagnostic frameworks, historical development, population disparities, risk factors, and the ethical imperatives relevant to clinical practice. The training aligns with APA's continuing education standards, emphasizing the application of psychological science, ethical competence, and multicultural awareness.

Definition and Scope of Eating Disorders

Eating disorders (EDs) refer to a group of psychiatric conditions marked by severe disturbances in how individuals eat, think about food, and perceive their bodies. These disturbances often reflect deeper psychological struggles involving self-worth, control, emotional regulation, trauma, and identity. While anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED) are the most recognized, diagnostic criteria have expanded in the DSM-5 and DSM-5-TR to include avoidant/restrictive food intake disorder (ARFID) and other specified feeding or eating disorders (OSFED). These changes underscore a growing

understanding of the heterogeneity of symptoms and the need for greater inclusivity in diagnosis (American Psychiatric Association, 2023).

EDs are highly prevalent and increasing globally. Lifetime prevalence in the U.S. alone is estimated to be around 9%, with recent data suggesting sharp rises among adolescents and young adults (Kazdin et al., 2017). Crucially, the medical consequences of EDs can be life-threatening. Anorexia nervosa, for example, has the highest mortality rate of any psychiatric condition, with mortality linked to both physical complications and suicide. These statistics place EDs at the intersection of mental health crisis and public health priority.

Epidemiological Trends and Cultural Considerations

The epidemiology of eating disorders reflects both global expansion and nuanced patterns of cultural expression. EDs are increasingly reported in non-Western countries, with rising prevalence in Asia, Latin America, and the Middle East. These patterns often correlate with economic globalization, urbanization, and the proliferation of Western media, especially idealized body images via social media platforms (Pike & Dunne, 2015). However, symptom presentation may vary significantly based on cultural context. For instance, in some Asian cultures, EDs may be expressed more somatically or through non-fat-phobic frameworks, where food refusal is driven by stress or gastrointestinal discomfort rather than body image concerns.

In the U.S., significant disparities exist in diagnosis and treatment access. Studies show that individuals from racial and ethnic minority backgrounds, particularly Black, Latinx, and Indigenous populations, are less likely to be diagnosed with EDs despite experiencing similar or greater rates of disordered eating behaviors (Moreno et al., 2023). Additionally, LGBTQIA+ youth are at elevated risk, often due to identity-related stressors, minority stress, and higher exposure to body image

pressures. For clinicians, understanding these disparities is critical to equitable practice. It requires a deliberate shift toward culturally competent care, which includes the use of culturally sensitive screening tools, culturally responsive psychoeducation, and partnership with community leaders and organizations.

Psychological and Behavioral Features

While each eating disorder has distinct diagnostic criteria, several features are common across the spectrum. These include a preoccupation with body image, fear of weight gain, rigid thinking around food and exercise, and significant psychological distress related to eating. Restriction, bingeing, purging, and compensatory behaviors often serve as maladaptive coping strategies for deeper emotional issues such as trauma, low self-esteem, or difficulty regulating affect.

Emotionally, many individuals with EDs experience chronic anxiety, perfectionism, shame, and a sense of internal emptiness. Cognitive distortions—such as black-and-white thinking and catastrophizing—further reinforce disordered eating cycles. Understanding these patterns is critical to effective intervention, particularly as most evidence-based therapies target these cognitive-emotional dynamics.

Comorbidity and Psychological Complexity

Eating disorders rarely exist in isolation. They often co-occur with mood and anxiety disorders, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and personality disorders, particularly borderline and avoidant types. The co-occurrence of EDs and substance use disorders also complicates treatment and heightens risk for poor outcomes (Attia et al., 2023).

This comorbidity poses diagnostic and treatment challenges. For instance, distinguishing between ED-related perfectionism and OCD compulsions may affect the chosen treatment modality. Similarly, trauma histories may necessitate trauma-informed care models that differ significantly from standard CBT-based approaches. Psychologists must therefore be equipped to conduct comprehensive, differential assessments and formulate personalized, multimodal treatment plans in collaboration with medical professionals, dietitians, and family systems.

Training, Cultural Competence, and Clinical Implications

APA's Multicultural Guidelines (2019) urge psychologists to integrate intersectional awareness into all aspects of practice. This includes acknowledging how systems of oppression (e.g., racism, sizeism, heteronormativity) shape ED experiences and treatment outcomes. Clinical training must move beyond general "cultural sensitivity" to cultivate deeper cultural humility, including the ability to work with interpreters, use culturally validated tools, and recognize the role of historical trauma in patient narratives (Clauss-Ehlers et al., 2019).

Psychologists must also ensure that their treatment environments reflect inclusivity. This may include visual cues (e.g., body-positive imagery), inclusive intake forms, and staff training on inclusive language. As research continues to demonstrate, such changes significantly enhance engagement and outcomes for diverse populations.

Section 2: Diagnostic Criteria and Symptomatology of Eating Disorders (DSM-5-TR)

Introduction

The accurate diagnosis of eating disorders (EDs) is both an art and a science. With evolving understandings of psychopathology, sociocultural pressures, and trauma-informed care, clinicians must be equipped with not only precise diagnostic tools but also a nuanced awareness of how symptoms may manifest differently across identities, cultures, and body types. The DSM-5-TR, released by the American Psychiatric Association in 2022, represents the most up-to-date taxonomy for categorizing eating disorders. This section offers an in-depth review of five major eating disorder diagnoses—Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge-Eating Disorder (BED), Avoidant/Restrictive Food Intake Disorder (ARFID), and Other Specified Feeding or Eating Disorder (OSFED)—emphasizing symptomatology, cross-cultural presentation, and ethical challenges that arise in clinical diagnosis.

Anorexia Nervosa (AN)

Anorexia Nervosa is characterized by persistent restriction of energy intake leading to significantly low body weight, an intense fear of gaining weight or becoming fat, and a disturbance in self-perceived weight or shape. The DSM-5-TR distinguishes between two subtypes: the restricting type, where weight loss is accomplished primarily through dieting, fasting, or excessive exercise; and the binge-eating/purging type, where the individual engages in recurrent episodes of binge eating or purging behaviors (American Psychiatric Association, 2022).

From a symptomatological perspective, AN is associated with severe body image distortion, denial of the seriousness of low body weight, ritualistic eating behaviors, and often high levels of perfectionism and control. However, not all individuals with AN appear underweight, a reality addressed in the diagnosis of Atypical Anorexia Nervosa, a subtype under OSFED. This has crucial implications, especially as individuals in larger bodies are frequently underdiagnosed due to weight bias in medical and mental health settings (Sharpe, 2024).

Ethically, clinicians must navigate complex issues of informed consent, especially in adolescents or adults with severely compromised physical health who may resist treatment. Further, cultural beliefs around thinness, modesty, and body ideals can affect symptom disclosure. In some Asian and Latinx cultures, for instance, food refusal may be explained through spiritual or familial frameworks rather than weight control (Birgegård et al., 2023).

Bulimia Nervosa (BN)

Bulimia Nervosa is defined by recurrent episodes of binge eating followed by inappropriate compensatory behaviors to prevent weight gain, such as vomiting, misuse of laxatives, diuretics, fasting, or excessive exercise. These behaviors must occur, on average, at least once a week for three months. Individuals with BN typically maintain a body weight at or above normal levels, which often delays diagnosis and intervention (Fakhrou et al., 2024).

The hallmark of BN lies in the cycle of bingeing and purging, often linked to emotional dysregulation, impulsivity, and shame. Binge episodes are described as eating an objectively large amount of food in a discrete period, accompanied by a sense of loss of control. Following this, individuals may feel guilt, disgust, or anxiety, prompting compensatory actions.

From a cultural perspective, BN has been historically under-identified in non-white populations due to biases in diagnostic training and a narrow understanding of what bingeing "looks like." Black and Latinx individuals, for example, may present with emotional eating or compensatory fasting practices that go unrecognized in clinical settings unless providers use culturally validated instruments (Hay et al., 2023).

Ethically, assessment for BN requires sensitivity around the use of screening tools that may pathologize cultural eating norms or behaviors without adequate context. Additionally, clinicians must be alert to co-occurring substance use or self-harm behaviors, which are more prevalent among individuals with BN than those with AN or BED.

Binge-Eating Disorder (BED)

Recognized as a formal diagnosis only in DSM-5, BED involves recurrent episodes of binge eating without the regular use of inappropriate compensatory behaviors. Binge eating is associated with eating more rapidly than normal, eating until uncomfortably full, eating large amounts of food when not physically hungry, eating alone due to embarrassment, and experiencing distress, disgust, or depression afterward.

BED is the most prevalent eating disorder in the general population and is highly comorbid with mood and anxiety disorders. It is also disproportionately diagnosed in individuals with higher body weights. While this recognition has increased visibility, it has also opened the door to weight-based stigma in treatment settings where the disorder is erroneously reduced to a “weight issue” rather than a complex mental health condition.

Ethically, psychologists must avoid reinforcing societal anti-fat bias in their approach to BED. It is unethical to frame weight loss as the primary treatment

goal unless medically necessary and collaboratively decided upon by the patient. Culturally, the experience of BED may intersect with food scarcity, cultural food rituals, or shame surrounding appetite in collectivist communities, all of which require careful, nonjudgmental exploration in therapy (Kenny, 2023).

Avoidant/Restrictive Food Intake Disorder (ARFID)

ARFID is a relatively new diagnosis introduced in DSM-5 and refined in DSM-5-TR. It is characterized by a persistent failure to meet appropriate nutritional and energy needs, not due to body image concerns. This can lead to significant weight loss, nutritional deficiency, dependence on enteral feeding or supplements, and marked interference with psychosocial functioning.

ARFID is often seen in children but can persist into or emerge during adulthood. Unlike AN or BN, the motivation is typically not weight-related. Instead, it may stem from sensory sensitivities, a fear of choking or vomiting, or general disinterest in food. Individuals with autism spectrum disorder, anxiety disorders, or sensory processing issues are at increased risk.

Culturally, ARFID may be misunderstood or mistaken for culturally normative picky eating, especially in immigrant households where children reject unfamiliar or traditional foods. Clinicians must differentiate between cultural food practices and pathological restriction, which often involves functional impairment and nutritional deficiency. Ethical challenges include ensuring that interventions respect family foodways while addressing life-threatening malnutrition or social impairments (Bourne, 2025).

Other Specified Feeding or Eating Disorder (OSFED)

OSFED encompasses clinically significant eating disturbances that do not meet the full criteria for AN, BN, BED, or ARFID but still cause significant distress and impairment. Common presentations include atypical anorexia nervosa, purging disorder, night eating syndrome, and subthreshold forms of other disorders.

The inclusion of OSFED highlights the DSM-5-TR's attempt to acknowledge the diverse and evolving nature of disordered eating. However, OSFED has often been misperceived as a "less serious" diagnosis, which can undermine access to treatment. Research now affirms that OSFED is associated with similar levels of psychological distress, suicidality, and functional impairment as threshold EDs (Birgegård et al., 2023).

Ethically, psychologists must challenge the minimization of OSFED presentations, ensuring parity in care regardless of label. Clinicians should also apply culturally and developmentally adapted measures to assess for distress, as symptoms may not align neatly with Westernized criteria. For instance, in Muslim communities where fasting has religious importance, clinicians must distinguish between spiritually motivated eating patterns and pathological restriction.

Ethical, Cultural, and Diagnostic Considerations

Diagnostic assessment for eating disorders must occur within a framework that integrates cultural humility, trauma sensitivity, and ethical rigor. APA's 2017 Multicultural Guidelines stress the need for psychologists to assess not just symptoms, but the context in which they arise. Misdiagnosis often occurs when clinicians impose dominant cultural narratives about food, weight, or body image onto patients whose realities differ.

It is unethical to rely on BMI alone as a marker for pathology, and clinicians must critically evaluate tools like the EDE-Q and EAT-26, which may lack cross-cultural validity. Psychologists should also use inclusive language, offer interpreter services, and seek supervision when working with populations outside their scope of familiarity.

Conclusion

Understanding the DSM-5-TR diagnostic criteria and symptomatology for eating disorders is a foundational competency for psychologists. Yet, accurate diagnosis is not merely a matter of criteria matching. It requires clinical judgment informed by ethical awareness, cultural knowledge, and humility in the face of complexity. By staying grounded in the evidence and sensitive to diverse expressions of distress, psychologists can offer more accurate diagnoses, reduce harm, and ensure a more equitable path to recovery for all clients.

Section 3: Differentiating Between Primary Eating Disorders and Disordered Eating Behaviors

Introduction

Distinguishing between clinically diagnosable eating disorders and disordered eating behaviors is essential for effective treatment planning, early intervention, and ethical psychological care. While eating disorders such as anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED) are clearly defined in the DSM-5-TR, disordered eating encompasses a broader array of problematic behaviors that do not meet full diagnostic criteria. These include chronic dieting, fasting, body checking, and emotional eating, which may still result in significant

psychological distress or serve as precursors to full-blown disorders. This section examines the continuum of eating pathology through the lenses of psychopathology, culture, identity, and ethics—clarifying the boundary between maladaptive but subclinical behaviors and clinically impairing disorders.

Understanding the Spectrum: From Disordered Eating to Diagnosis

Disordered eating refers to a variety of irregular eating behaviors that may not warrant a clinical diagnosis. These behaviors can include skipping meals, engaging in fad diets, yo-yo dieting, rigid food rules, exercise compulsion, and emotionally driven eating patterns. Although such behaviors may not meet DSM-5-TR criteria, they are often accompanied by distress, functional impairment, and heightened risk of transitioning into a clinical eating disorder (Kazdin et al., 2017).

In contrast, a primary eating disorder is marked by sustained patterns of behavior and thought consistent with DSM criteria, resulting in significant physical, psychological, or social impairment. Importantly, the presence of weight and shape concerns, emotional distress, and maladaptive coping mechanisms are common across the spectrum—but disorders differ in the intensity, duration, rigidity, and impact of these patterns.

For example, a college student who skips meals during stressful exam weeks and feels occasional guilt may be exhibiting disordered eating. However, a student who persistently restricts caloric intake, expresses fear of weight gain, and meets low BMI thresholds over months may meet the criteria for anorexia nervosa.

Diagnostic Criteria: What Makes a Disorder "Primary"?

Primary eating disorders—AN, BN, BED, ARFID, and OSFED—share common diagnostic features outlined in the DSM-5-TR (APA, 2022). These include:

- Persistent disturbance in eating or eating-related behavior
- Significant impairment in physical health or psychosocial functioning
- A pattern lasting at least several weeks (depending on the specific diagnosis)
- Distress associated with eating, weight, or shape
- Rigid, repetitive behavior with little flexibility or adaptability

Disordered eating, on the other hand, lacks these rigid criteria. While distress and maladaptive thoughts may be present, the behaviors are often episodic, situational, or context-driven—such as fasting before events or excessive eating during holidays. Still, clinicians must remain vigilant, as such behaviors can escalate, particularly when influenced by psychological vulnerabilities or environmental stressors.

The Role of Culture and Identity

Cultural beliefs surrounding food, body ideals, and health behaviors significantly shape both disordered eating and eating disorders. In many collectivist cultures, for example, food is a central part of identity and family cohesion. A client's refusal to eat traditional foods may reflect underlying distress about identity, assimilation, or trauma rather than body image issues alone (Rodgers et al., 2018). Mislabeling these behaviors as eating disorders can lead to over-pathologizing culturally normative practices.

Conversely, failure to recognize disordered eating in minoritized populations often stems from stereotypes that eating disorders only affect thin, white, affluent women. Studies have shown that Black women, Latinx individuals, and LGBTQIA+ youth often experience delays in diagnosis due to provider bias and lack of

culturally validated assessment tools (Cheng et al., 2019). Therefore, cultural and individual context must be incorporated into both diagnosis and treatment planning.

Prevention and Early Intervention

Distinguishing between primary eating disorders and disordered eating allows for targeted prevention efforts. Individuals exhibiting subclinical patterns may benefit from interventions such as:

- Psychoeducation about body image and media literacy
- Mindful eating practices
- Cognitive restructuring to challenge dieting myths
- Building emotional regulation skills

These early interventions, often overlooked in primary care or educational settings, can prevent progression into more severe disorders and reduce long-term treatment costs.

Conclusion

The differentiation between disordered eating and primary eating disorders is more than a diagnostic task—it is a clinical, ethical, and cultural imperative. Psychologists must be equipped to recognize when disordered behaviors reflect broader mental health challenges, identity conflicts, or sociocultural distress. Through culturally informed assessment, critical ethical awareness, and evidence-based screening, clinicians can make accurate diagnoses and provide responsive, individualized care. Doing so is not only essential for treatment efficacy—it is a commitment to equity, justice, and professional integrity.

Section 4: Risk Factors and Etiology of Eating Disorders

Introduction

Understanding the etiology and risk factors of eating disorders is crucial for psychologists, not only to diagnose and treat these complex conditions but also to implement prevention strategies and inform ethical, culturally sensitive care. Eating disorders such as anorexia nervosa, bulimia nervosa, binge-eating disorder, ARFID, and OSFED arise from a multifactorial interplay of genetic vulnerability, neurobiological regulation, psychological traits, trauma exposure, and sociocultural influences. These risk factors interact uniquely in each individual, leading to varied symptom presentations and treatment needs. This section explores these diverse etiological contributors and examines how comorbidities, identity, and cultural context shape clinical understanding and intervention.

Genetic and Biological Contributions

Genetic heritability plays a significant role in the development of eating disorders. Twin and family studies estimate that the heritability of anorexia nervosa may be as high as 50–60%, with similar though slightly lower estimates for bulimia nervosa and binge-eating disorder. Genome-wide association studies (GWAS) have identified potential genetic loci associated with metabolic regulation, anxiety traits, and reward processing—suggesting that the biological underpinnings of eating disorders are not purely psychiatric but also involve somatic processes, particularly in anorexia (Watson et al., 2019).

Neurobiological research highlights disruptions in the reward circuitry of the brain, especially the dopaminergic pathways involved in pleasure and motivation. For

example, individuals with AN often experience reduced reward sensitivity to food stimuli, whereas those with BED and BN may show heightened reward responses during binge episodes. Additionally, neuroimaging studies point to abnormalities in the insula, anterior cingulate cortex, and hypothalamus—regions responsible for interoception, satiety, and emotion regulation. These insights support a model of dysregulated appetite and emotion processing as central to ED pathophysiology.

Trauma and Psychological Vulnerability

Trauma is a well-established risk factor, particularly in cases involving emotional, sexual, or physical abuse. Research shows a strong association between childhood trauma and the development of EDs, especially bulimia nervosa and binge-eating disorder. Trauma can influence the onset of eating disorders through mechanisms like dissociation, body dissatisfaction, and emotion numbing. Individuals who have experienced early trauma may use food-related behaviors as coping strategies to manage overwhelming emotions or regain control over their environment (Brewerton, 2016).

Psychological vulnerabilities often co-occur with trauma and include perfectionism, obsessive-compulsive traits, neuroticism, low self-esteem, and emotional dysregulation. Perfectionism—especially socially prescribed perfectionism—has been closely linked with anorexia nervosa and bulimia. Individuals with rigid cognitive styles may use dietary restriction or purging as a way to attain a perceived ideal or exert control. Emotional dysregulation, on the other hand, is commonly seen in binge-eating disorder and bulimia, where food becomes a means of soothing or avoiding intense affective states.

Comorbid Mental Health Conditions

Eating disorders rarely occur in isolation. High rates of comorbidity are observed with major depressive disorder, generalized anxiety disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and various personality disorders—especially borderline and avoidant types.

- **PTSD:** Traumatized individuals may experience body-focused flashbacks, dissociation, or shame that drives disordered eating patterns, particularly in bulimia and BED.
- **OCD:** Many individuals with AN or BN show rigid routines, compulsive exercise, and obsessive food rituals resembling OCD symptomatology.
- **Depression:** Feelings of worthlessness, anhedonia, and low energy can reinforce food restriction or binge episodes.
- **Personality disorders:** Features such as impulsivity (in BPD) or excessive control (in OCPD) may influence the type and trajectory of an eating disorder.

Ethically, psychologists must differentiate between ED symptoms and comorbid traits to guide appropriate treatment. Failure to address underlying PTSD or mood symptoms may result in ineffective or even harmful interventions. Differential diagnosis is crucial, as the presence of comorbidities often necessitates integrated or modified treatment protocols.

Conclusion

The etiology of eating disorders is multifaceted, involving an interplay of biological vulnerability, psychological predisposition, trauma history, and sociocultural context. These disorders cannot be fully understood—or ethically treated—

without accounting for the complexity and individuality of each person's experience. As psychologists, we are charged with the responsibility not only to understand these risk factors but to apply that understanding with cultural humility, ethical integrity, and evidence-based care.

Section 5: Psychological Factors and Comorbid Mental Health Conditions in Eating Disorders

Introduction

Eating disorders (EDs) are not simply about food—they are psychological illnesses deeply rooted in issues of identity, control, emotion regulation, trauma, and cognition. Behind the observable symptoms of food restriction, bingeing, or purging lie intricate mental health mechanisms and emotional struggles. Understanding the psychological underpinnings of eating disorders—such as perfectionism, need for control, and emotional dysregulation—is crucial for effective assessment and treatment. Equally important is recognizing the high prevalence of comorbid mental health conditions, including anxiety disorders, depression, PTSD, OCD, and personality disorders. These co-occurring conditions often influence the onset, maintenance, and treatment of eating disorders and demand an integrative, person-centered approach grounded in ethical and culturally responsive care.

Perfectionism and Control: Cognitive and Personality Foundations

Among the most frequently observed personality traits in individuals with eating disorders is perfectionism. Particularly in those with anorexia nervosa and bulimia nervosa, perfectionism manifests as an inflexible drive to meet excessively high

standards—often in appearance, academics, or athletics. Research differentiates between self-oriented perfectionism (internally imposed demands) and socially prescribed perfectionism (perceived expectations from others), both of which are risk factors for disordered eating. These perfectionistic tendencies are not merely cognitive distortions but are embedded in the individual's identity, contributing to a sense of worth derived from performance or compliance with idealized standards (Bardone-Cone et al., 2018).

Closely related to perfectionism is the need for control. For many individuals with eating disorders, controlling food intake and body size becomes a coping mechanism in response to environments where they feel helpless, invalidated, or chaotic. Restriction, bingeing, or purging may serve as symbolic means of regaining mastery over an otherwise uncontrollable world. This is particularly evident in adolescents experiencing transitions, familial instability, or trauma—contexts where control over the body may provide an illusion of agency.

Emotional Dysregulation and Coping Deficits

Emotional dysregulation is another core psychological component of eating disorders. Many individuals with EDs have difficulty identifying, expressing, or tolerating emotional states. This alexithymia—the inability to recognize and verbalize emotional experiences—often leads to externalizing emotional pain through food behaviors. For instance, binge-eating may serve to numb overwhelming sadness or anxiety, while food restriction may become a way to "shut down" feelings entirely.

Dialectical Behavior Therapy (DBT) research supports the view that ED behaviors serve emotion-regulation functions, especially in individuals with co-occurring borderline personality disorder or trauma histories (Safer et al., 2009). Emotion regulation skills deficits have been shown to predict ED severity and persistence,

suggesting that interventions must focus not only on food-related behavior but on helping clients build tolerance for emotional distress.

Comorbidity with Anxiety and Depressive Disorders

Comorbid anxiety disorders are extremely common in ED populations. Generalized anxiety disorder (GAD), panic disorder, and social anxiety disorder frequently precede or co-occur with eating disorders, contributing to a cycle of avoidance, rigidity, and maladaptive behaviors. For example, a person with social anxiety may restrict food intake to conform to beauty standards, avoid public eating, or suppress anxiety through compulsive exercise.

Depression is another widespread comorbidity. Up to 70% of individuals with EDs meet criteria for major depressive disorder at some point during their illness. Symptoms of low self-worth, anhedonia, hopelessness, and suicidal ideation can exacerbate disordered eating and vice versa. Depression may follow the development of an ED due to social withdrawal, malnutrition, or shame—or it may precede the ED as part of a larger mood dysregulation pattern.

When both ED and mood symptoms are present, ethical care requires accurate assessment and prioritization. For example, severe malnutrition in anorexia can produce depressive-like symptoms (e.g., low mood, cognitive slowing), which may resolve with nutritional rehabilitation alone. Thus, psychologists must consider physiological and psychological interactions when diagnosing comorbidity.

Obsessive-Compulsive Disorder and Compulsivity

Obsessive-compulsive disorder (OCD) shares substantial overlap with anorexia and bulimia, especially in the form of rigid thinking, compulsive rituals, and fear-based avoidance. In anorexia, obsessions may revolve around weight gain, "unclean"

foods, or the "correct" timing of meals. Compulsions often include calorie counting, exercise, or food rituals that must be performed precisely or repeatedly. These behaviors provide temporary relief from anxiety, reinforcing the OCD-ED cycle.

Neuroimaging research suggests that both EDs and OCD involve dysfunction in cortico-striatal circuits—areas of the brain responsible for habit formation, decision-making, and impulse control. This neurological overlap partially explains why SSRIs and cognitive-behavioral strategies used in OCD may also benefit ED patients.

Clinically, it's vital to differentiate between ED behaviors and comorbid OCD symptoms. While both involve rigidity, the motivational drivers differ: OCD-related rituals may be about contamination or morality, while ED behaviors often focus on control, appearance, or weight-related fears. Misdiagnosis can lead to suboptimal treatment.

Post-Traumatic Stress Disorder (PTSD) and Trauma-Related Pathology

A large subset of individuals with eating disorders have a history of trauma, and many meet criteria for post-traumatic stress disorder (PTSD). Traumatic experiences—especially those involving sexual abuse, emotional neglect, or violence—are strongly associated with the development of bulimia nervosa and binge-eating disorder. In these cases, disordered eating becomes a coping strategy to manage dysphoria, numbness, or intrusive trauma-related symptoms.

PTSD can also complicate treatment. For example, body image work in ED therapy may trigger flashbacks in clients with a history of body-based trauma. Likewise, food restriction or purging may serve as reenactments of self-harm or methods of dissociation. Thus, trauma-informed care is essential. This includes collaboration

with trauma specialists, adaptation of exposure work, and the use of grounding techniques in therapy.

Ethically, trauma histories must be approached with care, consent, and attunement. Psychologists must never pressure clients to disclose trauma prematurely and must integrate trauma recovery work only when the client is emotionally stable enough to engage.

Personality Disorders and Trait Vulnerabilities

Certain personality disorders—and associated traits—commonly co-occur with EDs, especially in complex or treatment-resistant cases. Borderline personality disorder (BPD) is often seen in clients with bulimia or binge-eating disorder. Impulsivity, affective instability, identity diffusion, and interpersonal chaos in BPD mirror the emotional volatility and behavioral dysregulation seen in EDs.

Obsessive-compulsive personality disorder (OCPD) traits are frequently observed in restrictive-type anorexia. These individuals may present as rigid, perfectionistic, highly moralistic, and preoccupied with rules. Unlike OCD, OCPD traits are ego-syntonic—meaning the client sees them as integral to their identity and often resists change.

Clinically, recognizing personality vulnerabilities is essential for long-term planning and predicting treatment response. DBT and schema therapy have shown efficacy for ED clients with BPD traits, while motivational interviewing may help those with OCPD traits move toward cognitive flexibility and recovery.

Conclusion

Eating disorders are multifaceted psychological conditions fueled by perfectionism, emotional avoidance, and underlying psychiatric vulnerabilities.

The presence of comorbid mental health disorders further complicates their presentation and treatment. A comprehensive understanding of these psychological and diagnostic dimensions is critical to accurate assessment, effective intervention, and ethical care. Psychologists must remain grounded in the latest evidence, culturally competent practices, and person-centered values to ensure lasting recovery for clients navigating these challenging conditions.

Section 6: The Intersection of Eating Disorders

Introduction

Comorbidity is the rule rather than the exception in eating disorders. Most individuals presenting with an eating disorder (ED) will also meet diagnostic criteria for one or more additional psychiatric conditions, including anxiety disorders, major depressive disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and various personality disorders. These comorbidities shape the onset, maintenance, and severity of ED symptoms and are often predictive of treatment outcomes. This section provides a comprehensive understanding of these intersections, emphasizing ethical considerations, trauma-informed practice, and culturally competent care.

Comorbidity with Anxiety Disorders

Anxiety disorders—especially generalized anxiety disorder (GAD), social anxiety disorder, and panic disorder—are common precursors to and co-occurring diagnoses in individuals with EDs. Research indicates that anxiety disorders often emerge during childhood or early adolescence and may increase vulnerability to eating pathology through mechanisms such as heightened threat sensitivity, intolerance of uncertainty, and perfectionistic coping (Kaye et al., 2020). For

instance, individuals with GAD may fixate on controlling food intake as a way to manage pervasive anxiety, while those with social anxiety may develop intense fear of eating in public or being judged for their appearance.

From a treatment perspective, this intersection calls for integrated approaches that address both eating behaviors and underlying anxiety processes. Cognitive-behavioral therapy (CBT) techniques for anxiety—such as exposure and response prevention—can be adapted to challenge food-related fears and body image distress.

Major Depressive Disorder (MDD) and Eating Disorders

Depression is perhaps the most frequently observed comorbidity in EDs. Studies suggest that up to 70% of individuals with anorexia nervosa or bulimia nervosa experience a depressive episode during the course of their illness. Symptoms of anhedonia, low self-worth, guilt, and suicidal ideation are particularly prevalent in individuals with restrictive-type EDs (Stice et al., 2013). In some cases, depressive symptoms predate the ED and contribute to its onset. In others, malnutrition or the psychosocial consequences of the ED (e.g., isolation, shame) can result in secondary depression.

Clinically, it's crucial to differentiate between primary depression and depression caused by starvation. A full assessment of affective symptoms, appetite, sleep, and cognitive function—especially after nutritional stabilization—can clarify diagnosis and treatment targets. Ethically, clinicians must monitor suicide risk continuously, especially in individuals with severe restriction or chronic binge–purge cycles, as these populations have elevated rates of suicidal behavior (Levinson et al., 2020).

Obsessive-Compulsive Disorder (OCD)

EDs and OCD share significant cognitive and behavioral overlap, including obsessional thinking, rigid rules, and compulsive behaviors. Individuals with anorexia nervosa often display OCD-like symptoms related to meal planning, weighing, and cleanliness. In bulimia and BED, obsessions about guilt or "undoing" food consumption can drive purging or fasting behaviors. Neurobiologically, shared abnormalities in the cortico-striatal-thalamo-cortical circuits have been implicated in both OCD and EDs, suggesting common pathways of cognitive rigidity and behavioral reinforcement.

Therapeutic strategies effective for OCD—such as exposure and response prevention (ERP)—can be adapted to help clients confront feared foods, reduce ritualistic behaviors, and tolerate body image anxiety. The ethical imperative in these cases is to avoid over-pathologizing culturally informed rituals (e.g., religious fasting) and to clarify the motivational drivers of behavior during assessment.

PTSD and Trauma

A growing body of evidence points to trauma, particularly complex trauma, as a significant contributor to the development and chronicity of eating disorders. PTSD is most commonly linked to binge-eating disorder and bulimia nervosa, though it also appears in restrictive EDs. Traumatic experiences—such as sexual abuse, emotional neglect, and bullying—can contribute to dissociation from the body, negative self-image, and maladaptive coping strategies involving food and body control (Brewerton, 2016).

Many clients use bingeing or purging to regulate trauma-driven affect, escape intrusive thoughts, or punish themselves. Trauma-informed care, including phase-based treatment models, is essential. Therapists must be trained in grounding, pacing, and titrated exposure techniques. Ethical practice requires that trauma

work be consented to, paced, and contextualized within a safe therapeutic relationship.

Personality Disorders

The relationship between eating disorders and personality disorders (PDs)—particularly borderline personality disorder (BPD), obsessive-compulsive personality disorder (OCPD), and avoidant PD—is well-documented. One study found that individuals with BPD were four times more likely to have multiple Axis I disorders, including eating disorders (Zanarini et al., 2018). Clients with BPD often present with impulsivity, affective instability, and identity confusion, all of which can intensify ED symptoms.

In contrast, clients with OCPD may display rigidity, perfectionism, and need for control, leading to more restrictive EDs. Recognizing these patterns is crucial for treatment planning, as certain evidence-based interventions—like Dialectical Behavior Therapy (DBT) for BPD and motivational interviewing for OCPD traits—are more effective than generic ED treatments alone.

Conclusion

The intersection of eating disorders with other psychiatric conditions is complex and multifactorial. Understanding these relationships is essential for accurate diagnosis, effective treatment, and ethical, individualized care. Clinicians must embrace a trauma-informed, culturally humble approach that accounts for identity, history, and context while drawing on evidence-based modalities tailored to comorbid presentations.

Section 7: Considerations for Differential Diagnosis and Treatment Planning; Evidence-Based Psychological Interventions

Introduction

Differential diagnosis and individualized treatment planning form the cornerstone of effective eating disorder (ED) intervention. Due to overlapping symptomatology and frequent comorbidities, clinicians face the challenge of distinguishing between primary eating disorders and related conditions, such as mood disorders, OCD, trauma responses, and personality pathology. This section addresses differential diagnostic strategies and outlines evidence-based psychological interventions, including CBT-E, DBT, FBT, and ACT, highlighting ethical and culturally informed applications.

Differential Diagnosis: Clinical and Ethical Frameworks

Differential diagnosis involves evaluating overlapping symptoms and determining the primary disorder driving the client's distress and impairment. For example, food restriction may be present in both anorexia nervosa and obsessive-compulsive disorder, but the motivation differs: AN involves weight and shape concerns, whereas OCD may reflect contamination fears. Similarly, bingeing can occur in BED, BN, and BPD, but only in BED is it the central diagnostic feature.

Clinicians must also account for cultural, developmental, and medical factors that influence symptom presentation. An adolescent from a collectivist culture may avoid eating as a form of protest or autonomy assertion—not necessarily due to fear of weight gain. Similarly, disordered eating in neurodivergent clients may arise from sensory sensitivities rather than body image concerns.

From an ethical standpoint, misdiagnosis can lead to inappropriate treatment and harm. APA guidelines emphasize competency, cultural responsiveness, and nonmaleficence. Comprehensive assessment—including medical evaluation, structured interviews, and collateral input—is essential to minimize diagnostic error.

Evidence-Based Psychological Interventions

Cognitive Behavioral Therapy for Eating Disorders (CBT-E)

CBT-E is the most empirically supported individual therapy for adults with anorexia, bulimia, and BED. It addresses dysfunctional beliefs about food, weight, and self-worth through behavioral experiments, cognitive restructuring, and exposure. CBT-E is transdiagnostic and adaptable to varying symptom presentations (Fairburn et al., 2008).

Ethically, it's critical to avoid reinforcing fat-phobic or perfectionistic ideals in CBT work. Clinicians should avoid overemphasis on weight as a marker of "success" and must tailor interventions to clients' cultural values and personal goals.

Dialectical Behavior Therapy (DBT)

Originally developed for BPD, DBT is particularly effective for ED clients with emotion regulation difficulties, impulsivity, and self-harm. DBT modules in distress tolerance, emotion regulation, and interpersonal effectiveness help reduce bingeing, purging, and self-injury.

DBT's nonjudgmental stance aligns with ethical practice by validating clients' distress without condoning maladaptive behaviors. It is especially helpful for LGBTQ+ clients or those with trauma histories who may have experienced invalidation.

Family-Based Therapy (FBT)

FBT is the first-line treatment for adolescents with anorexia and is increasingly used for other EDs. FBT externalizes the illness, empowering parents to take an active role in refeeding and symptom interruption.

Culturally, this can be adapted to involve extended family members or culturally significant caregivers. Ethical practice involves informed consent from both parents and adolescents, age-appropriate psychoeducation, and non-blaming frameworks.

Acceptance and Commitment Therapy (ACT)

ACT targets experiential avoidance and cognitive fusion by helping clients commit to values-driven behavior rather than symptom control. It is useful in chronic or treatment-resistant EDs and for clients who resonate less with traditional CBT models.

ACT's emphasis on values, acceptance, and mindfulness aligns well with culturally diverse clients who may view distress through a spiritual or collectivist lens.

Integrating Assessment and Intervention

Effective treatment planning requires valid, culturally adapted tools such as:

- Eating Disorder Examination Questionnaire (EDE-Q)
- Eating Attitudes Test (EAT-26)
- SCOFF questionnaire

Multidisciplinary collaboration is also essential. Psychologists must work with medical doctors, dietitians, and psychiatrists to address the biopsychosocial needs

of clients. Shared decision-making, respect for autonomy, and documentation of clinical rationale are ethical imperatives.

Conclusion

Differential diagnosis and evidence-based intervention are cornerstones of ethical, effective care in the treatment of eating disorders. By understanding overlapping conditions, applying nuanced assessment strategies, and integrating multiple evidence-based modalities, psychologists can design tailored treatment plans that respect the whole person—mind, body, culture, and context.

Section 8: Application of Cognitive Behavioral Therapy for Eating Disorders (CBT-E) in Individual and Group Therapy

Introduction

Cognitive Behavioral Therapy–Enhanced (CBT-E) is widely regarded as one of the most effective psychological treatments for eating disorders. Developed by Dr. Christopher Fairburn and colleagues, CBT-E represents a transdiagnostic model designed to treat a wide spectrum of eating disorders including anorexia nervosa, bulimia nervosa, binge-eating disorder, and other specified feeding or eating disorders (OSFED). Unlike earlier models of CBT that targeted bulimia nervosa exclusively, CBT-E adapts the principles of cognitive and behavioral theory to address the shared psychological mechanisms underlying various eating disorders. The core premise is that the overvaluation of weight, shape, and eating control drives and maintains disordered behaviors across diagnostic categories. CBT-E has a strong empirical foundation and is endorsed by both the National Institute for

Health and Care Excellence (NICE) and the American Psychological Association as a first-line treatment for eating disorders in adults and an emerging option for adolescents.

Theoretical Foundations of CBT-E

CBT-E is designed as a modular and individualized treatment approach that flexibly responds to the client's unique maintaining mechanisms and clinical context. The therapy typically follows a four-stage model delivered over 20 to 40 sessions, depending on the severity and chronicity of the disorder. The treatment begins with an intensive focus on engagement and psychoeducation, establishing a strong therapeutic alliance and demystifying the mechanisms that sustain eating pathology. Clients are introduced to structured eating patterns and begin monitoring their behaviors and thoughts in real time. This stage often includes collaborative weighing, regular meal scheduling, and the use of food and thought diaries. Monitoring not only serves as an intervention tool but also facilitates cognitive insight into the patterns linking mood, environment, and eating behavior.

As treatment progresses, CBT-E targets specific cognitive distortions and maladaptive behaviors. One of the most salient features of the model is its focus on dismantling dietary restraint and the internal rules that govern food intake. Clients are supported in challenging rigid beliefs such as "I must not eat after 6 PM" or "eating bread will make me gain weight." These beliefs are deconstructed through cognitive restructuring and real-life behavioral experiments. Another key component involves addressing body image dissatisfaction through techniques such as mirror exposure, cognitive defusion, and the modification of body-checking behaviors. In clients who present with broader maintaining mechanisms,

including perfectionism, low self-esteem, or interpersonal difficulties, the therapist can incorporate optional modules tailored to these issues.

Individual Therapy Application

In individual therapy, CBT-E is highly structured and therapist-led, emphasizing clarity, accountability, and specificity. Sessions are typically scheduled weekly and follow a collaborative agenda. Therapists act as both educators and change agents, helping clients understand the functional purpose of their symptoms while also supporting behavioral risk-taking. Therapy concludes with a relapse prevention phase that includes identification of early warning signs, coping plans for high-risk situations, and the consolidation of skills that promote long-term recovery. Therapists guide clients through future-based scenarios to help them maintain gains post-treatment, reinforcing their autonomy and capacity for self-management.

Group Therapy Adaptation

Group-based CBT-E has emerged as a valuable adaptation, particularly in partial hospitalization programs (PHPs), intensive outpatient programs (IOPs), and university counseling centers. Group CBT-E offers several benefits including social modeling, peer accountability, and normalization of shared experiences. In group settings, core CBT-E principles are retained, but interventions are modified to promote group engagement and cohesion. Group leaders facilitate discussion around topics such as emotion regulation, diet mentality, values clarification, and self-criticism. Group-based behavioral experiments may include shared meals, fear food exposures, or body image workshops. Group therapy also allows for role-play, skill rehearsal, and reflection that enrich cognitive restructuring work.

While group CBT-E holds promise, its implementation must be handled with clinical sensitivity and ethical rigor. Not all individuals are appropriate for group therapy—clients with severe trauma histories, social phobia, or significant interpersonal difficulties may experience distress in group settings or become triggered by others' disclosures. Clinicians must conduct thorough pre-group screening and provide clear psychoeducation about group rules, confidentiality, and mutual respect. It is also vital to monitor for intra-group comparison, symptom contagion, or competitive dynamics, especially around weight loss or meal compliance. Therapists must model neutrality, redirect unhelpful conversations, and ensure the safety and therapeutic benefit of all participants.

Cultural and Individual Diversity Considerations

Cultural responsiveness is a critical aspect of CBT-E implementation. Eating disorders manifest differently across sociocultural contexts, and standardized protocols must be adapted to account for these variations. For instance, the overvaluation of thinness may not be the central issue for clients from cultures that associate food with family obligation, religious practice, or economic survival. Therapists must avoid imposing Western body ideals or diagnostic assumptions and instead explore what the eating behavior symbolizes within the client’s specific sociocultural framework. Language modifications, incorporation of cultural values, and the inclusion of culturally relevant metaphors enhance engagement and reduce resistance. Clinicians should also challenge their own implicit biases, particularly when working with clients in larger bodies, clients of color, or gender-diverse populations, who are often misdiagnosed or dismissed in eating disorder care due to prevailing stereotypes.

Ethical Considerations

Ethical practice within CBT-E demands a commitment to informed consent, client autonomy, and beneficence. Therapists must explain the rationale for treatment strategies such as regular weighing or food exposure in ways that are transparent and collaborative. They should obtain explicit consent before engaging in body image work, mirror exposure, or other potentially distressing exercises. Additionally, therapists must remain alert to the risks of iatrogenic harm—for example, using rigid meal plans without regard for cultural or medical dietary needs. Ethical dilemmas may also arise when working with adolescents, especially in cases where parents request weight goals or control over treatment processes. Navigating these challenges requires a balance of clinical judgment, cultural humility, and ethical clarity.

Conclusion

In conclusion, CBT-E stands as a foundational intervention in modern eating disorder treatment. Its structured yet adaptable framework allows for the treatment of diverse clinical presentations, while its emphasis on collaborative engagement, behavioral experimentation, and cognitive transformation aligns with best practices in psychological care. When applied thoughtfully in both individual and group settings—and when enriched with ethical sensitivity and cultural responsiveness—CBT-E not only reduces symptoms but also fosters sustainable recovery, resilience, and psychological growth. It equips clients with the tools to reclaim their autonomy from the eating disorder and rebuild a life anchored in values, nourishment, and wholeness.

Section 9: Dialectical Behavior Therapy (DBT) for Emotion Regulation and Impulse Control in Adolescent Eating Disorder Patients

Introduction

Dialectical Behavior Therapy (DBT), developed by Dr. Marsha Linehan in the 1990s, was originally designed to treat chronically suicidal individuals diagnosed with borderline personality disorder. However, over the past two decades, DBT has evolved into a robust and widely validated treatment for a range of disorders characterized by emotional dysregulation, impulsivity, and interpersonal instability. Among its most impactful adaptations has been its application in the treatment of adolescents with eating disorders—particularly bulimia nervosa, binge-eating disorder, and the binge–purge subtype of anorexia nervosa. DBT is now regarded as a vital tool in treating adolescent clients who exhibit high levels of affective instability, impulsive eating behaviors, and co-occurring self-harm or suicidality. This section provides an in-depth exploration of DBT's principles, therapeutic framework, adolescent-specific applications, clinical implementation, ethical issues, and cultural considerations.

Theoretical Framework and Core Concepts

At the heart of DBT lies the biosocial theory, which posits that emotional dysregulation results from the interaction between biologically based vulnerability and an invalidating social environment. Adolescents with EDs who fit the DBT profile often exhibit a heightened sensitivity to emotional stimuli, delayed return to emotional baseline, and difficulties in identifying and expressing emotions. This internal chaos often leads to impulsive behaviors such as binge-eating, purging,

food restriction, and self-injury as attempts to regulate distress or achieve a sense of control.

DBT conceptualizes eating disorder symptoms in this population not as irrational or merely maladaptive, but as learned responses to emotional pain. For example, binge eating might momentarily alleviate emotional numbness, while purging may offer temporary relief from anxiety. DBT helps adolescents replace these behaviors with healthier emotion regulation strategies, developing the skills necessary to navigate the challenges of adolescence without resorting to harmful coping mechanisms.

Clinical Implementation of DBT in Adolescent ED Treatment

DBT for adolescents (DBT-A) typically includes four components: individual therapy, group skills training (usually with family), phone coaching for in-the-moment support, and consultation teams for therapists. The standard treatment protocol is 16 to 24 weeks, with the flexibility to extend based on clinical need. The skills taught in DBT are organized into four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. In adolescent DBT, a fifth module— "walking the middle path"—is often added to help caregivers and adolescents resolve common family conflicts and increase dialectical thinking.

Individual therapy focuses on behavioral chain analyses, a powerful technique that identifies the triggers, vulnerabilities, thoughts, emotions, and consequences associated with an ED behavior (e.g., a binge-purge episode). Therapists use this analysis to identify skill deficits and implement corrective strategies. For example, if an adolescent reports binge-eating after an argument with a parent, the therapist may help the client understand that the behavior was a response to emotional invalidation and introduce skills such as checking the facts or practicing opposite action to address the distress in future situations.

Group skills training, often conducted with family members present, serves to teach DBT skills in a didactic and experiential manner. Adolescents learn to tolerate discomfort (e.g., urges to restrict or purge) through distress tolerance skills like “TIPP” (temperature, intense exercise, paced breathing, and progressive muscle relaxation), while parents learn validation techniques and how to reinforce skill use at home. Family participation is essential in DBT-A as parents are taught to model dialectical thinking, avoid invalidation, and support the adolescent in using DBT skills during moments of emotional escalation.

Phone coaching allows adolescents to reach out to therapists between sessions for real-time support in applying DBT skills. This feature is particularly important for managing urges to engage in ED behaviors or self-injury. For example, an adolescent may call their therapist when feeling an urge to purge after a high-calorie meal, and the therapist can coach them through distress tolerance or self-soothing techniques.

Adolescent-Specific Considerations

The adolescent developmental period introduces unique clinical complexities that DBT addresses head-on. Adolescents are navigating identity formation, increasing autonomy, social pressures, and emotional intensity—all of which can exacerbate ED symptoms. DBT’s structured, skills-based format aligns well with the developmental task of self-regulation. In practice, DBT fosters emotional literacy, impulse control, and relational competence, while also attending to the family system in which the adolescent is embedded.

One notable challenge in this age group is the coexistence of multiple risk behaviors such as cutting, substance use, or sexual risk-taking. DBT’s treatment hierarchy prioritizes life-threatening behaviors first (e.g., suicidality, severe restriction), followed by therapy-interfering behaviors, and then quality-of-life-

interfering behaviors like disordered eating. This allows therapists to remain focused and effective, even in the face of complex comorbidities.

Motivational issues are also more prominent in adolescents. Many young clients are treatment-resistant or ambivalent about change. DBT addresses this through its dialectical stance: accepting the adolescent as they are while also encouraging movement toward change. Therapists balance validation with change strategies, allowing adolescents to feel seen while still being challenged.

Cultural and Individual Diversity Considerations

DBT's flexibility makes it uniquely suited to multicultural adaptation. The mindfulness component of DBT draws from Eastern traditions and can be adapted to suit clients from spiritual or collectivist cultures who value somatic and relational awareness. When working with adolescents from marginalized backgrounds—including LGBTQ+ youth, racial and ethnic minorities, or those in larger bodies—clinicians must tailor interventions to reflect these clients' lived realities.

Family dynamics also differ significantly across cultural groups. In collectivist cultures, for instance, it may be more appropriate to include extended family members or spiritual leaders in family work. Therapists must be prepared to assess the cultural fit of family participation and to remain flexible in structuring sessions around familial norms and beliefs.

Clinical Effectiveness and Outcomes

DBT has demonstrated strong empirical support in treating adolescents with eating disorders who also present with suicidality, non-suicidal self-injury (NSSI), or significant mood lability. Studies have shown reductions in binge/purge

frequency, improvements in emotional regulation, and enhanced interpersonal functioning following DBT-A. Furthermore, family involvement in DBT has been shown to reduce caregiver stress, improve parent–adolescent communication, and enhance treatment adherence. Though DBT is not traditionally a weight-restoration model, it has been effective in reducing behaviors that impede medical stabilization and in preparing clients for additional care modalities, such as FBT or nutritional counseling.

Conclusion

DBT provides a powerful, structured, and evidence-based intervention for adolescents with eating disorders marked by emotional dysregulation and impulsivity. Its integration of mindfulness, validation, skills training, and behavioral change aligns well with the needs of treatment-resistant or high-risk adolescents. Through its structured components and commitment to cultural and ethical sensitivity, DBT fosters resilience, insight, and behavioral stabilization. When used in conjunction with nutritional rehabilitation and medical monitoring, DBT can play a transformative role in helping adolescents interrupt dangerous behaviors and move toward a life of greater emotional flexibility, relational integrity, and psychological wellness.

Section 10: Family-Based Therapy (FBT) for Adolescent Clients and the Role of Caregivers in Treatment

Introduction

Family-Based Therapy (FBT), commonly referred to as the Maudsley approach, has emerged as the leading evidence-based treatment for adolescents with anorexia nervosa and is increasingly applied to bulimia nervosa and avoidant/restrictive food intake disorder (ARFID). FBT departs significantly from traditional psychodynamic or individually focused approaches by asserting that families are not to blame for the development of the eating disorder, and that parents and caregivers are essential resources in their adolescent's recovery. This method emphasizes swift behavioral intervention over extended exploration of etiology and centers nutritional rehabilitation as the first and most urgent step toward recovery. Over the past 15 years, FBT has reshaped clinical paradigms for treating adolescent eating disorders and has been endorsed by numerous organizations, including the American Psychiatric Association and the Academy for Eating Disorders, as the gold standard of care for early-onset anorexia nervosa.

Theoretical Foundations and Philosophy of FBT

FBT is grounded in several core assumptions. First, the primary therapeutic agent is the family unit, rather than the individual adolescent. Second, the eating disorder is viewed as a biopsychosocial illness that takes control of the adolescent's brain and behavior. Third, it is understood that adolescents in the grip of an eating disorder cannot be expected to make rational decisions about food, weight, or health, due to the ego-syntonic nature of the illness and the

neurological effects of starvation. These principles lead to the central tenet of FBT: that parents must temporarily take control of their adolescent's eating in a structured and non-blaming manner to restore physical health and set the stage for psychological healing.

FBT also emphasizes the importance of externalizing the eating disorder—viewing it as a separate entity from the adolescent (e.g., "This is not your daughter refusing food, this is the illness speaking"). This helps reduce parent–child conflict and shame, redirecting anger or anxiety away from the child and toward the disorder itself. This framing also empowers families to work collaboratively against a common adversary.

Role of Caregivers and Family Members

In FBT, caregivers are seen as central to recovery—not passive supports, but active agents of change. This can include parents, guardians, step-parents, grandparents, or any primary caregivers involved in daily life. The treatment is structured to empower caregivers, reinforcing their intuitive capacity to protect and nourish their adolescent even when they feel powerless in the face of the illness. The therapist's role is to bolster this confidence, not supplant it.

Caregivers are taught how to recognize subtle symptoms of ED behavior (such as small portion manipulation, meal avoidance, or excessive exercise), respond with consistent boundaries, and maintain a united front. They are also supported in managing their own emotional reactions—including guilt, fear, and frustration—through validation and psychoeducation. When caregivers become anxious or permissive, the illness may exploit these patterns; thus, FBT teaches them to remain firm, calm, and compassionate.

It is important to note that in families with complex dynamics, such as high conflict, divorce, or previous trauma, FBT may need modification. In these cases,

therapists may work with co-parents individually, include extended family, or bring in adjunct family therapy to address relational strain that interferes with effective teamwork.

Cultural and Individual Diversity Considerations

FBT's core principles are adaptable across cultures but require intentional modification to align with family values, structure, and worldview. In collectivist cultures, for instance, extended family members such as grandparents or uncles may play key caregiving roles and must be included in treatment planning. In religious communities, fasting rituals or modesty practices may intersect with ED symptoms and should be explored with cultural sensitivity. Therapists must avoid imposing Western ideals of individualism or autonomy and instead ground treatment in the family's cultural strengths.

Ethical Considerations in FBT

FBT presents unique ethical challenges, particularly around adolescent autonomy, informed consent, and power dynamics. Because FBT requires caregivers to override the adolescent's choices around food and daily functioning, it must be introduced carefully, with transparency and collaboration. Adolescents should be informed that their caregivers will temporarily take charge in service of their health and that their autonomy will be restored as they recover. Therapists must maintain a neutral, non-colluding position, avoiding alliances with either parents or adolescents.

Conclusion

Family-Based Therapy is a deeply collaborative, structured, and behaviorally grounded treatment that mobilizes the family system to intervene directly in the cycle of disordered eating. When implemented with clinical precision, cultural humility, and ethical integrity, FBT can transform the treatment experience for both adolescents and their caregivers. It empowers families to reclaim their caregiving roles, rebuild trust, and restore health to adolescents whose development has been derailed by the eating disorder. In doing so, it not only treats symptoms but reweaves the social fabric that supports long-term recovery.

Section 11: Integrating Acceptance and Commitment Therapy (ACT) and Other Therapies in Eating Disorder Treatment

Introduction

Third-wave behavioral therapies represent a significant evolution in the treatment of psychological disorders, including eating disorders (EDs). Unlike traditional cognitive-behavioral therapies that focus primarily on symptom reduction through cognitive restructuring and behavioral change, third-wave approaches emphasize processes such as mindfulness, acceptance, values-based action, and self-compassion. These therapies are especially valuable when treating clients with chronic, treatment-resistant, shame-driven, or identity-related eating disorders. Acceptance and Commitment Therapy (ACT) is the most empirically supported among third-wave interventions for EDs, but complementary models—including Compassion-Focused Therapy (CFT) and Mindfulness-Based Cognitive Therapy (MBCT)—also offer clinically rich pathways to recovery. This section explores how

these approaches can be effectively integrated into eating disorder care and how they align with ethical, developmental, and cultural best practices.

Theoretical Foundations of ACT and Therapies

Acceptance and Commitment Therapy (ACT), developed by Steven Hayes and colleagues, is grounded in Relational Frame Theory, a contextual behavioral science that explains how language and cognition contribute to psychological suffering. In the case of EDs, clients often become entangled in rigid cognitive narratives such as “I must be thin to be loved,” “I am disgusting if I eat too much,” or “I can’t feel my emotions—it’s dangerous.” ACT helps clients step back from these beliefs through a process called cognitive defusion, allowing them to recognize thoughts as transient mental events rather than literal truths.

The central goal of ACT is to foster psychological flexibility—the capacity to act in accordance with one’s values even in the presence of distressing thoughts or feelings. This stands in stark contrast to control-based strategies like restriction or purging, which aim to eliminate discomfort but ultimately entrench suffering. ACT introduces six core processes: acceptance, cognitive defusion, contact with the present moment, self-as-context, values, and committed action. These processes allow clients to explore a life beyond the eating disorder, where values—not fear or shame—guide behavior.

Compassion-Focused Therapy (CFT), developed by Paul Gilbert, targets shame, self-criticism, and emotional avoidance, which are often central to the maintenance of EDs. CFT posits that many clients with EDs operate within an overactivated threat system, which results in heightened self-monitoring, self-punishment, and social withdrawal. By developing the soothing system through self-compassion exercises, imagery work, and emotion regulation, CFT helps clients cultivate a sense of safety within themselves.

Mindfulness-Based Cognitive Therapy (MBCT), originally created for preventing relapse in depression, is increasingly applied in ED care, especially in clients prone to rumination, emotional suppression, or autopilot behavior. MBCT teaches clients to notice bodily cues, urges, and emotions with a nonjudgmental stance, thereby reducing impulsive eating behaviors and increasing interoceptive awareness.

Clinical Application in Eating Disorder Treatment

Third-wave therapies are particularly effective when clients have chronic illness courses, ambivalence toward recovery, or comorbid anxiety, depression, PTSD, or trauma-related dissociation. These models are well suited for clients who have previously failed to engage in traditional CBT or who report high levels of internalized stigma, identity confusion, or emotional avoidance.

In clinical practice, ACT can be used across all stages of ED recovery. In early treatment, ACT helps clients develop willingness to experience discomfort, particularly as they reintroduce feared foods or face body image distress. Instead of attempting to change thoughts like “I feel huge,” clients are taught to acknowledge such thoughts without acting on them. This approach is especially useful for clients who struggle with thought suppression, rigidity, or perfectionism.

Later in treatment, ACT helps clients rebuild life purpose and meaning, especially after the acute symptoms have subsided. Therapists facilitate values clarification exercises, where clients explore domains such as relationships, spirituality, creativity, and health—not defined by thinness or food rules but by freely chosen goals. This values-oriented work helps protect against relapse by increasing commitment to a life worth living.

CFT, when integrated into therapy, is effective for addressing toxic shame, self-loathing, and punitive inner voices that commonly persist even after behavioral symptoms subside. This is particularly beneficial for clients with a history of

trauma or attachment wounds. CFT helps clients construct a compassionate inner dialogue using exercises such as compassionate letter writing, safe place imagery, and soothing rhythm breathing.

MBCT practices such as body scanning, urge surfing, and anchor breathing support clients in increasing tolerance of uncomfortable bodily sensations, hunger cues, or urges to act compulsively. Clients learn to “sit with” discomfort, observe it non-reactively, and choose mindful, values-consistent actions. These techniques can be integrated into daily recovery practices and are especially useful in group or intensive outpatient settings.

Conclusion

Third-wave therapies such as ACT, CFT, and MBCT offer rich, flexible, and compassionate frameworks for treating eating disorders. They align well with diverse cultural and developmental contexts and provide essential tools for clients navigating chronic symptoms, ambivalence, and shame. These models honor the full humanity of clients by shifting the focus from control to connection, from perfectionism to purpose, and from fear to freedom. When delivered ethically and adaptively, third-wave therapies can transform the treatment of eating disorders from mere symptom management into a profound journey of personal growth and value-driven living.

Section 12: Psychological Assessment Tools for Eating Disorders

Introduction

Psychological assessment plays a critical role in the identification, diagnosis, treatment planning, and outcome monitoring of eating disorders (EDs). Because eating disorders often present with secrecy, shame, and denial, especially in early stages, validated screening and diagnostic tools provide clinicians with essential insights that may not emerge through interview alone. This section provides an in-depth exploration of the most widely used and research-supported assessment instruments for eating disorders—including the Eating Disorder Examination Questionnaire (EDE-Q), Eating Attitudes Test (EAT-26), and the SCOFF questionnaire—as well as newer and specialized measures. It also covers their application in clinical practice, psychometric properties, ethical use, and cultural sensitivity.

Importance of Psychological Assessment in Eating Disorder Care

Assessment in eating disorder treatment serves multiple purposes: screening for at-risk individuals, confirming clinical diagnoses based on DSM-5-TR criteria, evaluating symptom severity, measuring treatment progress, and assessing comorbid conditions such as depression, anxiety, and trauma. Standardized assessment allows for evidence-based treatment planning, facilitating appropriate level-of-care decisions and interprofessional collaboration. Furthermore, psychological measures enhance client insight and engagement by providing tangible data that can be tracked over time.

Importantly, assessment should not replace clinical judgment but rather inform it. Many individuals with eating disorders may minimize or conceal symptoms due to stigma or ambivalence. Clinicians must use a combination of structured tools and sensitive interviewing to elicit an accurate clinical picture. Tools must also be interpreted within cultural, medical, and developmental contexts, avoiding overreliance on rigid cutoffs or metrics such as body mass index (BMI), which can obscure severity in non-underweight presentations.

The Eating Disorder Examination Questionnaire (EDE-Q)

The EDE-Q is a self-report version of the Eating Disorder Examination (EDE), a semi-structured interview developed by Fairburn and Cooper. The EDE-Q assesses cognitive and behavioral symptoms of eating disorders over the past 28 days, covering four subscales: Restraint, Eating Concern, Shape Concern, and Weight Concern. It also includes items on frequency of binge eating, purging, excessive exercise, and laxative use.

The EDE-Q is widely used in both research and clinical settings due to its strong psychometric properties and ease of administration. Its clinical utility lies in identifying symptom patterns, tracking change across time, and targeting treatment interventions based on specific subscale elevations. For example, high Shape and Weight Concern scores may suggest the need for body image interventions, while high Restraint scores may call for dietary normalization strategies.

However, the EDE-Q is subject to limitations, including its reliance on self-report and the influence of underreporting or denial. It also requires careful interpretation across gender identities and cultural groups, as body image concerns and eating attitudes vary widely. For clients with low literacy or cognitive difficulties, the full EDE interview may be more appropriate.

The Eating Attitudes Test (EAT-26)

The EAT-26 is a widely used screening tool designed to identify symptoms and concerns characteristic of eating disorders, particularly anorexia nervosa. It includes three subscales: Dieting, Bulimia and Food Preoccupation, and Oral Control. A score of 20 or higher is typically used as a cutoff for further clinical evaluation, although this threshold should not be used as a diagnostic marker.

The EAT-26 is particularly useful in community, school, and primary care settings due to its brevity and scalability. It has demonstrated good sensitivity and specificity, though its original validation focused largely on white, female, cisgender populations, which has raised concerns about its cultural applicability.

The EAT-26 is less useful for assessing binge eating disorder or ARFID, as it emphasizes restrictive behaviors and body image distortion. Additionally, it may miss muscle dysmorphia or orthorexia presentations more common in males and athletes. Clinicians should interpret EAT-26 results alongside a full clinical interview and explore non-dieting motives for food restriction (e.g., religious fasting, GI symptoms, sensory sensitivity).

The SCOFF Questionnaire

The SCOFF questionnaire is a five-item screening tool developed in the UK to rapidly detect the presence of eating disorders in medical and primary care settings. Each yes/no question corresponds to a hallmark symptom of anorexia or bulimia. An acronym, SCOFF stands for:

- Sick (Do you make yourself sick because you feel uncomfortably full?)
- Control (Do you worry you have lost control over how much you eat?)

- One stone (Have you recently lost more than one stone [14 lbs] in a 3-month period?)
- Fat (Do you believe yourself to be fat when others say you are too thin?)
- Food (Would you say food dominates your life?)

A score of two or more positive answers typically warrants further assessment.

The SCOFF is valued for its speed, simplicity, and high sensitivity, especially in non-specialist settings. However, its simplicity can also lead to false positives and low specificity. Furthermore, its design is heavily influenced by restrictive ED profiles and may not detect ARFID or BED. Cultural adaptations are necessary when applying the tool in populations unfamiliar with UK measurements (e.g., "stone") or where body image ideals differ.

Additional Assessment Tools

In addition to the above, several other tools are commonly used to assess eating pathology and related variables:

- **The Binge Eating Scale (BES)** assesses severity of binge-eating behaviors and is helpful for differentiating between overeating and clinically significant binge episodes.
- **The Body Shape Questionnaire (BSQ)** and Multidimensional Body-Self Relations Questionnaire (MBSRQ) explore body dissatisfaction and appearance evaluation, offering insights for body image interventions.
- **The Eating Disorder Inventory-3 (EDI-3)** provides a multidimensional assessment of psychological traits associated with EDs, including interoceptive deficits, perfectionism, and interpersonal distrust.

- **The Clinical Impairment Assessment (CIA)** measures psychosocial functioning and quality of life in clients with EDs, helping clinicians assess functional impairment beyond behavioral symptoms.

Section 13: The Role of Clinical Psychologists in Multidisciplinary Settings

Introduction

The treatment of eating disorders demands a multidisciplinary approach, as these illnesses span the psychological, nutritional, and medical domains. Clinical psychologists play a central role in such teams, not only by delivering evidence-based psychotherapy but also by providing psychological assessments, coordinating care, advocating for patient needs, and helping navigate the complex interface of mental and physical health. This section explores the essential functions of clinical psychologists within multidisciplinary teams (MDTs), the nature of interprofessional collaboration, and the medical and ethical considerations involved in the comprehensive care of eating disorder patients. It emphasizes a systems-oriented, collaborative framework that integrates psychological expertise with the specialized knowledge of dietitians, psychiatrists, and primary care or hospital-based physicians.

The Central Role of Psychologists in ED Care

Clinical psychologists are often the first point of contact for individuals seeking treatment for eating disorders or are referred by pediatricians, school counselors, or concerned family members. Their initial responsibilities include conducting a comprehensive psychological assessment, establishing diagnostic clarity using

DSM-5-TR criteria, evaluating for co-occurring conditions such as anxiety, depression, PTSD, or obsessive-compulsive disorder, and determining the appropriate level of care (e.g., outpatient, IOP, PHP, residential, or inpatient). Psychologists must be adept at using standardized assessment tools (e.g., EDE-Q, EAT-26, CIA) and must synthesize findings into formulations that inform individualized treatment plans.

In treatment delivery, psychologists implement evidence-based psychotherapies such as CBT-E, FBT, DBT, or ACT, depending on the client's diagnosis, age, symptom severity, and developmental needs. Psychologists also serve as coordinators of care, engaging in regular case conferencing and chart reviews with medical and nutritional professionals. Their ability to track behavioral progress, emotional regulation, and cognitive change positions them as the team member best equipped to monitor motivation for recovery, readiness for transitions between care levels, and psychological risk factors such as suicidality or trauma triggers.

Collaborating with Dietitians: Nutritional Restoration and Behavioral Integration

Registered dietitians (RDs) play an essential and complementary role in the treatment of eating disorders, focusing on nutritional rehabilitation, meal planning, and re-establishing normalized eating patterns. Collaboration between psychologists and RDs is critical for reinforcing therapy goals, addressing food fears, and ensuring consistency between nutritional and psychological interventions.

Clinical psychologists must work closely with dietitians to understand food-related exposures, body image distress, and client resistance. For instance, if a client is engaging in secretive binge eating while reporting full compliance to the RD, the psychologist may detect avoidance through therapy and bring this to the

dietitian's attention. Conversely, the RD may observe caloric restriction or macronutrient fears that have not yet been addressed in therapy and communicate these patterns to the psychologist.

It is ethically imperative that psychologists respect the scope of practice of the dietitian—avoiding meal plan creation or nutritional counseling—and instead provide psychological support for behavioral change. This includes helping clients tolerate distress during food challenges, explore perfectionism around eating, or reduce cognitive distortions related to caloric intake or "clean eating." Weekly coordination meetings or shared documentation systems enhance this relationship and reduce treatment fragmentation.

Collaborating with Psychiatrists: Managing Medication, Comorbidities, and Psychiatric Risk

Psychiatrists are vital members of eating disorder treatment teams, particularly in complex cases involving comorbid psychiatric conditions, psychotropic medication management, or risk assessment for suicidality and self-harm. Given that eating disorders often co-occur with mood disorders, anxiety disorders, and personality disorders, clinical psychologists must engage in close consultation with psychiatrists to ensure that mental health symptoms are properly managed in parallel with psychotherapy.

While medication is not the frontline treatment for most eating disorders, SSRIs (e.g., fluoxetine) may be indicated for bulimia nervosa and depression, antipsychotics (e.g., olanzapine) may be cautiously used in severe anorexia nervosa to reduce obsessive thoughts, and mood stabilizers may be used in co-occurring bipolar disorder. Psychologists must inform psychiatrists of emotional patterns, dissociation, and treatment resistance that may not emerge during brief medication checks.

Coordination also becomes critical when addressing treatment interference caused by side effects or when navigating client ambivalence toward pharmacological treatment. Psychologists often serve as the liaison between the psychiatrist and client, using motivational interviewing to increase medication adherence or addressing fears about weight gain or stigma associated with psychiatric care.

Collaborating with Medical Professionals: Monitoring Physical Health and Safety

Given the medical risks associated with eating disorders—including electrolyte imbalance, cardiac arrhythmias, amenorrhea, osteoporosis, and gastrointestinal dysfunction—collaboration with primary care physicians, endocrinologists, and inpatient medical staff is essential. Clinical psychologists must remain informed about clients' vital signs, lab results, weight stability, and any red flags indicating medical instability.

Psychologists are not licensed to interpret lab results or prescribe interventions but must recognize when to advocate for higher levels of care. For example, a psychologist may need to initiate hospitalization when a client is bradycardic, hypotensive, or severely malnourished. Early collaboration with medical providers ensures that the team is prepared for acute medical deterioration and prevents fragmentation during transitions in care.

Ethically, psychologists must uphold the principle of nonmaleficence by deferring to medical professionals on physical health decisions while continuing to provide emotional containment and therapeutic presence. In some cases, they may participate in interdisciplinary rounds or communicate with pediatricians to educate families on the medical seriousness of an ED diagnosis.

Ethical Considerations in Multidisciplinary Collaboration

Collaborative treatment introduces unique ethical responsibilities. First, clear role delineation must be established to avoid boundary violations, duplication of services, or contradictory messaging. Each team member should understand the limits of their expertise, and regular case conferences should be used to clarify responsibilities and share clinical observations.

Second, confidentiality must be maintained within legal and ethical bounds. Clients should be informed at intake that information will be shared within the treatment team to coordinate care. Informed consent should specify what information will be disclosed, to whom, and for what purposes. In the case of minors, psychologists must balance legal requirements for parental access with the adolescent's right to privacy, especially regarding topics like suicidality, sexual identity, or trauma.

Third, ethical treatment planning must consider the least restrictive level of care while balancing safety and effectiveness. Clinical psychologists must use empirically supported indicators—such as the APA Guidelines for Level of Care Determination for Eating Disorders—to determine when a client should be stepped up or down in care. Collaborative advocacy becomes essential when insurance barriers, systemic inequities, or caregiver disagreement impede access to needed treatment.

Conclusion

The treatment of eating disorders requires integrated, ethically sound collaboration among clinical psychologists, dietitians, psychiatrists, and medical professionals. Psychologists serve not only as expert providers of evidence-based psychotherapy but also as system navigators, team communicators, and client advocates. Their ability to bridge psychological, medical, and nutritional care

enhances treatment cohesion, safety, and outcome efficacy. When practiced with cultural humility, ethical precision, and interdisciplinary respect, multidisciplinary teamwork becomes a model for comprehensive, human-centered care that addresses the full complexity of eating disorders.

Section 14: Recognizing Red Flags for Medical Instability and When to Refer for Higher Levels of Care

Introduction

Eating disorders are not only severe psychiatric conditions but also life-threatening medical illnesses with complex physiological consequences. Despite being often viewed through a psychological lens, the somatic complications of disorders like anorexia nervosa, bulimia nervosa, and ARFID can lead to sudden cardiac events, multi-organ failure, and death. Therefore, it is imperative that clinical psychologists—who are frequently the first to engage with patients—develop competence in identifying signs of medical instability and understand when to initiate referrals to higher levels of care such as inpatient medical stabilization, residential treatment, or intensive outpatient programs (IOPs). This section provides a thorough overview of the medical warning signs of decompensation, outlines levels of care, and offers guidance on ethical, clinical, and collaborative referral processes.

Understanding Medical Instability in Eating Disorders

Medical instability refers to the compromise of essential physiological systems due to malnutrition, electrolyte imbalance, or disordered eating behaviors. These

conditions can be deceptive in presentation. For example, patients with anorexia nervosa may appear functional, alert, and articulate—even while their vital signs indicate profound instability. Similarly, individuals with bulimia may appear of average weight or overweight, masking the internal damage caused by purging, diuretic use, or binge eating.

Medical red flags include:

- Cardiac abnormalities: bradycardia (heart rate < 50 bpm in adults, < 45 bpm in adolescents), orthostatic hypotension (≥20 mmHg drop in systolic BP or ≥10 mmHg in diastolic BP when standing), and arrhythmias.
- Severe electrolyte disturbances: particularly hypokalemia (low potassium), hypophosphatemia, and hyponatremia, which may result from purging, laxative abuse, or refeeding syndrome.
- Amenorrhea or delayed puberty in adolescents, indicating hypothalamic suppression.
- Low body temperature (hypothermia), especially <96°F (35.5°C), and hypoglycemia.
- Fainting, dizziness, or seizures.
- Rapid weight loss: >15% of body weight within 3 months or BMI < 15 in adults.
- Inability to maintain hydration or nutrition orally, despite outpatient support.
- Psychiatric instability such as suicidal ideation, self-harm, severe depression, or psychosis.

These symptoms, particularly in combination, often necessitate hospitalization for medical stabilization or referral to a residential eating disorder facility capable of 24-hour medical monitoring.

Levels of Care: Indications and Referral Timing

The American Psychiatric Association and the Academy for Eating Disorders recommend a stepped care model based on severity, medical risk, psychiatric comorbidity, and functional impairment. Psychologists must be familiar with the following levels of care and their referral thresholds:

1. **Outpatient Care:**
   Clients are medically stable, eating with some consistency, and can function in school or work settings. Psychotherapy, nutritional counseling, and medical monitoring occur weekly or biweekly.

2. **Intensive Outpatient Program (IOP):**
   Clients attend structured meals and group therapy 3–5 days a week for 3–4 hours/day. Appropriate for those with moderate symptom severity but who are medically stable.

3. **Partial Hospitalization Program (PHP):**
   Clients participate in programming for 6–10 hours/day, 5–7 days/week. PHPs offer close medical monitoring, supervised meals, and intensive psychotherapy, and are ideal for those who are medically stable but require full-day support.

4. **Residential Treatment:**
   Clients live on site in a 24-hour therapeutic setting, with multidisciplinary teams providing full psychiatric, nutritional, and behavioral support. This is

indicated for individuals who are medically stable but unable to interrupt behaviors or function in less structured environments.

5. **Inpatient Hospitalization:**
   Necessary when a client is medically unstable, at risk of cardiac arrest, electrolyte derangement, severe bradycardia, or organ failure. This level includes refeeding protocols and 24/7 telemetry and nursing.

Psychologists are often the first to detect early warning signs—such as treatment resistance, dramatic weight loss, emotional decompensation, or hiding behaviors—and should not delay referrals. Waiting until clients "look" sick enough can result in catastrophic outcomes.

The Psychologist's Role in Referral and Advocacy

Psychologists must assess not only the client's psychological readiness for treatment but also their medical safety in outpatient settings. This requires regular collaboration with physicians, dietitians, and sometimes school or family systems. Key referral responsibilities include:

- Identifying medical instability or psychiatric decompensation that exceeds outpatient scope.
- Coordinating with the client's primary care physician or pediatrician for medical clearance and labs.
- Consulting with higher-level programs to determine fit and availability.
- Supporting the client and family in navigating insurance or logistical barriers to admission.
- Preparing the client emotionally for transitions and addressing resistance or ambivalence.

Ethically, psychologists must document red flags clearly, communicate urgency with both clients and providers, and avoid enabling continued deterioration by maintaining a “wait-and-see” approach when the clinical picture is urgent.

Medical Collaboration and Treatment Transitions

Once a referral is made, clinical psychologists should remain involved in the continuity of care. In inpatient or residential programs, this may involve sharing treatment history, psychological formulation, and risk factors with admitting teams. After discharge, the psychologist may resume care as the outpatient provider or assist in aftercare planning.

Effective treatment transitions require preparation and psychoeducation, especially for adolescents and families. Explaining that hospitalization is not a failure but a safety measure helps reduce shame and resistance. Psychologists can also offer brief check-ins or therapy “bridging” during waitlists to maintain support until admission.

In multicultural contexts, discussions about hospitalization or residential care must be approached with cultural humility and transparency. Some families may fear institutionalization due to systemic distrust or cultural stigma. Psychologists must honor these perspectives while clearly explaining the medical necessity and available safeguards.

Conclusion

The timely identification of medical instability and referral to higher levels of care is a core responsibility of clinical psychologists working with eating disorders. While psychologists may not provide direct medical treatment, their vigilance in recognizing red flags—combined with interdisciplinary coordination—can be life-

saving. By grounding referrals in ethical practice, cultural responsiveness, and clinical rigor, psychologists not only protect client safety but help restore health, dignity, and hope for recovery.

Section 15: Navigating the Ethical Challenges of Treating Eating Disorders

Introduction

The treatment of eating disorders presents some of the most complex ethical challenges in mental health practice. These conditions often involve ego-syntonic symptoms, severe medical risk, developmental factors, and high levels of denial or resistance. Psychologists working with eating disorders must skillfully navigate the ethical terrain of informed consent, confidentiality, and, in some cases, involuntary treatment. This complexity is heightened in vulnerable populations such as minors, individuals with co-occurring psychiatric disorders, and those from marginalized communities. Guided by the APA Ethical Principles of Psychologists and Code of Conduct (2017) and the APA Continuing Education Standards, this section explores the key ethical domains relevant to eating disorder care and provides best practices for ethically sound and culturally responsive intervention.

The Ethical Framework: APA Principles and Standards

The APA Code of Ethics serves as the foundational guide for all psychological practice, with five overarching principles:

1. Beneficence and Nonmaleficence – Psychologists strive to benefit those they serve while taking care to do no harm.

2. Fidelity and Responsibility – Professionals are responsible to their clients, colleagues, and the public.
3. Integrity – Honesty and transparency in professional roles are essential.
4. Justice – Psychologists recognize that fairness and justice entitle all persons to access and benefit from psychological services.
5. Respect for People's Rights and Dignity – This includes honoring autonomy, privacy, and cultural context.

These principles are operationalized through enforceable standards, such as:

- Standard 3.10: Informed Consent
- Standard 4.01–4.05: Privacy and Confidentiality
- Standard 10.01–10.10: Therapy Relationships and Termination
- Standard 1.04–1.06: Avoiding Harm, Misuse of Influence, and Resolving Ethical Conflicts

Informed Consent and Decisional Capacity in Eating Disorders

Informed consent is a dynamic process, not a one-time signature. In the context of eating disorders—particularly in adolescents or medically compromised adults—obtaining meaningful consent requires careful evaluation of decisional capacity. Clients with anorexia nervosa, for example, may deny illness despite life-threatening emaciation or cardiac compromise. In such cases, the psychologist must assess whether the client can:

- Understand the nature and purpose of treatment.
- Appreciate the consequences of refusing care.

- Reason logically about options.
- Communicate a choice consistently.

If decisional capacity is impaired, consent may need to be obtained from a legal guardian, with continued efforts to include the client in decision-making. Assent, though not legally binding, is ethically desirable and developmentally appropriate, especially with minors.

Psychologists must provide clear, jargon-free explanations of the treatment plan, potential risks, expected benefits, and alternatives. This is especially important in multidisciplinary settings where medical risks (e.g., refeeding syndrome, weight gain, or tube feeding) intersect with psychological distress. Consent must also cover data sharing across treatment team members, especially in PHP, IOP, or residential settings.

Confidentiality in Eating Disorder Treatment

Confidentiality is the cornerstone of psychological care but presents unique tensions in the context of eating disorders. Clients may disclose dangerous behaviors (e.g., daily purging, water loading, compulsive exercise) while refusing to involve family or medical providers. Psychologists must balance the ethical principle of autonomy with duty to protect, especially when clients are at risk of imminent harm due to medical deterioration.

The APA Code allows for limited breaches of confidentiality (Standard 4.05) when disclosure is mandated by law or necessary to prevent serious harm. This includes:

- Suicidality or self-injury.
- Medical instability (e.g., bradycardia, syncope, purging with hypokalemia).
- Child or elder abuse.

- Court-ordered evaluations.

In such situations, psychologists should first attempt to obtain voluntary consent for disclosure and explain what information will be shared and with whom. Even when breaching confidentiality is justified, it should be done minimally and respectfully, focusing only on what is needed for safety and coordination.

Working with minors adds complexity. In many jurisdictions, parents have the legal right to access their child's medical records. However, APA ethics support limited confidentiality for adolescents to foster therapeutic trust, particularly around sensitive issues such as body image, sexuality, and trauma. Psychologists must clarify confidentiality limits during informed consent and revisit them as treatment progresses.

Involuntary Treatment and Ethical Justification

Involuntary hospitalization or forced feeding is a last-resort measure often used in cases of life-threatening anorexia nervosa when the patient refuses treatment. Such decisions are ethically fraught, implicating both autonomy and nonmaleficence. In these cases, psychologists must determine whether the patient is incapable of making informed decisions and whether there is a clear and immediate threat to life.

Involuntary care can be initiated under civil commitment laws, which vary by jurisdiction. In most cases, the psychologist initiates an evaluation or petition, and a physician or judge determines eligibility for detention. Ethical considerations include:

- Exhausting all voluntary options first.
- Documenting the basis for concern (e.g., lab abnormalities, vital sign instability, suicidal ideation).

- Involving the client in decisions as much as possible.
- Ensuring that involuntary care is time-limited and directed toward stabilization, not long-term behavior change.

Some clients may retrospectively appreciate life-saving interventions, while others may experience trauma, loss of trust, or legal conflict. Psychologists must process these experiences in therapy, validate the client's feelings, and distinguish between protecting life and controlling autonomy.

Addressing Countertransference, Bias, and Moral Distress

Treating eating disorders can evoke powerful countertransference in clinicians. Feelings of helplessness, frustration, protectiveness, or even admiration for the client's control can interfere with objective decision-making. Ethical practice requires supervision, consultation, and self-reflection to manage these dynamics.

Moral distress may arise when systemic barriers (e.g., insurance refusal, program inaccessibility, family resistance) prevent ethical care. Psychologists should advocate for the client's rights, document care barriers, and consider ethics consultations in institutional settings. They should also participate in systemic change efforts, such as supporting policy reforms to expand eating disorder coverage or developing inclusive treatment programs.

Conclusion

Navigating the ethical landscape of eating disorder treatment requires clinical acumen, legal knowledge, cultural humility, and a deep commitment to client dignity. Informed consent, confidentiality, and the judicious use of involuntary care are not just legal obligations—they are relational acts that shape the recovery process. Psychologists must be prepared to walk the line between autonomy and

safety, advocacy and accountability, compassion and clarity. When ethical decisions are made with transparency, respect, and collaboration, clients are more likely to trust the process—and themselves.

Section 16: Addressing Personal Biases and Stigma in Clinical Practice to Foster a Supportive Therapeutic Environment

Introduction

Eating disorders exist not in a vacuum but within a sociocultural landscape that is heavily influenced by appearance-based norms, fatphobia, racism, gender oppression, ableism, and mental health stigma. These societal forces do not stop at the clinic door—they often shape the perceptions, assumptions, and behaviors of even the most well-intentioned healthcare providers. As such, clinical psychologists must actively examine how their implicit biases and internalized beliefs may contribute to diagnostic errors, invalidation, or the perpetuation of stigma in the therapeutic setting. This section explores how biases around body size, race, gender, sexuality, disability, and mental illness can influence care for individuals with eating disorders, and provides actionable strategies for cultivating an inclusive and affirming therapeutic environment.

Understanding the Nature of Bias in Eating Disorder Treatment

Bias can be explicit or implicit, conscious or unconscious. In clinical settings, bias often presents subtly—in the form of microaggressions, misdiagnoses, or unequal access to care. For example, a clinician may unconsciously dismiss binge eating behaviors in a higher-weight Black woman as "overeating" rather than recognizing

them as part of a clinical disorder. Alternatively, a thin white adolescent may be rapidly diagnosed and referred for inpatient treatment based on visual cues alone, despite showing less overall risk than another client.

These disparities are not accidental. Decades of research have shown that eating disorder diagnosis and treatment access is deeply shaped by stereotype-based assumptions, particularly the long-held (and false) belief that eating disorders primarily affect thin, white, cisgender, affluent females. As a result, transgender youth, BIPOC clients, men, people with disabilities, and individuals in larger bodies are often underdiagnosed, misdiagnosed, or excluded from treatment altogether.

Psychologists must acknowledge that our field has historically colluded with systems of appearance-based oppression—both through the use of BMI-centric diagnostics and through uncritical reinforcement of weight loss as a therapeutic goal. Failing to examine these structural influences risks retraumatizing clients, eroding trust, and furthering their alienation from care.

Weight Bias in Clinical Settings

Weight stigma—defined as negative attitudes, beliefs, and behaviors toward individuals based on body size—is pervasive in healthcare and psychology. Research shows that clinicians, including psychologists, often endorse anti-fat attitudes, sometimes viewing clients in larger bodies as less motivated, noncompliant, or personally responsible for their condition. These biases can manifest in language (e.g., "noncompliant with weight goals"), assumptions about health (e.g., equating higher weight with poor diet or sedentary behavior), or diagnostic overshadowing (e.g., attributing all symptoms to weight rather than psychological distress).

Weight bias in eating disorder treatment is particularly dangerous. A client who purges daily but has a BMI over 25 may be told they don’t meet criteria for

anorexia, despite engaging in life-threatening behaviors. Alternatively, clients recovering from restriction may be pressured to lose weight once they reach the “normal” range, even if they remain psychologically compromised. These clinical decisions reflect anti-fat cultural norms, not evidence-based care.

Creating a weight-inclusive environment means challenging these assumptions at every level. Therapists should avoid using BMI categories as diagnostic shortcuts, refrain from moralizing food choices, and eliminate fatphobic language from both documentation and dialogue. Embracing the principles of Health at Every Size (HAES), intuitive eating, and body liberation can help guide more equitable, person-centered care.

Addressing Racism, Cultural Stereotypes, and Health Disparities

Racial and ethnic minorities are less likely to be screened for eating disorders, less likely to be referred for specialty care, and less likely to receive culturally adapted interventions. Black adolescents, for example, are 50% more likely than white peers to engage in bulimic behaviors but are significantly less likely to be identified or treated. This gap is fueled in part by provider assumptions that eating disorders are "white problems" and that body dissatisfaction is less relevant in communities of color.

Psychologists must confront the Eurocentric body ideals and diagnostic frameworks embedded in many treatment models. For instance, the overvaluation of thinness may not be the central feature of distress in all cultural contexts. In some cultures, food restriction may reflect religious fasting, community norms, or socioeconomic realities. In others, body ideals may center muscularity or curviness, rather than thinness. Failing to account for these nuances risks pathologizing culturally congruent behaviors or missing disorder-consistent distress.

Ethical practice demands that clinicians assess body image, eating behaviors, and identity-based distress within the client's cultural framework. This includes using culturally validated assessment tools, offering translation or interpretation services when needed, and recognizing the impact of racism, colonialism, and intergenerational trauma on eating and body relationships.

Creating a Supportive and Inclusive Therapeutic Environment

Addressing bias is not a one-time act—it is an ongoing ethical responsibility. Clinical psychologists must cultivate self-awareness, engage in lifelong cultural humility, and remain open to feedback from clients and communities. Strategies include:

- Seeking supervision and consultation around identity-based countertransference.
- Participating in continuing education on anti-oppressive practice and equity.
- Reflecting regularly on one's own privileges, biases, and blind spots.
- Modifying treatment goals, interventions, and language to reflect each client's lived experience.

Creating a supportive environment also means transforming physical and symbolic aspects of care. This includes offering chairs and medical equipment that accommodate larger bodies, displaying inclusive signage, and ensuring that intake forms, therapy content, and educational materials are free from stigmatizing assumptions.

Conclusion

The therapeutic space should be one of safety, affirmation, and radical empathy—particularly for those whose bodies, identities, and experiences have been pathologized or erased. Clinical psychologists must confront their own biases and work to dismantle the systemic stigma that permeates eating disorder treatment. By doing so, they become more than clinicians—they become advocates for justice, dignity, and true healing.

Section 17: Cultural and Individual Diversity in Eating Disorder Treatment

Introduction

Eating disorders have historically been understood and treated through a predominantly white, Western, cisgender, thin-centric lens. This framing has contributed to the underdiagnosis, misdiagnosis, and undertreatment of individuals from diverse cultural, racial, ethnic, gender, socioeconomic, and ability backgrounds. In recent years, the American Psychological Association (APA), along with a growing body of clinicians and researchers, has called for a paradigm shift—one that places diversity, equity, and inclusion (DEI) at the center of ethical and effective eating disorder care.

The APA's Multicultural Guidelines (2017) define multicultural competence as a "developmental process" requiring psychologists to consider the intersectional identity of individuals, institutional oppression, historical trauma, and structural inequities. Treating eating disorders through a culturally humble and inclusive lens is not optional—it is an ethical imperative (APA, 2017). This section provides a robust framework for understanding and addressing relevant cultural and

individual diversity concerns in eating disorder treatment, and offers strategies for integrating DEI principles in assessment, diagnosis, therapeutic alliance, and treatment planning.

Cultural and Sociopolitical Contexts of Eating Disorders

Traditional models of eating disorder pathology often locate distress within the individual, overlooking how sociocultural systems contribute to body dissatisfaction and disordered eating. However, research consistently shows that racism, fatphobia, gender-based oppression, anti-immigrant bias, and socioeconomic inequality all play significant roles in shaping eating behaviors and body image.

For example, Black women in the U.S. experience unique pressures around body size, often navigating cultural ideals that differ from the Eurocentric thin ideal while simultaneously facing hypersexualization and systemic racism. Similarly, LGBTQ+ youth may engage in disordered eating as a means of coping with gender dysphoria, social rejection, or efforts to conform to rigid appearance norms. For Indigenous communities, intergenerational trauma, food insecurity, and colonial narratives around "discipline" and "control" over the body may influence disordered patterns that don’t align with DSM-based symptom presentations.

Thus, psychologists must contextualize disordered eating within each client’s historical, cultural, and community narrative, recognizing that oppression and resistance both shape body relationships. This requires a move away from universalist assumptions and toward culturally grounded formulations that explore how clients have come to understand food, body, and self-worth in their specific social context.

Barriers to Access and Representation in Eating Disorder Care

Historically, research and treatment have centered on white, cisgender, affluent, and female bodies, often excluding others from both scientific inquiry and clinical care. A consequence of this bias is that many marginalized individuals are screened less frequently, diagnosed later, and referred to lower levels of care—even when presenting with high acuity symptoms (Cheng et al., 2019).

For example:

- Latinx and Asian clients are less likely to meet DSM diagnostic criteria even when presenting with significant distress, due to culturally incongruent symptom expression.
- Transgender clients report high rates of disordered eating but are often excluded from gendered treatment environments that misalign with their identity.
- Clients in larger bodies often experience weight stigma, leading to dismissive medical care and invalidation in ED treatment settings.

Psychologists must address these disparities by critiquing and adapting standard tools, advocating for inclusive policies, and providing affirming, identity-responsive care. It is not enough to be non-biased; clinicians must be proactively inclusive, ensuring that all clients feel safe, seen, and valued.

Key DEI Components for Clinical Application

Diversity

Diversity in eating disorder treatment refers to recognizing and honoring the intersectionality of each client's identity—including race, ethnicity, gender

identity, sexual orientation, age, religion, socioeconomic status, neurodiversity, and disability status. Psychologists must inquire about these dimensions early and integrate them into case formulation. For instance, a client's food rituals may be tied to cultural or religious practice, while their relationship to thinness may be influenced by generational trauma or survival strategies within systemic oppression.

Equity

Equity goes beyond equality by addressing systemic barriers that prevent clients from accessing appropriate care. Psychologists should:

- Challenge BMI-based criteria that exclude higher-weight clients from care.
- Advocate for insurance coverage of culturally competent treatment.
- Recognize how zip code, immigration status, and education level impact access to nutrition and therapy.

Equity also involves flexibility in treatment models—adapting evidence-based protocols to match clients' lived realities, rather than expecting rigid adherence to Eurocentric norms.

Inclusion

Inclusion ensures that clients from marginalized backgrounds experience psychological safety and are able to participate fully in their care. This involves:

- Using inclusive language and pronouns.
- Offering materials and group programming that reflect diverse experiences.
- Employing staff and supervisors with shared lived experience or cultural knowledge.

Inclusion also means decolonizing treatment approaches, incorporating non-Western healing traditions (with cultural humility), and being willing to challenge traditional models when they don't fit a client's worldview.

Conclusion

Addressing cultural and individual diversity in eating disorder treatment is a clinical, ethical, and moral imperative. The task of dismantling systemic bias and building inclusive care is ongoing, complex, and deeply rewarding. When psychologists engage with DEI as core competencies—not optional add-ons—they not only enhance treatment outcomes, but also restore dignity and justice to those who have been historically excluded from healing.

Section 18: Future Directions in Eating Disorder Treatment

Eating disorders are among the most psychologically complex and medically dangerous psychiatric conditions, requiring clinicians to work at the intersection of psychopathology, neurobiology, sociocultural influence, and identity development. Over the course of this training, we have explored the diagnostic landscape (DSM-5-TR), primary and subthreshold presentations, evidence-based treatments, psychological comorbidities, trauma intersections, diversity considerations, ethical dilemmas, and collaborative care pathways.

One of the most important takeaways is that effective eating disorder treatment demands more than protocol mastery—it requires cultural humility, ethical clarity, systemic literacy, and a deep appreciation for individual complexity. Psychologists must cultivate these competencies to ensure they are not merely delivering care,

but doing so in a way that is inclusive, safe, trauma-informed, and identity-affirming (APA, 2017).

This course has also emphasized that eating disorders do not discriminate—they affect individuals across all gender identities, races, ethnicities, body sizes, socioeconomic statuses, sexual orientations, and neurotypes. Yet, access to diagnosis, treatment, and recovery resources remains unequally distributed. Psychologists are uniquely positioned to interrupt these disparities through clinical practice, advocacy, and scholarly contributions.

The Evolving Landscape of Eating Disorder Research and Treatment

The field of eating disorder research has grown significantly in recent years. Advances in neuroimaging, genetics, and psychoneuroendocrinology have highlighted the biological substrates of eating disorders, reinforcing the view that these are brain-based illnesses influenced by sociocultural forces, not lifestyle choices or superficial concerns (Kaye et al., 2020). Simultaneously, the expansion of trauma-informed care, body diversity models, and weight-neutral frameworks is shifting clinical paradigms toward more holistic, inclusive treatment.

Future treatment directions are also emphasizing early intervention and prevention. Studies show that intervening within three years of symptom onset significantly improves prognosis (Le Grange & Lock, 2015). Psychologists should therefore strengthen partnerships with schools, pediatricians, college health systems, and athletic departments to catch symptoms earlier.

Digital health is another major innovation. Telehealth and app-based interventions have become widespread post-COVID-19, and studies indicate that virtual CBT-E, DBT, and FBT can be effective when implemented with fidelity (Linardon et al., 2021). However, digital care raises new ethical concerns—such as data privacy,

crisis management at a distance, and technology access equity—which must be addressed through ongoing policy development.

Additionally, co-design models—where clients and marginalized communities help shape treatment programs—are emerging as best practice. Including lived experience voices ensures that care is more relevant, less stigmatizing, and more responsive to community needs (Conti et al., 2021).

Ethical and Professional Imperatives for the Future

Ethical challenges will continue to evolve alongside changes in society, health policy, and technology. Psychologists must remain grounded in APA's Ethical Principles and Code of Conduct (2017) and stay current with multicultural and DEI standards. This includes:

- Ensuring informed consent is accessible, linguistically appropriate, and developmentally attuned.
- Protecting confidentiality in digital environments.
- Advocating for access to care, especially for underinsured or marginalized populations.
- Avoiding the use of weight-based metrics (e.g., BMI cutoffs) as the sole criteria for diagnosis or referral (Puhl & Suh, 2015).

There is also a growing call for psychologists to become change agents beyond the therapy room—participating in policy development, research translation, public health campaigns, and the training of future clinicians.

Conclusion

In sum, the future of eating disorder treatment lies in an integrated, equitable, and compassionate approach—one that honors science, ethics, identity, and human dignity. Psychologists who embody these values will not only reduce suffering but will become stewards of a more just and inclusive future for mental health care. Let this course not be a conclusion, but a foundation—a starting point for your continued growth as a clinician, advocate, and agent of recovery.

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