Eating Disorder Myth Buster

Inspired by Nine Truths about Eating Disorders from the Academy of Eating Disorders and Dr. Cynthia Bulick's 2014 "9 Eating Disorders Myths Busted" presentation at the National Institute of Mental Health Alliance for Research Progress

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Objectives

- Identify myths about eating disorders and identify facts
- Identify multicultural considerations in the assessment & prevalence trends of eating disorders
- When and where to refer a client to specialized treatment in Ohio

Please go to www.menti.com on your device and use the code to participate in the activity

Choose whether the following statements are True or False. Choose the answer that first comes to mind – don't think too hard about your response

1.	You can tell by looking at someone whether or not they have an eating disorder.	True	False
2.	An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.	True	False
3.	A person chooses whether or not to have an eating disorder.	True	False
4.	Eating disorders are primarily a problem of White, middle/upper-middle class teenage girls.	True	False
5.	Eating disorders have the highest mortality rate of any mental illness.	True	False
6.	Eating disorders are primarily the result of societal pressure for women to be thin and internalized ideals of beauty.	True	False

Person-First Language

Anorexic; bulimic; binge-eater	Person with anorexia nervosa; client with bulimia nervosa; client with binge eating disorder
Mentally ill	Person with a mental illness
Schizophrenic	Person living with schizophrenia
"My bipolar client..."	A client with bipolar disorder
"She's so borderline" "That's a borderline for ya'"	"That client is living with borderline PD." "That client displays traits typical of BPD."
Eating disorder client vs. healthy/normal person or controls (research)	A person *with* an eating disorder vs. people *without* eating disorders
Crazy, nuts, psycho	Highly emotionally dysregulated; suffering from severe mood dysregulation; displaying signs of psychosis
Alcoholic/Addict	A person suffering from alcoholism
Autistic	Child with autism
Disabled	Person with a physical disability; person with a developmental delay

Clinician Reaction to Clients with Eating Disorders

- Clinicians across disciplines experience strong negative reactions
- Often decline to treat
  - More pronounced in new professionals or those inexperienced w/ treating eating disorders
  - More pronounced in male professionals
- Medical professionals
- Clinician attitude toward self – opposite

Case Studies

Case Study 1 - Vivian

- Vivian is a 44-year-old black female. She presents to the agency for depression, over-eating, and health issues related to her weight. She lives alone, has never been married, and works full-time for a major insurance company in the area.
- She reports that she's been overweight since childhood and all of her immediate and distant family members are also overweight or obese. She reports that food has been part of every major life event or celebration for as long as she can remember, as well as serving as coping mechanisms for stress and depression. She goes on to state "I love food," and her eating pattern is impulsive and chaotic.
- •Her BMI is 49.02, and she reports being diagnosed with diabetes and sleep apnea in the last 2 years. She becomes tearful when describing these diagnoses and the shame that accompanies the belief "I'm eating myself to death" and the fact that she has not been successful with commercial diets like Weight Watchers or Jenny Craig. She also noted her doctor told her he cannot help her unless she begins to exercise and lose weight.

Case Study 1 - Vivian

- Initial impressions?
- What else would you want to know?
- What recommendations would you make?
- Multicultural considerations?

Case Study 2 - Emma

- Emma is a 19-year-old straight white female. She recently started college at a large local state university, whose counseling center referred her to your agency for ongoing outpatient counseling. She is living on a campus in a dorm with 3 other women.
- During the intake assessment, Emma states she used to have bulimia nervosa and was hospitalized once during high school due to health complications from frequent purging by self-induced vomiting and over-exercise, including abnormal heart rate, low potassium and dehydration. She then spent several weeks in a partial hospitalization program out of state before returning to school, but notes she was never medically cleared to participate on her school's track and field team again.
- Today, Emma appears to be of normal weight for her height, and appears healthy and energetic. She refers to bulimia nervosa in the past tense, states she considers herself recovered, and is now an advocate for healthy eating through an organic, plant-based diet and daily exercise, noting her concern for "the Freshman 15". She states she has met with a personal trainer at the college's rec center, is going jogging every morning as part of her morning ritual before class, and has signed up for the club field hockey team and has been feeling great.

Case Study 2 - Emma

- Any red flags? Any yellow flags?
- What would you want to know more about?
- What referrals, if any, would you consider for Emma's ongoing support?

What is a myth?

- "an idea or story that is believed by many people but that is not true"
- "any invented story, idea, or concept"

Eating Disorder Myths & Facts

1. You can tell by looking at someone whether or not they have an eating disorder (ED).

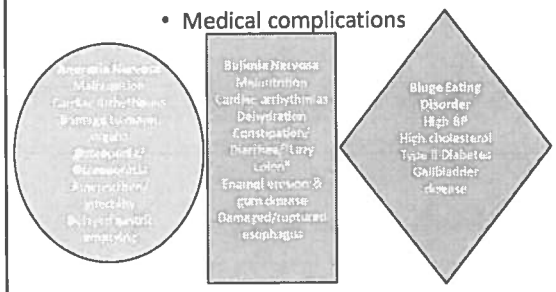
- MYTH!
- *"Many people with eating disorders look healthy, yet may be extremely ill."* – Academy for Eating Disorders (2015)
- Anorexia nervosa – only diagnosis with weight as a criteria
- Contributes to the under-diagnosis of eating disorders

2. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.

- Truth!
- Eating disorders affect personal, social, emotional, psychological, vocational, financial, and spiritual functioning
  - Not a fad or a phase
- Anorexia nervosa = highest mortality rate of any mental illness (more on this later)

2. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.

- Medical complications



2. An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.

- Comorbidity
  - Anxiety disorders
    - 42% of individuals (n=672) with an ED had the onset of 1 or more anxiety d/o in childhood
      - 23% had OCD prior onset of ED
      - 13% had social phobia prior onset of ED
      - 10% had a specific phobia prior onset of ED
  - PTSD and trauma histories – 20-50%
  - OCD
  - Depression
  - Substance abuse – Research suggests up to 50% of individuals w/ ED are also abusing a substance

3. A person chooses whether or not to have an eating disorder.

- Myth!
- EDs are ego-syntonic
- There is no one cause of an eating disorder and maintaining factors change over time
- Brain imaging studies suggest eating disorders are neurobiologically-based illnesses
  - AN – Overactive inhibitory control + under-active reward circuits
  - BN – Dysfunction in both inhibitory and reward circuits (results in chaotic swinging between over-eating and under-eating)
  - BED – Altered sensitivity to reward regions
- And food restriction impacts the brain
  - *"Malnutrition in AN is associated with changes in brain structure (e.g., reduction in gray matter, altered white matter integrity) and profound metabolic, electrolyte, and endocrine disturbances."* (Kaye, et. al, 2013)
- Contributing factors:
  - Genetics and family history
  - Body dissatisfaction
  - Thin-ideal internalization
  - Dieting
  - Family/social support deficits

3. *A person chooses whether or not to have an eating disorder.*

- Eating disorders are generally poorly understood AND research is dramatically under-funded relative to other mental health disorders
- Research funding (NIH Research Funds, 2011)
  - Alzheimer's disease=$88/affected individual
  - Schizophrenia=$81
  - Autism=$44
  - Eating disorders=0.93 CENTS

4. Eating disorders are primarily a problem of White, middle/upper-middle class teenage girls.

- Is this who you think of when you think of eating disorders?

4. Eating disorders are primarily a problem of White, middle/upper-middle class teenage girls.

- Myth!
- Eating disorders affect males and females and a range of cultural groups
  - 20 million women and 10 million men (NEDA)
- Interplay of under-reporting and stigma (seeing a theme here?)
- Prevalence rates
- AN = 0.3%
- BN = 0.9%
- BED = 1.6% - the most common eating disorder

5. Eating disorders have the highest mortality rate of any mental illness.

- Truth!
- Mortality rates vary by study
- Public health problem
- All EDs have a heightened mortality rate
  - Highest in clients with AN
    - 1 in 5 died by suicide (Arcelus, J., 2011)
    - 6-fold increase in mortality in those w/ AN (Papadopoulos, F.C., Ekbom, A., Brandt, L., & Ekselius, L., 2008)

6. Eating disorders are primarily the result of societal pressure for women to be thin and internalized ideals of beauty.

- Myth!
  - Risk Factors
- **Genetic** – Anorexia Nervosa Genetics Initiative (ANGI) headed by Dr. Bulick
- **Biological** – neurochemicals affecting hunger, appetite and digestion are being researched; early menarche and onset of puberty
- **Psychological** – low self-esteem, feelings of inadequacy or lack of control, depression, anxiety, anger, stress, loneliness
- **Personality/Temperament** - anxious, perfectionistic, harm-avoidance, inflexibility
- **Social/Cultural** - thin/muscular ideal, over-emphasis on obtaining the "perfect body", valuing physical appearance over personal characteristics, fitness culture ("fitspo")
- **Interpersonal factors** – troubled personal relationships with difficulty expressing emotions, hx of weight/appearance-based bullying, hx of physical or sexual abuse
- *Parents (moms)/Families cause eating disorders = Myth!*

Multicultural Considerations

Multicultural Considerations – Males

- Tremendous stigma
- 10-15% of ED cases
- Binge Eating Disorder most common ED in men
- Penn State kicker Joey Julius recently "came out" about his diagnosis and treatment for BED
  - *I learned that for the last 11 years of my life I have suffered through a disorder known as binge eating disorder. Although I showed signs of bilemia through stints of purging from extreme anxiety placed on myself I am certain that binge eating disorder is my true diagnosis thru extensive care this summer for about three months of treatment in St. LOUIS Missouri until July 26th.*

Multicultural Considerations – Males (cont.)

Points to know...

- Muscle dysmorphia and exercise
  - First termed "reverse anorexia nervosa" in 1993
  - Relationship between muscle dysmorphia and body dysmorphic disorder is understudied
- Men feel too heavy at 130% IBW; women at 90%
- SHAPE concerns > weight concerns
  - % body fat vs # on the scale
- Drive for muscularity rather than drive for thinness
- Exercise more common as a symptom
- *Men with eating disorders are gay = Myth!*

Male body image role models?

Multicultural Considerations - Age

- In 2003, 1/3 of inpatient hospital admissions for specialized ED treatment were >30 years old (NEDA)
- Body image dissatisfaction during midlife has doubled from 1972 to 1997
  - Pervasive across the lifespan

- Average age of client at The Center for Balanced Living: 38 years old

Multicultural Considerations – Age (cont.)

- Midlife precipitating events
  - Unemployment/financial/retirement
  - "Empty nest" or "bounce back" children
  - Infidelity
  - Illness
  - Perimenopause – under-studied biological factor
  - Death of a loved one
  - Trauma

Multicultural Considerations – Race & Ethnicity

- Non-White cultures = larger body shape ideals
  - May be a protective factor against development of ED

Culture values different body types that are more attainable and realistic = insulated against unhealthy BI & ED

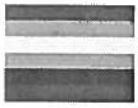
Acculturation = Risk for ED and BI dissatisfaction increases

Multicultural – LGBT

- Similar prevalence amongst heterosexual, bisexual and lesbian women, maybe?
- GENERALLY speaking, gay men:
  - idealize a thinner body size
  - are more concerned about their weight
  - are more afraid of becoming fat than straight men
  - share the drive for muscularity with straight men
- Subcultures exist within the LGBT community – not all emphasize thin body types
- A hidden epidemic?

Multicultural – LGBT (cont.)

- Contributing/Complicating Factors
  - Coming out
  - Internalized negative messages about LGBT, non-conforming gender expression or sexuality
  - Violence and PTSD
  - Discrimination
  - Bullying
  - Gender dysphoria
  - Homelessness (especially youth)
  - Lack of family/social support
  - Subcultures within the LGBT community
  - Access to services and culturally-competent providers who understand the intersection of these identities and concerns



Referrals

When to Refer

- Concern for medical stability
- Chronicity
- Multiple co-occurring dx
- Lack of progress at OP level of care
  - Ambivalence or resistance to treatment
- Low access to multi-disciplinary team/consultation
- The Center for Balanced Living website > Treatment > Professionals > Referrals/Admissions
  - LOC criteria and referral process

Referrals in Ohio

- The Center for Balanced Living
  - Columbus, OH
  - Only free-standing, non-profit facility in Ohio providing specialized ED treatment
  - OP(16+), IOP (16+) and PHP (18+) levels of care
  - Male and female clients
  - 614-896-8222 to refer
- Nationwide Children's Hospital Eating Disorder Program
  - Columbus, OH
  - OP, IOP and PHP levels of care
  - Male and female clients
  - 614-355-6300

Referrals (cont.)

- The Emily Program (formerly the Cleveland Center for Eating Disorders)
  - Cleveland, OH
  - OP, IOP, PHP and residential levels of care
  - Male and female adolescents and adults
  - 1-888-EMILY-77
- Eating Recovery Center of Ohio
  - Cincinnati, OH
  - OP, IOP and PHP levels of care
  - Male and female adolescents and adults
  - 513-342-5934
- Lindner Center of HOPE Eating Disorders Program
  - Mason, OH
  - OP, PHP and inpatient levels of care
  - Male and female adolescents and adults
  - 513-536-HOPE

Good places to start for further information...

- National Eating Disorder Association
- The National Association for Males with Eating Disorders
- Binge Eating Disorder Association
- Health at Every Size
- The Center for Balanced Living – website or professional conferences

The Center for Balanced Living

Case Study 3 - Sarah

- Sarah is a 19-year-old straight female who identifies as White. She recently started college at a small, liberal arts school about 2 hours away from her hometown in Ohio. She is referred to you as her school's counseling center cannot provide long-term outpatient therapy.
- During the assessment, Sarah appears to be of normal weight with no obvious signs of distress or malnourishment. She states she has been in outpatient and intensive outpatient treatment before for her eating disorder, depression, and social anxiety. She reports she has had body image and eating issues since as far back as age 3, at which time she can recall not wanting to wear a puffy winter jacket for fear that it would make her appear fat.
- She states she has a structured meal plan created for her by a registered dietitian from her last treatment team, and has not had binge-eating or purging behaviors for 4 weeks. She notes that she weighs herself at least one time per day, and has had a pervasive desire to lose weight since early childhood. She expresses a concern for how she will adapt her structured meal plan to her campus dining plan.

Case Study 3 - Sarah

- Does Sarah have an eating disorder?
- If pressed to make a diagnosis, what would it be?
- What else do you need to know?
- What referrals would you make?
- What might be on your treatment plan?

Case Study 4 – Debbie

- Debbie is a 44 year-old heterosexual, White female. She has been married for 20 years and lives at home with her husband and 2 teenage daughters. She works part-time at a library. She presents to you with chief complaints of anxiety (racing thoughts, obsessive thoughts, constant worry, panic attacks) and depression (low mood, low energy, low self-esteem, disturbed sleep, passive SI).
- Debbie mentions her obsessive thoughts are related to fear of weight gain. She appears slim and well-looking and is well-dressed and groomed. During your assessment, she notes a lifelong fear of gaining weight. She states she is saving up money to get plastic surgery to reduce the size of her thighs and this is a point of argument between her and her husband, but states she would "rather die than be fat".
- When you further assess eating and weight concerns, Debbie becomes defensive and states she used to weigh much less but begrudgingly regained weight for her husband, points out "obvious" areas of fat on her body, and can name numerous statistics related to the "obesity epidemic" and health concerns associated with overweight and obesity. She speaks highly of the virtue of her "healthy diet", that she only feeds her family the best, "healthiest" foods available and notes her primary care doctor has applauded her healthy lifestyle and weight management.

Case Study 4 – Debbie

- Does Debbie have an eating disorder?
- What kind of further assessment would you do?
- Would you make any referrals?

References

- A. (n.d.). Nine Truths About Eating Disorders. Retrieved September 20, 2016, from http://www.aedweb.org/index.php/10-news/171-9-truths-about-eating-disorders
- Alice Ely, PhD, Laura A. Berner, PhD, Christina E. Wierenga, PhD, and Walter H. Kaye, MD. (n.d.). Neurobiology of Eating Disorders: Clinical Implications. Retrieved October 19, 2016, from http://www.psychiatrictimes.com/special-reports/neurobiology-eating-disorders-clinical-implications
- Arcelus, J. (2011). Mortality Rates in Patients With Anorexia Nervosa and Other Eating Disorders. *Archives of General Psychiatry, 68*(7), 724. doi:10.1001/archgenpsychiatry.2011.74
- Eating disorders. (n.d.). Retrieved October 04, 2016, from http://umm.edu/health/medical/reports/articles/eating-disorders
- Feldman, M. B., & Meyer, I. H. (2007). Eating disorders in diverse lesbian, gay, and bisexual populations. *Int. J. Eat. Disord. International Journal of Eating Disorders, 40*(3), 218-226. doi:10.1002/eat.20360
- Kaye, W. H., Wierenga, C. E., Bailer, U. F., Simmons, A. N., & Bischoff-Grethe, A. (2013, February). Nothing tastes as good as skinny feels: The neurobiology of anorexia nervosa. Trends in Neuroscience, 36(2), 110-120. http://dx.doi.org/10.1016/j.tins.2013.01.003
- Myth [Def. 1]. (n.d.). *Merriam-Webster Online*. In Merriam-Webster. Retrieved August 23rd, 2016, from http://www.merriam-webster.com/dictionary/myth
- Myth [Def. 1]. (n.d.). *Dictionary.com*. August 23rd, 2016, from http://www.dictionary.com/browse/myth?s=t
- N. (2014). Myth # 5: Eating Disorders are the province of white upper-middle class teenage girls. Retrieved October 04, 2016, from https://www.youtube.com/watch?v=pQKY-JVs0PA

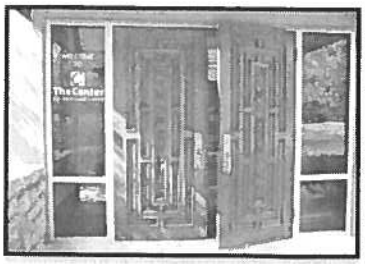
References

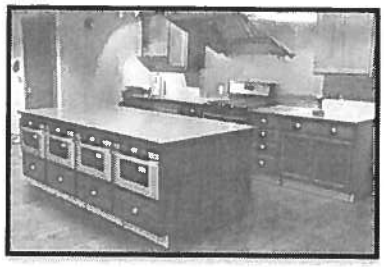
- N. (n.d.). Eating Disorders in LGBT Populations. Retrieved September 20, 2016, from https://www.nationaleatingdisorders.org/eating-disorders-lgbt-populations
- N. (n.d.). Get the Facts on Eating Disorders. Retrieved September 20, 2016, from https://www.nationaleatingdisorders.org/get-facts-eating-disorders
- NIMH » Eating Disorders. (n.d.). Retrieved October 04, 2016, from https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml#part_145412
- Papadopoulos, F. C., Ekbom, A., Brandt, L., & Ekselius, L. (2008). Excess mortality, causes of death and prognostic factors in anorexia nervosa. The British Journal of Psychiatry, 194(1), 10-17. doi:10.1192/bjp.bp.108.054742
- Pope HG Jr, Katz DL, Hudson JI. (1993). Anorexia nervosa and "reverse anorexia" among 108 male bodybuilders. Compr Psychiatry. Nov-Dec; 34(6):406-9
- Strother, E., Lemberg, R., Stanford, S. C., & Turberville, D. (2012). Eating Disorders in Men: Underdiagnosed, Undertreated, and Misunderstood. Eating Disorders, 20(5), 346-355. doi:10.1080/10640266.2012.715512
- T. (n.d.). Binge-Eating Disorder | N.A.M.E.D. Retrieved September 20, 2016, from http://namedinc.org/?page_id=38
- Thompson-Brenner, H., Satir, D. A., Franko, D. L., & Herzog, D. B. (2012). Clinician Reactions to Patients With Eating Disorders: A Review of the Literature. PS Psychiatric Services, 63(1), 73-78. doi:10.1176/appi.ps.201100050
- Yean, C., Benau, E. M., Dakanalis, A., Hormes, J. M., Perone, J., & Timko, C. A. (2013). The relationship of sex and sexual orientation to self-esteem, body shape satisfaction, and eating disorder symptomatology. *Frontiers in Psychology Front. Psychol.*, *4*. doi:10.3389/fpsyg.2013.00887

Quiz: Eating Disorder Myth vs. Fact

Choose whether the following statements are True or False. Choose the answer that first comes to mind – don't think too hard about your response

1.	You can tell by looking at someone whether or not they have an eating disorder.	True	False
2.	An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.	True	False
3.	A person chooses whether or not to have an eating disorder.	True	False
4.	Eating disorders are primarily a problem of White, middle/upper-middle class teenage girls.	True	False
5.	Eating disorders have the highest mortality rate of any mental illness.	True	False
6.	Eating disorders are primarily the result of societal pressure for women to be thin and internalized ideals of beauty.	True	False






Our Services

5 Day Intensive Treatment for Eating Disorders (NEW FED TR)

Intensive treatment for clients ages 16+ with anorexia traits. Family/support attends all 40 hours of treatment with client. Offered the second full week of each month, Sunday-Friday

M's Place Partial Hospital Program for Eating Disorders (PHP-ED)

Specialized day treatment program for ages 18+. Meets 30 hours/week, Monday-Friday

M's Aftercare Program (MAP)

Specialized intensive outpatient program (IOP) for clients transitioning from PHP-ED to outpatient care

Intensive Outpatient Programs for Eating Disorders (IOP-ED)

Specialized, eight-week eating disorder treatment for ages 16+. Meets 9 hours per week on Monday, Wednesday and Thursday evenings and Saturday mornings

Alcohol and Other Drug Intensive Outpatient Program (AOD-IOP)

Evidence-based therapy (CBT/DBT) for individuals 18+ with co-occurring eating disorder and substance use disorder. Harm-reduction model tailored to meet needs of each individual. Meets 9 hours per week on Mondays, Tuesday and Thursdays. *Not detox, rehab or 12 step program.*

Dialectical Behavior Therapy Intensive Outpatient Program (DBT-IOP)

Intensive outpatient program based on DBT principles targeting general mental health concerns for clients with eating disorders. Meets 9 hours/week

Dialectical Behavior Therapy for Eating Disorders (DBT-ED)

Weekly skills education group for people struggling with eating disorders *and* long-standing patterns of behavior interfering with: forming relationships, maintaining mental health, and using effective coping skills

Outpatient Services

Specialized assessments, individual/couples/family therapy, nutrition counseling, medication management

Special Groups for Specific Populations

WOW (for women 60+); HOPE (for individuals who binge eat/overeat); TREAD (for individuals who are uncomfortable with movement and/or gyms): ED101 (for college students over holiday break)

Free Eating Disorder Support Groups

Groups for anorexia nervosa, bulimia nervosa, binge eating disorder and family & friends. Open to the public. Held the first and third Tuesday of each month, 6:30 pm-8:00 pm

Educational Programs, Conferences, Webinars and Videos

Visit TheCenterForBalancedLiving.org

The Center
For Balanced Living

8001 Ravines Edge Ct., Ste. 201, Columbus, OH 43235 614.896.8222 www.TheCenterForBalancedLiving.org

The Emily Program

Real help for eating disorders

The "Eating" Part of Eating Disorders: Effective Strategies for Normalizing the Relationship with Food

Join us for a complimentary continuing education event

December 1st, 2016

Normalizing eating and restoring or establishing a healthy relationship with food is a primary treatment goal. While normalization of eating is key to many treatment approaches, patients, families, and clinicians often find themselves faced with challenging questions regarding how to actually implement and sustain changes in eating. How does this normalization actually happen for individuals across the spectrum of eating disorders and therapeutic interventions? Once established, how can the wide variety of impacts on eating decisions be managed in order to keep eating on track? This presentation will provide a discussion and description of a range of techniques related to normalization of eating with clinical examples of each. Clinically useful tips regarding implementation of techniques such as establishing meal pattern, teaching self-monitoring, establishment of a regular meal and snack pattern, reducing restrictive eating, reintroducing challenging foods, and practicing mindful eating will be presented. The numerous impacts on eating, both internal and external will be discussed, with strategies for maintaining normalized eating. This presentation aims to be interactive and add to the clinician's tool box of strategies.

Participants will walk away being able to:

- Discuss the many internal and external influences on one's eating patterns
- Implement one new technique into clinical practice to help individuals with eating disorders address eating behavior change
- Describe strategies for maintaining normalized eating

Date: Dec. 1, 2016

Time: 8:30-11:00 AM

Location:
The Center for Balanced Living
8001 Ravines Edge Court
Columbus, OH 43235

Schedule:

8:30-9:00 AM	Check-in
9:00-10:30 AM	Presentation
10:30-11:00 AM	Q&A/Evaluations

Coffee and pastries will be served.

RSVP Today (seating is limited)
Contact Katie Dent at
(216) 765-0500 ext. 4221 or
Katie.Dent@emilyprogram.com

About the Presenter

Jillian Lampert, PhD, RD, LD, MPH, FAED

Dr. Lampert is the Chief Strategy Officer for The Emily Program, a comprehensive eating disorder treatment program with locations in Minnesota, Ohio, Pennsylvania, and Washington, where she oversees community connections, marketing, business development, and policy work. Additionally, Dr. Lampert is President of the Residential Eating Disorders Consortium (REDC), an organization whose main goal is to ensure access to residential care for individuals by working collaboratively to address issues that impact the residential eating disorder treatment community. She is a current board member of The Emily Program Foundation, a Minnesota-based organization promoting eating disorder education and advocacy, and a member of the Eating Disorder Research Society (EDRS). She holds an adjunct graduate faculty position in the Department of Food Science and Nutrition at the University of Minnesota.

Approved by the American Psychological Association to sponsor continuing education for psychologists for two (2) continuing education units. The Emily Program maintains responsibility for this program and its content.

Pending approval of two (2) continuing education units by the Commission on Dietetic Registration. Also pending approval by the Counselor, Social Worker, and Marriage and Family Therapist Board to sponsor continuing education for professional counselors, social workers and marriage and family therapists. The Emily Program is offering