

***The Maiya Project***

Conceived by Jenn Friedman

Directed and Choreographed by Renée Locher

Featuring: Jennifer Converse, Anna Vlasova  
and Katie Kilbourn

*Produced in collaboration with Robyn Hussa Farrell*

*The Maiya Project*

*The Maiya Project*, Co-Produced by Jenn Friedman and Mental Fitness, Inc., is a short dance and music film highlighting the internal eating disorder conflict. It is based on Jenn Friedman's song, "Maiya," - which is about the recovery of a personal friend, Maiya - as well as Jenn's own recovery, and is brilliantly choreographed by Renée Locher.

The film follows three dancers through the woods - Maiya's representation, the eating disorder voice, and the recovery voice - with Maiya herself making select appearances throughout in a variety of mediums. The three characters make their way through the woods via an excruciatingly choreographed contemporary movement struggle. We see Maiya's progression from captivity inside the eating disorder voice toward the alignment with the recovery voice. We watch as her autonomy gradually and courageously takes hold.

As Maiya's character evolves from containment to freedom, we are reminded of the power within ourselves to find our own personal freedom; we note a parallel between the very physical struggle on the screen and the often invisible struggle inside ourselves. While we equate the entanglement of the woods with our own confusion, chaos, and internment, we also equate the freedom and purity of nature with our own unbound potential.

**Biographies**

Jenn Friedman is a musician (singer/songwriter/piano-player), author and eating disorder recovery advocate. Her book, Eating Disorders on the Wire: Music and Metaphor as Pathways to Recovery (H.T.F.K. Press), explores her eating disorder recovery through metaphor. Each chapter has a corresponding song on the album, "On the Wire" (Personal Bias Records). Jenn has lectured and performed at Monte Nido EDTNY, Insight Behavioral Health, New York State Psychiatric Institute, The Emily Program, SUNY Purchase, the Eating Disorder Coalition's "Mothers and Others March Against Eating Disorders" on Capitol Hill, and the Philadelphia NEDA Walk. She graduated from SUNY Purchase with a BA in Liberal Arts and Music, The New School with a Certificate in Creative Arts Therapy, and Goldsmiths University of London with a Masters in Counseling. She is passionate about fostering hope, healing, and connection through speaking and performing. www.jennfriedman.com

Renée Locher is a dancer, choreographer, editor, actor, director, teacher and motivator. From a young age Renée has been captivated by creativity in many forms. Initially seeking fulfillment through dance, she then went on to experiment with acting. As a form of self-expression, the arts have helped her make her way through life with constant stimulation, formulation and execution of ideas. With a father who is a musician, Renée was exposed to many different types of music from before even being born. Renée is energized by music, sounds, and feelings that come from it. She incorporates her love and instinct towards musicality into the creation of any work, and constantly seeks possibility. Having created work for stage and film, she feels most alive and inspired when creating and would choose to live no other way than as an artist with constant curiosity and discovery.

Robyn Hussa Farrell

Robyn is an award winning New York City producer who created Transport Group theatre company, Founded Mental Fitness – a nonprofit agency building resilience in youth through evidence-based programs and co-Founded Sharpen - -a digital resiliency platform. She has been developing arts-focused projects that support mental wellness for over 25 years. More info at sharpenminds.com.



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Credits: *The Maiya Project*

Executive Producers: Jenn Friedman

Senior Producer: Robyn Hussa Farrell

Director / Choreographer / Editor / Hair and Makeup Artist: Renée Locher

Concept Creator / Musician / Composer / Assistant to Director: Jenn Friedman

Videographer / Assistant to Editor: Javale Jean-Pierre

Dancer - Maiya: Jennifer Converse

Dancer - Healthy Voice: Anna Vlasova

Dancer - Eating Disordered Voice: Katie Kilbourn

Maiya Willett as Herself

Photographer: Ev Horrosh

Filmed at Wicker's Creek, Dobb's Ferry, NY

Music: "Maiya"

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Vocals and Piano: Jenn Friedman

Drums: Patrick Roman

Cello: Anthony Fischer

Bass and other instruments: Wayne Becker

Recorded by Wayne Becker at Westwires Recording USA

[www.westwires.com](http://www.westwires.com/)

Produced by Wayne Becker and Jenn Friedman

Released by Personal Bias Records

[www.personalbiasrecords.com](http://www.personalbiasrecords.com/)

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**Disordered Eating Prevention Fact Sheet**

*(Source: National Institute of Mental Health, unless otherwise noted) REV 2016*

***Primary Prevention***

“Universal prevention efforts target whole communities (e.g. national, local, community, district) and aim to promote general health and well-being, foster resilience, and reduce the risk of eating disorders amongst non-symptomatic populations.

In the short-term, universal prevention programs may increase resilience and decrease risk factors. In the long-term, it is expected that those changes will lead to fewer eating problems and fewer cases of eating disorders in society. While the aims of all these interventions can vary slightly, they do share common goals that are focused on enhancing the prevention of eating disorders in general” (“Preventing eating disorders,” 2015).

These goals include:

* Improving general health, nutrition, and psychological well-being, such as increasing mindfulness/stress-management skills, social-emotional skills, and positive body image
* Enhancing media literacy, which provides education on the media’s promotion of unrealistic standards of “beauty,” so that people may learn to critically analyze media messages and thus reduce the risk of developing eating disorders
* Building community connections and reducing violence / bullying, including weight-based teasing
  + Overweight during middle childhood increases risk of early adolescence internalizing symptoms. Peer victimization and body dissatisfaction are partly responsible for this link (Pryor et al., 2016).

***Secondary Prevention***

“Secondary prevention interventions aim to lower the severity and duration of an eating disorder in a person who already has the illness. There is considerable overlap between indicated prevention and secondary prevention, with both methods sharing various aims and targeting similar groups.

Secondary prevention is achieved through early intervention, including early detection and early treatment. These interventions can occur at any stage of life, from childhood to older age. The distinguishing feature of secondary prevention is that intervention occurs once the eating disorder has commenced.

At this stage of an eating disorder, secondary interventions emphasize that eating disorders are highly treatable, very common, and a normal progression from disordered eating behavior. These attempts to normalize the person’s behaviors are intended to encourage a person in the early stage of an eating disorder to seek help” (“Preventing eating disorders,” 2015).

***Tertiary Prevention***

“Tertiary prevention aims to reduce the impact of an eating disorder on a person’s life through approaches such as rehabilitation and relapse prevention. It also includes actions to ensure people have access to support within the community, such as being employed and maintaining social interactions. Tertiary prevention is utilized in regards to those who have been experiencing an eating disorder for some time” (“Preventing eating disorders,” 2015).

***Why and How Prevention Works***

“It is likely that, in general, effective [eating disorder] prevention programs work by reducing key proximal risk factors such as internalization of the slender beauty ideal, body dissatisfaction, and negative emotionality. (Levine, 2015).

***Risk Factors***

The factors that contribute to the onset of an eating disorder are complex. No single cause of eating disorders has been identified; however, known contributing risk factors include:

* *Genetic vulnerability*
  + “The genes that are most implicated in passing on eating disorders are within biological systems that relate to food intake, appetite, metabolism, mood, and reward-pleasure responses. It has been shown that this genetic influence is not simply due to the inheritance of any one gene but results from a much more complicated interaction between many genes and quite possibly non-inherited genetic factors as well” (“Eating disorders risk factors,” 2015).
* *Psychological factors*
  + “Research into Anorexia Nervosa and Bulimia Nervosa specifically, has identified a number of personality traits that may be present before, during, and after recovery from an eating disorder. These include:
    - **Perfectionism**
    - **Obsessive-compulsiveness**
    - **Neuroticism**
    - **Negative emotionality**
    - **Body dissatisfaction**: Poor body image can contribute to impaired mental and physical health, lower social functionality, and poor lifestyle choices. Body dissatisfaction, the experience of feelings of shame, sadness or anger associated with the body, can lead to extreme weight control behaviors and is a leading risk factor for the development of eating disorders.
    - **Core low self-esteem traits**: Low self-esteem has been identified by many research studies as a general risk factor for the development of eating disorders. Strong self-esteem has been described as essential for psychological well-being and for building resilience” (“Eating disorders risk factors,” 2015).
* *Socio-cultural influences*
  + “Evidence shows that socio-cultural influences play a role in the development of eating disorders, particularly among people who internalize the Western beauty ideal of thinness. (“Eating disorders risk factors,” 2015).

**Guidelines for Leading “Maiya” Screenings**

**Pre-Seminar / Training:**

1. Arrange for a 60-­‐75 minute training for school administrators, educators and staff.

2. Arrange to have AT LEAST one EATING DISORDER SPECIALIST present for the Q&A discussions. You can search for CEDS (Certified Eating Disorders Specialists in your area through the iaedp website (International Association for Eating Disorders Professionals).

3. Jenn Friedman will provide you with an electronic copy of the film as well as electronic copies of handouts, as applicable.

**At Seminar / Training:**

1. After screening the film, please distribute the Myth Buster Sheet and Resources from this handout packet and invite the CEDS panelists to join the Q&A discussion

2. Follow the Q&A guidelines below.

3. After Q&A, please distribute the post-­‐program questionnaires and ask participants to put them into their white envelope, seal the envelope and give them to facilitator.

4. Please be sure to record the total number of participants and (roughly) the number of individuals who came forward after the presentation to speak with the eating disorders specialists to get help for a student, etc. After your screening, please email these results to us at programs@mentalfitnessinc.org.

**Guidelines for Q&A Discussion after Screening (we recommend you have at least one CEDS psychotherapist on your panel, one person who is at least one year out of recovery and – if possible – a registered dietician who is also a CEDS):**

• Begin by asking each panelist to introduce themselves.

• Please ask each panelist one question (to get the ball rolling. Sample questions: “what should an educator or parent do if they know a student is struggling?” or “With ‘disordered eating’ being such a normative behavior in our culture, how do we know when a student may actually have a diagnosable eating disorder?” (other facts and data from this packet can be incorporated into the questions as well).

• After a few questions have been asked, ask the audience if they have specific questions for the panel.

**Other Talking Points To Cover During Q&A**

• The sooner a person receives treatment, the greater the chance of a full recovery.

• Many factors influence the development of biologically based illnesses, such as eating disorders. PARENTS and the media do NOT cause them.

• There are a range of treatment options and services available to help people of all ages recover. Many of the treatment centers and resources are listed in the educational packet that has been provided.

• The following techniques have been shown to improve protective factors for eating disorders, substance use disorders and other mental illnesses: journal writing, practicing deep breathing and mindfulness exercises, sharing feelings, building social-emotional skills.

• Many serious issues can occur along with eating disorders, which is why they require specialized treatment. For example, many patients with eating disorders may also be suffering from depression, anxiety disorders, or PTSD.

• Dieting and exercise are considered “gateway behaviors” to eating disorders. These are behaviors that start “innocently” but can develop into bigger problems, in those who are biologically at-risk for eating disorders.

• We usually can’t tell by looking at a person whether he or she is struggling with a serious mental illness like an eating disorder. In other words, just because a person is large or small, thin or heavy, doesn’t mean they are struggling with a psychiatric illness.

Prior to ending the Q&A, please remind the audience that they are free to speak with each individual panelist.

**Myth Busters About Eating Disorders / Serious Mental Illness**

*(Source: National Institute of Mental Health, unless otherwise noted) REV 2016*

* There are **at LEAST SIX** types of Eating Disorders: **Anorexia** Nervosa, **Bulimia** Nervosa, **Binge** **Eating** Disorder, **OSFED\***(Otherwise Specified Feeding or Eating Disorder – two sub-types (Purging or a-typical Anorexia))**, UFED**(Unidentified), **ARFID**(Avoidant or Restrictive Food Intake Disorder).
  + Significant changes were made to the **DSM-V in 2013** with regard to eating disorders. Most notably, **Binge Eating Disorder (BED) has been acknowledged as a separate diagnosis for the first time**. This will help increase awareness of the differences between Binge Eating Disorder and the more common issue of overeating.
  + Additionally, the category that was known as Eating Disorder Not Otherwise Specified (EDNOS), has been removed. There are two new categories; **Other Specified Feeding or Eating Disorder (OSFED) and Unspecified Feeding or Eating Disorder (UFED).** These new categories are intended to more appropriately recognize and categorize conditions that do not more accurately fit into Anorexia Nervosa, Bulimia Nervosa, BED, or the other eating and feeding disorders. It is important to note that these new categories are not an indication of a less severe eating disorder, simply a different constellation of symptoms.
  + Another significant change is the **inclusion of some types of ‘Feeding Disorders’** that were previously listed in other chapters of the DSM, and now listed together with eating disorders. *(American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.)*
* **Disordered Eating** (dieting and chaotic eating patterns that include restricting food), is the “norm” in American culture and can lead to serious illnesses such as female athlete triad syndrome, cardiac complications and eating disorders.
* **At Least 38 million** Americans are struggling with an eating disorder. *(National Eating Disorders Association, Binge Eating Disorder Association, National Association for Males with Eating Disorders)*
* **7 million** of those struggling with eating disorders are **males**. **Male eating disorders often go undiagnosed**. *(National Association for Males with Eating Disorders)*
* **More people die from eating disorders than from any other psychiatric illness**
* **More women struggle with eating disorders than with breast cancer**. *(2010 National Cancer Institute, SEER, National Eating Disorders Association, Binge Eating Disorder Association)*
* Eating disorders frequently **co-exist with other psychiatric disorders such as depression, alcoholism or substance abuse, self-harming, OCD, PTSD, ADHD or anxiety disorders**.
* **People with anorexia are up to ten times more likely to die as a result of their illness.** The most common complications that lead to death are **cardiac arrest**, **electrolyte imbalances** and **suicide**.
* The prevalence of traumatic events in ED patients has ranged from 37% to 100% *(Dalle Grave R, Rigamonti R, Todisco P, Oliosi E. Dissociation and traumatic experiences in eating disorders. European Eating Disorders Review. 1996;4:232–240., Mitchell KS, Mazzeo SE, Schlesinger MR, Brewerton TD, Smith BN Int J Eat Disord. 2012 Apr; 45(3):307-15.)*. Despite the literature in this area, there are some limitations regarding the precision and accuracy of trauma data collection and classification. Most of the studies have focused exclusively on specific trauma domains, such as interpersonal post-traumatic events, and, therefore, contribute to the **underreporting of other types of traumas in this population**. *(Tagay, S., Schlottbohm, E., Reyes-Rodriguez, M. L., Repic, N., & Senf, W. (2014). Eating Disorders, Trauma, PTSD and Psychosocial Resources. Eating Disorders, 22(1), 33–49. http://doi.org/10.1080/10640266.2014.857517)*
* **Crime victimization experiences**, such as rape, molestation, and aggravated assault **are significantly associated with bulimia nervosa** (BN) and associated psychiatric comorbidity such as posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and substance abuse. Lifetime diagnosis of extreme obesity (BMI > 40) was strongly associated with history of rape, childhood sexual abuse, childhood abuse, and current and lifetime PTSD in comparison to all other BMI groups. *(Brewerton, T.D., O’Neil, P., Dansky, B., Kilpatrick, D., (2015) Eating Disorders, Extreme Obesity and its Associations with Victimization, PTSD, Major Depression and Eating Disorders in a National Sample of Women. Journal of Obesity & Eating Disorders, Vol 1 No 2:6)*
* Data from multiple sources have converged over the past several decades to support the idea that **exposure to severe adversity, especially during childhood, can plan an individual at increased risk of subsequently development psychiatric and medical disorders, including substance use disorders, eating disorders and all related comorbidity**. *(Brady, Killeen, Brewerton, & Lucerini, 2000: Brewerton, 2004, 2007; Dansky, Brewerton, O’Neil, & Kilpatrick, 1997; Felitti et. al., 1998; Kessler, 2000; Kessler, Davis & Kendler, 1997; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Wonderlich, Brewerton, Jocic, Dansky, & Abbott, 1997)*.
* Much has been learned about the psychoneurobiology of stress response, trauma and PTSD and associated comorbidity over the last several years. **Trauma and in particular PTSD predispose toward both addictions and eating disorders, particularly bulimic-spectrum disorders**. *(Brady, K., Brewerton, T., The Role of Stress, Trauma and PTSD in the Etiology and Treatment of Eating Disorders, Addictions and Substance Use Disorders. Eating Disorders, Addictions and Substance Use Disorders, DOI 10.1007/978-3-642-45378-6\_17, Springer-Verlag Berlin Heidelberg 2014. TD Brewerton and AB Dennis (eds.))*
* **Rates of dieting among adolescent girls are estimated at 60 and 70 percent, as reported by a 2006 study by Drs. James D. Lock and Daniel Le Grange.**(*HELP YOUR TEENAGER BEAT AN EATING DISORDER by James Lock, MD, Ph.D. and Daniel Le Grange, Ph.D., p.132-33)*
* **35% - 40% of dieters will develop an eating disorder.**
* **Eating disorders are increasing among diverse ethnic and sociocultural communities**, despite the erroneous beliefs that this only affects Caucasian teens.
* Between **30% to 50% of those in treatment for obesity may be struggling with ANY of the eating disorders, including binge eating disorder or restrictive disorders**. *(Binge Eating Disorder Association)*
* **Dieting** and **exercise** **are NOT the best treatment interventions** for those with eating disorders, including binge eating disorder. *(Craig Johnson, Ph.D., FAED, CEDS, Clinical Director, Eating Recovery Center)*.
* **Effective treatment for Binge Eating Disorder is similar to Bulimia**.
* OSFED -- causes significant clinical distress or impairment in important areas of functioning but don't meet full criteria for any of the feeding or eating disorders.  Examples include: 1. Atypical Anorexia Nervosa -- Criteria for AN are met, except that despite significant weight loss, weight is still within the normal or above normal range. 2. Low frequency and/or limited duration Bulimia Nervosa -- All criteria for BN are met except binge eating and compensatory behaviors occur on average less than once per week and/or for less than 3 months. 3. Low frequency and/or limited duration BED -- Binge eating occurs on average less than once per week and/or for less than 3 months. 4. Purging disorder -- Recurrent purging behavior (vomiting, laxatives, diuretics, other medications) to influence body shape or weight in the absence of binge episodes.5. Night Eating Syndrome --  episodes of eating after awakening from sleep or excessive food consumption after the evening meal.  There is awareness and recall of the eating episodes.  It is not due to changes in sleep-wake cycles, social norms, binge eating disorder, a medical disorder or effect of a medication.
* ***Primary prevention*** refers to attempts to reduce the occurrence of new cases of a specific disorder. ***Secondary prevention*** refers to the early identification of individuals at risk and to interventions that aim to arrest the development of a full-blown disorder. ***Tertiary prevention*** involves the prompt identification and treatment of individuals who have developed the full syndrome. Effective prevention in the field of eating disorders requires a collaborative endeavor within and across all three levels. *(Preventing Eating Disorders, A Handbook of Interventions and Special Challenges. Piran, N., Levine, M., Steiner-Adair, C., eds. Routledge 1999, 2014.)*

*References*

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http://www.nedc.com.au/risk-factors

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Levine, M.P. (2015). Does prevention work (and is this even a fair question)? *Gurze-Salucore Online Catalogue,* http://www.edcatalogue.com/does-prevention-work/

Levine, M.P., & Smolak, L. (2006). *The prevention of eating problems and eating disorders: Theory, research, and practice.* Mahwah, NJ: Lawrence Erlbaum Associates.

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Overweight during childhood and internalizing symptoms in early adolescence: The mediating role of peer victimization and the desire to be thinner. *Journal of Affective Disorders, 202,* 203-209, <http://dx.doi.org/10.1016/j.jad.2016.05.022>.

**For more research and fact sheets, please visit the Maiya Sharpen app and attend the eating disorders modules in the HEAL section.**

Resources

**NATIONAL EATING DISORDER TREATMENT CENTERS**

* **Columbia University Medical Center Eating Disorders Treatment** (Evelyn Attia) -- http://www.columbiapsychiatry.org/clinicalservices/eating-disorders 212.543.5739) (opportunity for free treatment in exchange for research participation)
* **Reasons Eating Disorder Center (Los Angeles, CA – Norman Kim, Ph.D.)** www.ReasonsEDC.com
* **Veritas Collaborative (Durham, NC – Chase Bannister, MDiv, MSW, LCSW, CEDS)** http://veritascollaborative.com
* **UNC Center for Excellence in Eating Disorders (Chapel Hill, NC – Cindy Bulik, PhD, FAED)** http://www.med.unc.edu/psych/eatingdisorders

**LEGAL SUPPORT and ERISA / INSURANCE EXPERT:**

* **Kantor & Kantor Law** – Lisa Kantor fights insurance for families www.kantorlaw.net

**EATING DISORDER SUPPORT AND INFORMATIONAL ORGANIZATIONS:**

* **AED** – Academy for Eating Disorders – www.AEDWeb.org
* **BEDA** - BINGE EATING DISORDER ASSOCIATION – www.BedaOnline.com
* **IAEDP** – International Association of Eating Disorders Professionals – www.iaedp.com
* **NATIONAL EATING DISORDERS ASSOCIATION. (Claire Mysko, CEO)** – www.NationalEatingDisorders.org

**OTHER MENTAL HEALTH SUPPORT / INFORMATIONAL ORGANIZATIONS:**

* **ASHIC --** American Self-Harm Information Clearinghouse -- www.selfinjury.org
* **AFSP --** American Foundation for Suicide Prevention -- www.afsp.org
* **DBSA --** Depression and Bipolar Support Alliance -- www.ndmda.org
* **SAFE --** Alternatives: Self Abuse Finally Ends -- www.selfinjury.com
* **MENTAL HEALTH AMERICA** – Offers Mental Health First Aid trainings. Nancy Holland: nholland@mha-sc.org
* **NATIONAL ALLIANCE FOR MENTAL ILLNESS** – Spartanburg: https://namispartanburgsc.org, Greenville: https://namigreenvillesc.org

**Art Therapists:**

* American Art Therapy Association 2012 Eating Disorders Toolkit

<http://www.normal-life.org/wp-content/uploads/2012/07/eatingdisorderstoolkit.pdf>

* International Art Therapy Association

<http://www.ieata.org>

* National Coalition of Creative Arts Therapies

<http://www.nccata.org/index.htm>

**Drama Therapists:**

* American Society for Group Psychotherapy and Psychodrama

<http://www.asgpp.org>

* Healthy Selfitude-20+ exercises that teach self-acceptance through arts and yoga

<https://www.amazon.com/Healthy-Selfitude-self-acceptance-performing-techniques-ebook/dp/B007SANM6E/ref=asap_bc?ie=UTF8/Writings.html>

* National Association for Drama Therapy

<http://www.nadta.org>

* Tian Dayton, Ph.D., Books and Resources

<http://www.tiandayton.com/books-for-professionals>

**Dance Movement Therapist**

* American Dance Therapy Association

<https://adta.org/?s=find+a+therapist>

**Yoga therapist**

* International Association of Yoga Therapists

<http://www.iayt.org>

* Meditation and Mindfulness Workshops for ED Recovery --- Guidebook for Yoga Instructors

<https://www.amazon.com/Mindfulness-Meditation-Workshops-instructors-psychotherapists/dp/0985252812/ref=sr_1_8?ie=UTF8&qid=1344624945&sr=8-8&keywords=hussa>

**How To Help a Student Who May Be Struggling**

(Developed by Laura Lees, PsyD, CEDS with Carolyn Costin, Robyn Hussa, Karen Sossin & Dawn Smith-Theodore)

* Find a time to talk when both of you are **calm** – not at or during meals or during exercise. Please make sure you will be away from other distractions.
* The individual who has the **best rapport** (friend, coach, parent, etc.) should set a time to talk. Set aside a time for a private, respectful meeting with the person to discuss your concerns openly and honestly in a caring, supportive way.
* Remember that the person isn’t engaging in an eating disorder (or other behavior) on purpose.
* Share with the person what behaviors you have actually ***seen*** them doing, such as: “I have seen you withdrawing and isolating from friends, do you want to talk?” “I have seen you avoiding food and I’m concerned.” “I have seen you working out a lot lately. It’s like you can’t stop. I’m concerned about you.”
* Let the person know that you care, are there to listen, if they want to talk and that you will ***go with them*** to talk to someone who can help.
* **Express your continued support**. Remind them that you care and that you want them to be happy.
* **Focus on health, not weight,** food, or moral issues during the conversation.
* Acknowledge that seeking outside help is beneficial and is never a sign of weakness.
* For specific information about helping an athlete, please visit www.ThinkEatPlay.org
* **Choose “I” statements** over “You” statements to avoid placing the athlete on the defensive, For example, “I’ve noticed that you’ve been fatigued lately”, and “I’m concerned about you.” Is preferable to “You need to eat and everything will be fine.”
* “I have seen you withdrawing and isolating from friends, do you want to talk?”
* “I have seen you avoiding food / skipping meals and I’m concerned.”
* “I have seen you working out a lot lately. It’s like you can’t stop. I’m concerned about you.”
* “The light in your eyes doesn’t seem to be there as much anymore and I am really concerned. Are you okay? Do you want to talk?”

**GUIDE TO FINDING AN EATING DISORDERS SPECIALIST**

*(Source: Laura Lees, Psy.D., CEDS)*

Anorexia, Bulimia, Binge Eating Disorder and EDNOS / OSFED often require treatment by a team of providers, including a licensed psychotherapist, nutritionist, physician and psychiatrist.

These are questions you can ask a therapist to determine if each are an eating disorder specialist:

* Have you had specialized training specifically in eating disorders? What kind of training? How Long?
* Have you ever trained or worked in a hospital eating disorders program? Where? How Long?
* Do you have any credentials showing you are an eating disorder specialist? What are they? Through what certifying organization? (note: CEDS and FAED are highest regarded credentials)
* Do you currently have a supervisor who is an eating disorders specialist? Who is it?
* What professional eating disorder associations are you a member of? NOTE: The major associations are: Academy for Eating Disorders (AED), International Association of Eating Disorder Professionals (IAEDP) and National Eating Disorder Association (NEDA)
* What eating disorder journals do you read? NOTE: The major journals and newsletters are: International Journal of Eating Disorders, Journal of the Treatment and Prevention of Eating Disorders, Renfrew Perspectives, IAEDP Connections, Eating Disorders Review
* What continuing education have you received or taught on eating disorders in the past two years? NOTE: Therapists should attend seminars or conventions or engage in self-study for continuing education credits to continue their professional development on a regular basis.

If a provider has no formal eating disorders training, hospital experience or supervisor, it would be advisable to find a specialist with appropriate qualifications to help you. If you have questions, please contact us.