Goals and Objectives

Objective 1
Upon completion of this objective, the learner will be able to list the main types of eating disorders and their DSM-5 criteria.

Objective 2
Upon completion of this objective, the learner will be able to describe the medical complications and signs and symptoms of the different eating disorders.

Objective 3
Upon completion of this objective, the learner will be able describe the similarities and differences between patients with substance use disorders and eating disorders or both.

Objective 4
Upon completion of this objective, the learner will be able to review the behavioral and pharmacological advances in the treatments for eating disorders.

Eating Disorder Prevalence by Disorder??

<table>
<thead>
<tr>
<th>Eating Disorder</th>
<th>Percentage of Population</th>
<th>Number of Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia and Bulimia</td>
<td>1.5%</td>
<td>1.6 million</td>
</tr>
<tr>
<td>Binge Eating Disorder</td>
<td>2.6%</td>
<td>2.8 million</td>
</tr>
</tbody>
</table>

Why discuss ED with Substance Abuse??

- Eating Disorders have the highest mortality rate of any mental illness 6-7%.
- Mortality rate associated with Eating Disorders is 12 times higher than the death rate of ALL causes of death for females ages 15-24 and the third most chronic illness among adolescents.
- Five to ten percent of anorexics die within ten years of onset, 18-20 percent die within twenty years of onset, and only 50 percent report ever being cured.

APA Practice Guidelines 2006
Prevalence of eating disorders and substance use disorders in females:

- Up to 50% of individuals with an ED abuse alcohol or illicit drugs compared with 9% in the general population
- Up to 35% of alcohol or illicit drug abuses have eating disorders compared to 3-4 percent of the population

As with Classical Addictions, Eating Disorders...

- Very Resistant to Treatment
- Long Term Illness
- Relapses
- Life Threatening
- Increased Risk for Suicide

As with Classical Addictions, Eating Disorders...

- Compulsive craving
- Loss of control
- Continued "use/ behaviors" despite negative consequences
- Cognitive impairment
- Negative impact on all organ systems
- Issues with self esteem
- Mood and anxiety disorders
- Trauma history
- High Incident of personality disorders

Food for Thought: Substance Abuse and Eating Disorders, The National Center on Addiction and Substance Abuse at Columbia University, December 2003.
As with Classical Addictions, Eating Disorders...

- Maladaptive Behaviors (DBT-Ineffective behaviors)
  - To escape
  - To avoid
  - To numb
  - To manage mood, anxiety, trauma
  - To punish negative self

Differences...

VS.

- Tolerance, physical dependence and withdrawal are not seen in Eating Disorders with food, possibly exercise.
- Treatment focus on increased restraint vs. moderating over control.
- Significant differences in the field with psychotherapy, medications interventions and self help.

Warning Signs That Someone has an Eating Disorder.

- Dramatic weight loss or drastic fluctuations
- A preoccupation with weight, food, food labels and dieting
- Excessive drinking of fluids or denial of hunger
- Avoidance of meal times and situations involving food
- Withdrawal from friends and activities
- Self-induced vomiting or abuse of laxatives, diuretics or diet pills
- Excessive, rigid exercise regimen
- A change in dress, such as over-sized clothing to cover the body or revealing clothes to flaunt weight loss
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Kevin Wandler, MD  CMO-Advanced Recovery Systems

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DSM-5: Eating Disorders
The Diagnostic and Statistical Manual (DSM-5) currently recognizes three main categories of eating disorders:
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder (BED)

Anorexia Nervosa DSM-5
- A. Restriction of energy intake relative to requirements leading to a significantly low body weight
- B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.
- Binge-Eating/Purging or Restricting

Partial Remission / Full Remission
- Mild BMI < 17 kg/m² (87%)
- Moderate BMI 16-16.99 kg/m² (82%)
- Severe BMI 15.99-15 kg/m² (77%)
- Extreme BMI < 15 kg/m² (<77%)

Facts about Anorexia and Substance Abuse
Surprisingly—most patients with anorexia nervosa use the least amount of drugs compared to BED and BN
- Nicotine
- Caffeine
- Cocaine/ Stimulants
- Little alcohol, marijuana
- Little opiates, meth

DSM-5 Bulimia Nervosa
1. Binge eating
   - A. Eating an amount of food definitely larger than what most people eat
   - B. Sense of lack of control
2. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications, fasting; or excessive exercise.
3. Above occur 1x/week for 3 months
4. Body image issues
5. Does not occur during Anorexia Nervosa

Partial Remission / Full Remission
- Mild: an average of 1-3 episodes of inappropriate compensatory behaviors per week,
- Moderate: an average of 4-7 episodes per week
- Severe: an average of 8-13 episodes per week
- Extreme: an average of 14/week
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Facts about Bulimia Nervosa and Substance Abuse

- Bulimia is most commonly associated with substance abuse.
- Those who abuse laxatives tend to have more psychopathology.
- Much attempt at emotion regulation.
- Women with BN and Alcohol Dependence have higher rates of suicide attempts, anxiety, personality disorders, conduct disorders and other drug dependencies.

Binge Eating Disorder DSM-5
Must have all primary criteria!!

- Recurrent episodes of binge eating
  1. Eating an amount of food that is definitely larger than what most people would eat. (and)
  2. A sense of lack of control
- Binge (must have 3 out of 5)
  1. eating much more rapidly than normal
  2. eating until feeling uncomfortably full
  3. eating large amounts of food when not feeling physically hungry
  4. eating alone because of feeling embarrassed by how much one is eating
  5. feeling disgusted with oneself, depressed, or very guilty afterwards
- Distress, On average once a week for 3 months

Mild 1-3 binge-eating episodes per week. Moderate 4-7 binge-eating episodes per week. Severe 8-13 binge-eating episodes per week. Extreme greater than 14 binge-eating episodes per week.

How to weigh yourself correctly...

Obesity—The Problem

- 64.5% of adults in the U.S. are overweight, and 30.5% are obese.
- Being obese or overweight can lead to comorbid health concerns (e.g., heart disease, diabetes).
- Increased body weight can have psychological, economical, and social consequences.
Drunkorexia

- Not a medical term...is entering the English Lexicon...
- Starving all day, binging on food and alcohol and then purging so not to "gain weight"
- Usually college age female binge drinkers
- Normal weight
- These women are usually more bulimic
  - Not clear how the term -rexia happened...

Orthorexia

- Not a medical term, is entering the English Lexicon...
- An unhealthy obsession (OCD?) with what the patient considers to be healthy eating.
- Usually the patient avoids foods containing fats, preservatives and animal products and ultimately suffers malnutrition.
- Can lead to death.

Diabulimia

- Not a medical term...
- Diabetics who "purge" by avoiding taking their insulin
- As a result, they do not "absorb" calories and loose weight.
- Can lead to death...

Manorexia

- Not a medical term, but is also entering the English Lexicon...
- The male version of anorexia nervosa
- Two celebrities who have reportedly had this are Billy Bob Thornton and Dennis Quaid.
- Can lead to death
Etiology of Eating Disorders

Cultural Factors: Media Influences
- Magazine images are:
  - Cut & pasted; Computer enhanced & modified
  - Not very appropriate “models”
- Thinness is equated with:
  - Morality, goodness, and virtue
  - Financial success, positive relationships
  - Self-esteem and respect from others

TV Aftermath
- Fiji Study – Dr. Ann Becker
  - Traditional Fijian culture emphasizes a robust look
  - TV widely introduced in 1995
  - By 1999, 500% ↑ in girls’ vomiting to control weight
  - Enormous increases in girls dieting & feeling fat
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Media’s Role Models for us all??

Back in the day...

Are Eating Disorders an Addiction???
Yes, No, Maybe???

DOPAMINE

- Whenever an experience produces more pleasure than expected—your brain releases Dopamine (DA)
- Drugs of abuse (e.g., cocaine, alcohol, nicotine) release dopamine and other chemicals
- Dopamine regulates food intake through the meso-limbic circuitry of the brain – THE PLEASURE CENTER OF THE BRAIN
- Starving, bingeing and exercise all serve as a drug delivery devices since they increase circulating levels of ß-endorphins that are chemically identical to exogenous opiates.
- Endorphins are potentially addictive because of their ability to stimulate DA in the brain’s mesolimbic reward centers.

"Dying to be Thin":

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**DOPAMINE**

<table>
<thead>
<tr>
<th>Neurotransmitter or Drug</th>
<th>Eating Disorder Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dopamine</td>
<td>✅ Eating</td>
</tr>
<tr>
<td>Amphetamine/Cocaine &amp; Nicotine</td>
<td>✅ Eating</td>
</tr>
<tr>
<td>Anorexia/ OCD</td>
<td>✅ Eating</td>
</tr>
<tr>
<td>Purging</td>
<td>✅ Eating</td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>✅ Eating/ Improvement with OCD Behavior</td>
</tr>
<tr>
<td>Obesity</td>
<td>✅ Eating</td>
</tr>
</tbody>
</table>

**Genetic Contribution for ED/SUD:**

- Journal of Studies on Alcohol and Drugs
  8/2013 showed that if you have a gene for alcoholism or alcohol dependence, you are 38-53% at risk for developing bulimia—specifically binge eating and purging with vomiting, laxatives and diuretics.
What Contributes to the Development of an ED or SUD?

<table>
<thead>
<tr>
<th>Contributor</th>
<th>Eating Disorders</th>
<th>Substance Use Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetics</td>
<td>Account for about 40-60% of contribution</td>
<td>Account for about 40-60% of contribution</td>
</tr>
<tr>
<td></td>
<td>Females are 5-8 times more likely to develop an ED than Males</td>
<td>Males are twice as likely as females to have alcohol or drug addiction</td>
</tr>
<tr>
<td></td>
<td>Low self esteem</td>
<td>Low self esteem</td>
</tr>
<tr>
<td></td>
<td>Perfectionism</td>
<td>Impulsivity</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td>Family history</td>
<td>Family history</td>
</tr>
</tbody>
</table>

What Contributes to the Development of an ED or SUD?

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<tr>
<th>Contributor</th>
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<th>Substance Use Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Family's beliefs and attitudes toward food and behaviors</td>
<td>Family's beliefs and attitudes to drug use</td>
</tr>
<tr>
<td></td>
<td>Peer group that encourages dieting, diet pills, weight focused, laxatives and diuretics and SIV</td>
<td>Peer group that encourages drug use, experimentation</td>
</tr>
<tr>
<td></td>
<td>Media</td>
<td>Media</td>
</tr>
</tbody>
</table>

What Contributes to the Development of an ED or SUD?

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<tr>
<th>Contributor</th>
<th>Eating Disorders</th>
<th>Substance Use Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>Trauma</td>
<td>Trauma</td>
</tr>
<tr>
<td>Epigenetics</td>
<td>All the above and more!!</td>
<td>All the above and more!!</td>
</tr>
</tbody>
</table>

Drugs used by patients with Eating Disorders

<table>
<thead>
<tr>
<th>Substance</th>
<th>Effect on Eating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>↓ Eating, ↑ Purge</td>
</tr>
<tr>
<td>Amphetamine/Stimulants</td>
<td>↓ Eating</td>
</tr>
<tr>
<td>Cocaine/ Crack</td>
<td>↓ Eating</td>
</tr>
<tr>
<td>Marijuana</td>
<td>↑ Eating</td>
</tr>
<tr>
<td>Nicotine</td>
<td>↓ Eating</td>
</tr>
<tr>
<td>Steroids</td>
<td>↑ Eating, Body Building, Body Dysmorphia</td>
</tr>
</tbody>
</table>

Adapted from Roerig, et al 2003
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**Prevalence of alcohol abuse/dependence, drug use and drug abuse/dependence**

<table>
<thead>
<tr>
<th></th>
<th>AN-R N=328</th>
<th>AN-BP N=184</th>
<th>BN-R N=109</th>
<th>BN-P N=110</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse/Dependence</td>
<td>13.7%</td>
<td>19%</td>
<td>23.9%</td>
<td>35.5%</td>
</tr>
<tr>
<td>Drug use</td>
<td>23.2%</td>
<td>29.9%</td>
<td>25.7%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Drug abuse/Dependence</td>
<td>3.4%</td>
<td>14.1%</td>
<td>17.4%</td>
<td>31.8%</td>
</tr>
</tbody>
</table>


**“Drugs” used by patients with Eating Disorders**

- Caffeine ↓ Eating ↑ Purge
- Diuretics ↑ Purge
- Diet pills ↓ Eating
- Ipecac ↑ Purge
- Laxatives ↑ Purge
- Water ↓ Eating ↑ Purge

Adapted from Roerig, et al 2003

**ED & Trauma--1992**

**Is Childhood Sexual Abuse a Risk Factor for Bulimia Nervosa?**

**Conclusion:** Current evidence does not support the hypothesis that childhood sexual abuse is a risk factor for bulimia nervosa.

Am J Psychiatry 1992;149:455-463
Harrison Pope, MD and James Hudson, MD
ED & Trauma--1997

Childhood Sexual Abuse (CSA) has been clearly established as a significant (though nonspecific) risk factor for Eating Disorders and other psychiatric disorders as well (substance abuse, depression, anxiety, panic)


Risk Factor for ED or SUD

Trauma—a continuum of severity:
- Big T—sexual abuse, horrific accident, chronic exposure...
- Little T—bullying—people kill themselves after being bullied!!

Trauma Avoidance or Suppression
To “numb out” or feel different
Just wants to “disappear”

JAMA Psychiatry online Sept 20, 2013 ??A genetic predisposition to PTSD??

- Response to PTSD may be linked to availability of norepinephrine transmitter (NET), which is thought to be genetically determined—this clears NE (takes it away)
- Norepinephrine plays a central role in the fight-or-flight response—Specific to anxiety arousal symptoms such as hypervigilance
- ****NET levels were 41% lower in PTSD participants than in healthy controls—i.e. unable to clear the NE quickly→ ↑↑NE→Anxiety
- This may help in finding medications for PTSD
- This may explain variances in response to trauma
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Cause and Effect

Age of first rape occurred before the age of first binge in:
- 84% of all BN rape cases
- 96% of rapes occurring during adolescence 12-17
- 100% of rapes occurring during childhood ≤ 11


STARVATION AND THE BRAIN

With starvation → “Survival Mode”
With starvation → increase in anxiety, obsessive compulsive thinking
With starvation → Brain atrophy, hormonal imbalance and cognitive impairment
With starvation → Psychotropic medications do not work well!!
With Nutrition—the brain can recover and so then can the patient, but not until weight restored.

What should be treated first?


Eating Disorder Care...

For a woman or man to recover she/he must recognize they are starving!
Food is medicine
- First and foremost—Medical Stabilization
- Detox when necessary!!
- Cardiac Issues/ GI Issues/ Fall Risk
- Stop the behaviors
- Then safety—Depression/ Suicidal ideation/ Self-injurious Behaviors
- Address Anxiety/ Trauma

Alcohol/ stimulant / substance abuse (detoxification)/ nicotine dependence
Order of Treatment for Adults
Mood Disorders
Anxiety Disorders (Trauma)
ADHD
Co-Morbid Conditions Seen with Eating Disorders

- **Diagnosis:** OP/ Men and Women
- Depression 50-75%
- Bipolar 12%
- Substance Abuse 49%
- ADHD 5-10%
- Anxiety Disorders 43%
- OCD 10-13%
- PTSD ------
- Personality Disorders 50-75%
- Borderline PD 2-60%

Overall-Statistics from NEDA (National Eating Disorders Association)

Therapies for Our Patients

- Hospitalization/ Residential Care/ PHP/ IOP/ OP
- 12 Step Recovery Programs
- Dialectical Behavior Therapy (DBT)/ Cognitive Behavior Therapy (CBT)/ Cognitive Processing Therapy (CPT) for PTSD
- Eye Movement Desensitization and Reprocessing (EMDR) for trauma/ Somatic Experiencing Therapy (SE) for anxiety
- Motivational Interviewing (MI)
- Family Therapy/ Family Based Therapy
- Nutrition Therapy
- Exposure Response Prevention (ERP)

Fluoxetine (Prozac®)—Only FDA Approved Medication for Bulimia

- **20 mg fluoxetine**
  - 45% reduction in binge eating
  - 29% reduction in vomiting

- **60 mg fluoxetine**
  - 67% reduction in binge eating
  - 56% reduction in vomiting

Fluoxetine Bulimia Nervosa Collaborative Study Group, *Arch Gen Psychiatry* 1992:49(2)139-147.
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Lisdexamfetamine (Vyvanse®) Only
FDA Approved Medication for Moderate to Severe Binge Eating Disorder

50 or 70 mg of Vyvanse

- 83.7% reduction in binge days (study 1, n=190)
- 83.4% reduction in binge days (study 2, n=174)

Placebo

- 51.8% reduction in binge days (study 1, n=184)
- 49.7% reduction in binge days (study 2, n=176)

- Dosing is 30 mg q AM then 50 mg or 70 mg
- Potential for addiction, do not give to a patient with a history of SUD, must monitor frequently!!
- There is a reason it is a C-II, need to rewrite scripts monthly and need frequent monitoring of patients!!

Psych Meds for EDs and Co-Occurring Disorders

Psychotropic medications used to treat EDs and co-morbidity:
- Depression
  - SSRIs (i.e., Prozac, Paxil, Zoloft, Luvox, Celexa, Lexapro)
  - Wellbutrin-SR & XL, Effexor-XR
- Anxiety
  - SSRIs
  - Low dose Atypical Antipsychotics
    (i.e. Seroquel, Geodon and Abilify)
- Avoid benzodiazepines: Xanax, Klonopin or Ativan
- Mood Stabilizers
  - Lamictal, Tegretol, Gabapentin
- Painful and distorted thinking—body image disturbance
- Avoid benzodiazepines: Xanax, Klonopin or Ativan
- Insomnia
  - Prudent use of Benadryl, Vistaril, Trazodone, Melatonin

Other Meds NOT under study.....

Anxiolytics are not effective for the treatment of ED!!!
(Xanax, Ativan, Klonopin, Valium, Librium)

Often prescribed by their psychiatrist or PCP for anxiety around meals!!
Does not help!!
Does give them an Anxiolytic Dependency!!

Now they can be hospitalized for DETOX!!


Medications for Recovery from Substances

Alcohol:
- Naltrexone (ReVia®) / Depot Naltrexone (Vivitrol®)
- Acamprosate (Campral®)
- Disulfiram (Antabuse®)
- Naltrexone (ReVia®)

Opiates:
- Naltrexone (ReVia®)
- Depot Naltrexone (Vivitrol®)
- Buprenorphine (Subutex®)
- Buprenorphine + Naloxone (Suboxone®)
- Methadone

Nicotine:
- Varenicline (Chantix®)
- Bupropion (Wellbutrin® / Zyban®)
- Nicotine gum, patch, lozenge, inhaler
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Level of Care Criteria for ED (and SUD) Patients

- Level 1: Outpatient
- Level 2: Intensive Outpatient
- Level 3: Partial Hospitalization
- Level 4: Residential Treatment Center
- Level 5: Inpatient Hospitalization

APA Practice Guideline (2006)

Criteria for Treatment of Substance Use Disorder

- For Substance Abuse—use ASAM criteria
- Insurance does not like to pay for IP detox except for Alcohol and Benzodiazepines (Some pay for Opiates)
- ASAM Criteria updated for DSM-5 and includes emerging areas of focus—gambling and tobacco use disorders

www.asamcriteria.org/

Criteria for Hospitalization for ED

The following warrants IP hospitalization—
- Wt. < 85% IBW
- HR < 40 bpm
- BP < 90/60 mm Hg
- Orthostatic BP changes
- > 20 HR or > 10 mmHg drop of diastolic BP
- Temperature < 97 degrees F
- Hypokalemia K< 3mEq/L, electrolyte imbalance, hypophosphatemia, hypomagnesemia
- Poorly controlled diabetes


SCOFF

- The SCOFF questions: One point for every “yes”; a score of ≥2 indicates a likely case of anorexia nervosa or bulimia
- Do you make yourself Sick because you feel uncomfortably full?
- Do you worry that you have lost Control over how much you eat?
- Have you recently lost more than One stone (14 lbs.) in a 3-month period?
- Do you believe yourself to be Fat when others say you are too thin?
- Would you say that Food dominates your life?

Setting the threshold at two or more positive answers to all five questions provided 100% sensitivity for anorexia and/or bulimia.
Modified CAGE for Eating Disorders

- Have you ever felt you should cut down on your eating disorder behavior(s)?
- Have people annoyed you by criticizing your eating disorder behavior(s)?
- Have you ever felt bad or guilty about your eating disorder behavior(s)?
- Have you ever performed your eating disorder behaviors in the middle of night or very early so no one would see you and decrease your anxiety (eye opener)?

Scoring: Item responses on the CAGE are scored 0 or 1, with a higher score an indication of eating disorder behavior problems. A total score of 2 or greater is considered clinically significant.

Screening for Harmful Alcohol and Drug Use

1. Screen everyone at risk.
2. Use validated screening tools. (MAST, AUDIT)
3. Provide nonjudgmental feedback with their results.

Issues with Milieu Management for Patients with Eating

Monitoring Restricting Behaviors

- Meal Monitoring
- Meal Coaching
- Exercise Monitoring
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Monitoring Bulimic Behaviors

- Self-induced vomiting
- Misuse of laxatives
- Diuretics
- Weight loss medications
- Fasting
- Excessive exercise
- Binging

Summary

- Use of Substances along with an Eating Disorder increase the morbidity and mortality to the patient
- Substance abuse is common with Eating Disorders
- Evaluation of the patient with an Eating Disorder should always carefully screen for Substance Use Disorder
- Evaluation of a patient with a Substance Use Disorder should always carefully screen for an Eating Disorder
- Treatment must be fully integrated!!

Questions?

Thank you for all you do!!

Answers!

Kevin Wandler, MD
Chief Medical Officer
Kwandler@AdvancedRecoverySystems.com

The Recovery Village
The Recovery Village-Palmer Lake
Next Generation Village
Orlando Recovery Center
Blue Horizon
Next Step Village
The Recovery Village-Ridgefield
IAFF Center for Excellence

ONE TEAM
ONE VISION
“Dying to be Thin”:  
_The Diagnosis and Treatment of Eating Disorders_  
Kevin Wandler, MD  CMO-Advanced Recovery Systems

Resources

**E Resources:**
- Advanced Recovery Systems: www.advancedrecoverysystems.com
- info@advancedrecoverysystems.com
- Academy of Eating Disorders: www.aedweb.org
- Binge Eating Disorders Association: www.bedaonline.com
- International Association of Eating Disorder Professionals: www.iaedp.com
- National Eating Disorders Association: www.nationaleatingdisorders.org

**Textbooks:**