An Eating Disorder Professional Development Toolkit for Registered Dietitians

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Introduction

In the United States, it is estimated that 20 million women and 10 million men will at some point in their lives suffer from an eating disorder (ED) (National Eating Disorder Association [NEDA], 2018c). Adding to that, eating disorders have the second highest mortality rate of all mental health illnesses, with anorexia having a mortality rate of about 10% (NEDA, 2018b). Yet despite this knowledge, few dietetic programs provide sufficient education and training on eating disorders, leaving both aspiring and practicing registered dietitians (RDs) with limited skills in this important area. With the global prevalence of eating disorders increasing by 25%, but only 20% of affected individuals receiving treatment, there is a major need to address the deficit of trained RDs in this field (Treasure, Duarte, & Schmidt, 2020). Therefore, the aim of this toolkit is to provide RDs with resources for fulfilling their goal of effectively collaborating with patients and other professionals in the complex field of eating disorders. To accomplish this goal, the toolkit is split into two sections. The first is a detailed primer on eating disorders, ranging from characteristics of ED diagnoses to the role of the RD in the treatment process. The second section then details my findings from consultations with five RDs with a range of experience in the field of eating disorders.

Section 1: A Primer on Eating Disorders

Section 1 provides background knowledge on eating disorders including types of EDs, characteristics of each, etiology, prevalence and trends, levels of care, barriers to treatment, and the RD's role in the treatment of eating disorders. My primary method for creating this section included searches in PubMed, Google Scholar, and reputable websites such as the National Eating Disorder Association (NEDA). Where relevant, I also included information from interviews with two highly experienced RDs.

Types of Eating Disorders

Eating disorders are serious mental health disorders characterized by abnormal eating or weight-control behaviors (Treasure, Duarte, & Schmidt, 2020). All eating disorders can significantly disrupt psychosocial functioning as well as impair physical health, causing these illnesses to be disabling, costly, and deadly (Treasure, Duarte, & Schmidt, 2020). Eating disorders do not discriminate. They affect people of all ages, genders, races, ethnicities, religions, sexual orientations, weights, and body shapes (NEDA, 2018c). They are currently diagnosed by using the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) with the three primary eating disorder diagnoses being anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED; Treasure, Duarte, & Schmidt, 2020). Lesser-known eating disorders included in the DSM-5 are other specified feeding and eating disorder (OSFED), unspecified feeding and eating disorder (UFED), avoidant restrictive food intake disorder (ARFID), pica, rumination disorder, and while not formally recognized in the DSM-5 but still gaining awareness, orthorexia (NEDA, 2018a).

Table 1: Characteristics of Eating Disorder Diagnoses in the DSM-5 (NEDA, 2018a)

Type	Characteristics
Anorexia Nervosa (AN)	• Characterized by weight loss, or lack of appropriate weight gain in children, difficulties maintaining appropriate weight for height, age, and build, and in many people, distorted body image. • Most frequently begins in adolescents, but increasingly seen in children and adults.
Bulimia Nervosa (BN)	• Characterized by cycling between bingeing and compensatory behaviors such as self-induced vomiting.
Binge Eating Disorder (BED)	• Characterized by recurrent episodes of eating large quantities of food though not regularly using unhealthy compensatory measures (e.g. purging) to counter the binge eating. • There is a feeling of a loss of control during the binge and a sense of shame, distress or guilt afterwards.
Other Specified Feeding and Eating Disorder (OSFED)	• ED presentations that do not fit within the AN or BN diagnostic criteria but still classified as a significant eating disorder. o Atypical anorexia nervosa—individual meets the AN criteria but is not "underweight" even though they have encountered severe weight loss o BED of low frequency and/or limited duration o BN of low frequency and/or limited duration o Purging disorder o Night eating syndrome
Unspecified Feeding and Eating Disorder (UFED)	• Used when symptoms cause clinically significant impairment or distress in occupational, social, or additional areas, but do not fully meet the diagnostic criteria for any of the disorders found in the DSM-5.
Avoidant Restrictive Food Intake Disorder (ARFID)	• Characterized by limited quantity and/or variety of foods consumed, but without any distress about body shape or size or fears of fatness.

	• An individual does not consume enough calories to properly grow and develop.
Pica	• Characterized by eating non-food items that do not contain significant nutritional value. • Examples include dirt, hair, and paint chips.
Rumination Disorder	• Characterized by the regular regurgitation of food for at least one month. • Typically, the individual does not appear to be making an effort when regurgitating their food, nor do they seem to be upset, stressed, or repulsed.
Orthorexia	• Characterized by becoming fixated on what is seen as 'healthy eating' that one eventually damages their own health and well-being.

Etiology

Eating disorders are complex mental health illnesses often resulting from the interaction of multiple risk factors that can be biological, psychological, and sociocultural in nature (Culbert, Racine, & Klump, 2015). For instance, sociocultural and psychological factors such as thin-ideal internalization and personality traits, respectively, have solid foundations in biology (Culbert, Racine, & Klump, 2015). When such factors interact, they can influence the expression of genetic risk to spark the development of eating pathologies (Culbert, Racine, & Klump, 2015). Dr. Judith Stern, Distinguished Professor of Nutrition and Internal Medicine at the University of California, Davis, coined an analogy often used to describe this complex interaction between genes and environment in the creation of disease phenotypes: "Genetics loads the gun, but the environment pulls the trigger" (Ramos & Olden, 2008). From this analogy, it can be concluded that one's biology can set the stage for the development of an eating disorder if certain external factors (e.g., thin ideal portrayed in media) play a prominent role in one's life.

Biology

Regarding biology, twin adoption studies have identified a moderate-to-high heritability of AN, BN, and BED, as well as symptoms of disordered eating (Culbert, Racine, & Klump, 2015). Despite these studies, there is still little known about the specific genes that contribute to eating disorder risk (Culbert, Racine, & Klump, 2015).

Sociocultural

In Western cultures, the increased risk of disordered eating behaviors and eating disorders, particularly among adolescent and young adult females, is thought to stem from the following sociocultural influences: media outlets that predominantly portray stars with smaller, more "attractive" bodies, increased pressure to obtain the 'thin ideal' from such media exposures, thin-ideal idealization, and thinness expectancies (e.g., thinness results in general life improvements; Culbert, Racine, & Klump, 2015). During the 20th century in Western cultures,

there was a coinciding increase in the incidence of AN and BN and the idealization of thinness in women, thus supporting the notion that thin-ideal idealization feeds into the development of an eating disorder (Culbert, Racine, & Klump, 2015). Sociocultural influences do not discriminate. Males can also succumb to such factors causing body-image concerns and disordered eating behaviors (Culbert, Racine, & Klump, 2015). The gene-environment relationship described earlier plays a role in how someone will internalize such sociocultural influences. Pre-existing factors, such as genetics, determine for whom the pressure for thinness will be internalized in and possibly lead to an eating disorder (Culbert, Racine, & Klump, 2015).

Psychological

Certain personality traits have been linked in the etiology of EDs. Personality traits that have prospectively predicted the development of eating disorder characteristics include negative emotionality and neuroticism, perfectionism, and impulsivity and negative urgency, or the likeliness to engage in rash actions when in distress (Culbert, Racine, & Klump, 2015). However, it has been noted that future research is needed to strengthen these associations (Culbert, Racine, & Klump, 2015).

Prevalence & Trends

Table 2: Lifetime Prevalence Estimates for Adolescents (13-18 years) (Swanson et al., 2011)

	Anorexia Nervosa (AN)	**Bulimia Nervosa (BN)**	**Binge Eating Disorder (BED)**
Total, %	0.3	0.9	1.6
Gender, %			
Female	0.3	1.3	2.3
Male	0.3	0.5	0.8
Race/ethnicity, %			
Non-Hispanic White	0.4	0.7	1.4
Non-Hispanic Black	0.1	1.0	1.5
Hispanic	0.2	1.6	2.4
Other	0.0	1.3	1.4
Age in years, %			
13-14	0.3	0.8	1.4
15-16	0.3	0.9	1.6
17-18	0.2	0.9	1.9
Received helped, %	27.5	21.5	11.4

Table 3: Lifetime Prevalence Estimates for Adults 18 years and Older (Udo & Grilo, 2018)

	Anorexia Nervosa (AN)	Bulimia Nervosa (BN)	Binge Eating Disorder (BED)
Total, %	0.8	0.28	0.85
Gender, %			
Female	1.42	0.46	1.25
Male	0.12	0.08	0.42
Race/ethnicity, %			
Non-Hispanic White	0.96	0.31	0.84
Non-Hispanic Black	0.19	0.2	0.62
Hispanic	0.46	0.24	0.75
Other	1.05	0.59	0.59
Age in years, %			
18-29	0.86	0.4	0.89
30-44	1.02	0.42	0.96
45-59	0.96	0.21	1.0
≥60	0.34	0.1	0.54

While the prevalence estimates of eating disorders from population-based studies of adolescents and adults are relatively low, it should not be overlooked that EDs can have severe and significant effects on an individual's health, including role impairment, comorbidity, medical complications, mortality, and suicide (Swanson et al., 2011). As seen in Table 2, only a small percentage of adolescents with eating disorders talked to a professional (Swanson et al., 2011). Possible reasons for this include denial of the eating disorder, shame/stigma associated with having an eating disorder and/or receiving help for mental health issues, and lack of recognition of symptoms by healthcare professionals (Swanson et al., 2011). Adults also show a similar pattern of small proportions seeking treatment for an eating disorder within their lifetime. According to the National Comorbidity Replication Survey, 43.2%, 43.6%, and 33.8% of adults received treatment for bulimia nervosa, binge eating disorder, and anorexia nervosa, respectively, over the course of their lifetime (Hudson, Hiripi, Pope, and Kessler, 2007).

Levels of Care

For those seeking treatment, there is a continuum of care, with patients moving through the levels based on a variety of factors including treatment history, medical status, financial limitations, and symptom severity (Anderson, et al., 2017). There are five main levels of care: outpatient care, intensive outpatient program (IOP), partial hospitalization program (PHP), residential program, and inpatient hospitalization (Anderson, et al., 2017). The path of recovering from an eating disorder, regardless of the severity, is not a linear path. Movement through the levels can be bidirectional based on the patient's needs at the time (Anderson, et al., 2017).

Inpatient Hospitalization

The highest level of care is inpatient hospitalization and is reserved for those who are medically unstable (Anderson et al., 2017). When a patient is hospitalized, all meals are supervised, medical consultation is readily available, and one-to-one monitoring is available if needed (The Alliance, 2021).

Residential Program

A step below inpatient hospitalization is a residential program and this is recommended for those who are medically stable but require around-the-clock care and supervision (The Alliance, 2021). Individuals are housed full-time in a non-hospital setting where they receive meal support for all meals and snacks and multidisciplinary treatment from group and individual therapy sessions (Anderson et al., 2017).

Partial Hospitalization Program (PHP)

Following residential is PHP. Patients receive treatment at a specialized setting for about 6 to 10 hours per day, 3 to 7 days a week (Anderson et al., 2017). Within this level, patients receive more intensive and structured support but are medically stable enough to spend nights and sometimes weekends at their homes (Anderson et al., 2017). Patients will receive daily meals, snacks, and group therapy along with consistently meeting with the dietitian, psychiatrist, and therapist (Anderson et al., 2017).

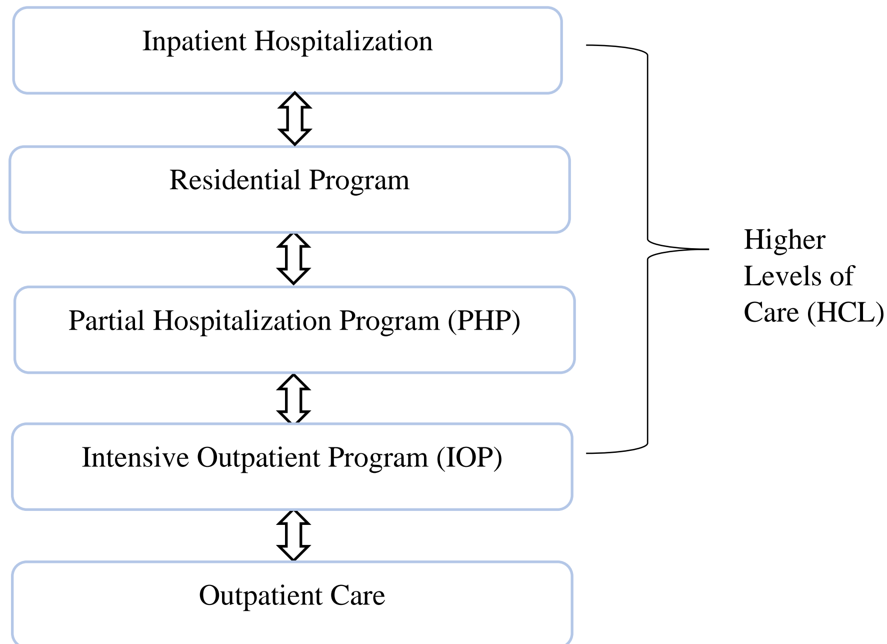
Intensive Outpatient Program (IOP)

IOP is utilized for those who are medically stable but need more support in the recovery process (The Alliance, 2021). Patients receive treatment in a specialized setting for about 3 hours per day, 3 to 5 days a week and engage in activities such as meal support, group therapy, and dietary sessions (Anderson et al., 2017).

Outpatient Care

Outpatient care is the only level not considered a higher level of care (HLC) and is usually reserved for mild ED presentations (Anderson et al., 2017). The patient should be medically stable, have their eating disorder behaviors well-managed, and be self-sufficient in meeting their nutritional needs (The Alliance, 2021). Outpatient care is composed of patients living at home and attending weekly sessions at the RD’s office (The Alliance, 2021). This type of care should still include a collaborative team that can consist of a RD, therapist, primary care physician, psychiatrist, and family therapist (The Alliance, 2021).

Figure 1. Levels of Care for Eating Disorder Treatment



Barriers to Eating Disorder Treatment

As described earlier in Table 2, only a small percentage of adolescents with an eating disorder receive treatment. Some of the identified barriers to access and utilization of eating disorder treatment include the following: health beliefs, ethnicity/race and culture, financial barriers, physician's beliefs, social stigma and stereotyping, and distance to a provider (Thompson & Park, 2016).

Health Beliefs

Health beliefs can serve as a barrier to treatment depending on the degree to which the individual perceives the severity of their illness (Thompson & Park, 2016). For example, those who see their illness as unproblematic or not severe compared to others are more likely to forgo accessing treatment (Thompson & Park, 2016). Among women specifically, the belief that those with an eating disorder should help themselves rather than seeking treatment has also been an important barrier towards receiving treatment (Thompson & Park, 2016).

Ethnicity, Race & Culture

Ethnicity, race, and culture also play a role in limiting access and utilization of eating disorder treatment. For example, one study showed that Asians, African Americans, and Latinos were less likely to obtain a recommendation to see a healthcare professional by their clinician compared to Caucasian patients, highlighting the inequalities in access and utilization of treatment among ethnic minorities (Thompson & Park, 2016). Additionally, racial and ethnic minorities are less likely to disclose their issues, making it more challenging for clinicians to

identify the presence of an eating disorder (Thompson & Park, 2016). Furthermore, Haley Goodrich and Anna Lutz, both Certified Eating Disorder Registered Dietitians (CEDRDs), explained that because the dietetics field lacks diversity in eating disorder clinicians, it can be difficult to treat the diverse population of individuals who are struggling with an eating disorder (H. Goodrich & A. Lutz, personal communication, February 15 & 19, 2021). As this field is mainly composed of white females, individuals who are neither white nor female may feel as if eating disorder care is inaccessible to them and the clinicians will not understand their lived experiences (H. Goodrich & A. Lutz, personal communication, February 15 & 19, 2021).

Finances

Finances are one of the main barriers to seeking eating disorder treatment (Thompson & Park, 2016). According to a 2016 review, only ten states required private insurance companies to cover treatment for bulimia and anorexia (Thompson & Park, 2016). However, with the average cost of inpatient treatment being $30,000 a month and IOP being $500-$2,000 per day, even with insurance, patients and their families are still responsible for a significant sum (Thompson & Park, 2016). Insurance companies also display weight stigma when it comes to treatment. Some insurers will only cover a limited number of weeks or deny coverage if a patient's anthropometrics or lab values do not fit the "normal" criteria for having an ED (H. Goodrich, personal communication, February 15, 2021).

Physician Beliefs

Despite physicians being healthcare professionals, their beliefs can serve as barriers to their patients pursuing treatment (Thompson & Park, 2016). Physicians' beliefs may be misguided due to their lack of adequate training or experience with eating disorders, nutrition, or psychology, which could cause them to possibly discount the severity of an ED if there is a lack of immediate physical consequences (Thompson & Park, 2016). Physicians also have their own biases. For instance, if a physician holds a preconceived notion of what a person with an eating disorder looks like, it may prevent them from properly diagnosing and referring patients to higher levels of care (A. Lutz, personal communication, February 19, 2021). In other words, physicians can have misconceptions about what an individual with an eating disorder "should" look like, thus placing non-stereotypical individuals at risk for being undiagnosed, untreated, and experiencing long-term adverse effects (Thompson & Park, 2016).

Social Stigma & Stereotyping

Social stigma and stereotyping also play a major role in treatment utilization. Individuals may forgo treatment to conceal their illness and avoid the stigma, shame, or guilt that has been associated with having an eating disorder (Thompson & Park, 2016). In a 2018 study, men were less likely to seek treatment for an eating disorder than women given the stereotype that eating disorders only occur among women (Grillot & Keel, 2018). Anna Lutz further supported this notion in her interview by adding that the stereotype of eating disorders mainly affecting wealthy, white women can keep individuals from seeking help. If the individual does not fit the stereotype, they may believe that they don't actually have an ED or fear that people won't believe that they are suffering from one (A. Lutz, personal communication, February 19, 2021).

Furthermore, in the same 2018 study, additional reasons why men were less likely to seek treatment were explored. These included the concern about being labeled as homosexual, the idea that seeking help implies a lack of self-control that can then challenge their masculinity, and the belief that treatments cannot address their unique needs since most were created and evaluated predominately for women (Thompson & Park, 2016).

Distance

Lastly, the distance to treatments centers and/or private practices can be a significant barrier (Thompson & Park, 2016). There are few inpatient and IOP treatment centers in the U.S. with most of them located in metropolitan settings and in states such as California and Florida (Thompson & Park, 2016). Furthermore, according to Eating Disorder Registered Dietitians & Professionals (EDRDPro), as of April 2021, there are only about 90 eating disorder professionals in the United States, highlighting the major need for more professionals in this field.

A Registered Dietitian's Role in the Treatment of Eating Disorders

Registered dietitians play a crucial role in the treatment of eating disorders, regardless of the setting. Whether the RD works in an outpatient, residential, or inpatient setting, they will implement the four components of the Nutrition Care Process (NCP): nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation. Since RDs are a part of an interdisciplinary team, some of their roles and responsibilities also revolve around care coordination. Refer to Table 4 for a more detailed look into the RD's role.

Table 4: Application of the Nutrition Care Process (NCP) by a Registered Dietitian in the Treatment of Eating Disorders (American Dietetic Association, 2011).

Nutrition Assessment	Identify nutrition problems such as eating disorder symptoms and behaviors. a) Anthropometrics such as height, weight, and growth chart history b) Biochemical data, especially to assess risk for refeeding syndrome c) Evaluate dietary intake d) Evaluate behavioral-environmental symptoms such as food restriction, bingeing, rituals, purging etc.
Nutrition Diagnosis	Apply a nutrition diagnosis based on nutrition assessment
Nutrition Intervention	Create a plan to resolve the nutrition problem stated in the diagnosis and coordinate plan with the interdisciplinary team. a) Ensure diet quality and consistent eating patterns that allow the patient to meet body composition and health goals b) Aid patient in increasing amount and variety of foods consumed, normalize hunger and satiety cues, and suggestions about need for supplements c) Psychosocial support and positive reinforcement throughout structured refeeding plan

	d) Counsel patients and caregivers about food selection, health history, and physical and psychological factors e) Utilize motivational interviewing to promote intrinsic motivation to change within the patient
Nutrition Monitoring & Evaluation	Monitor nutrient intake and adjust if needed to meet goals. a) Monitor weight gain and adjust food intake once weight restoration is complete b) Communicate progress with all team members and adjust as needed
Care Coordination	Be an integral member of the interdisciplinary team. a) Work collaboratively with the patient's team and communicate needs across all levels of care b) Act as a resource to healthcare professionals and family members c) Advocate for access to care and evidence-based treatment

Section 2: Consultations with Eating Disorder Registered Dietitians

In this section of the toolkit, I present my findings from five semi-structured interviews with practicing RDs who have found success in the field of eating disorders, allowing me to put together a collection of key themes and takeaways for RDs pursuing a career in this field. By collaborating with RDs who have already made an impact, my aim is to provide readers with the direction and support needed to confidently develop their own path. Of the five RDs interviewed, three of them are Certified Eating Disorder Registered Dietitian-Supervisors (CEDRD-S), meaning they are approved to be an eating disorder supervisor by the International Association of Eating Disorder Professionals (iaedp™). Three of them received their Master of Public Health (MPH) from Gillings School of Global Public Health at UNC Chapel Hill and one received her Master of Science (MS) in Nutrition. The professions of these RDs include founding and owning medical nutrition therapy private practices, being managers and supervisors at eating disorder treatment centers, and having an influential presence on social media supporting and advocating for ED recovery and inclusive, stigma free healthcare. Refer to Appendix B for a complete list of the RDs interviewed and their contact information. All RDs graciously allowed me to include their contact information in this toolkit.

Key Takeaways

The expansion of knowledge pertaining to Health at Every Size®, intuitive eating, and weight-inclusive care is often obtained outside of one's nutrition program.

Anthropometric assessment is a critical component of the Nutrition Care Process but hasn't been paired with education on Health at Every Size® (HAES) and intuitive eating (IE) in many dietetic programs. Furthermore, the lack of formal training on eating disorders/disordered eating, other than the basic information, makes it challenging for students and RDs to feel sufficiently prepared and confident to enter this specialty. This is true of all specialties and not unique to eating disorders, so be prepared to learn on the job. It can be easy to feel discouraged

when first entering this field but know that it will take some time to gain skills and feel competent working with this population. While a nutrition program's curriculum provides vital information on topics such as treating malnutrition, it is not uncommon to have to unlearn some of what you were taught in school, particularly regarding weight-centric topics. For example, as (future) dietitians, we are generally guided by the Dietary Guidelines for Americans (DGAs), which provide dietary recommendations such as having half of your grains be whole grains, making half of your plate fruits and vegetables, choosing low-fat or fat-free dairy, and limiting added sugars to less than 10 percent of total calories (United States Department of Agriculture [USDA], 2020). While the DGAs is grounded in science, these recommendations were created for the general public, not for those who are recovering from an ED. While providers want to make sure their patients are adequately nourished, recovery is often more about building a healthy relationship with all foods, regardless of their nutrient value. This may look like the patient choosing to eat a hamburger instead of a grilled chicken sandwich, whole milk yogurt instead of low-fat yogurt, or potato chips instead of an apple. As recovery progresses, the patient may realize that they genuinely enjoy one food option over the other for how it tastes and makes them feel. However, during the treatment process, focus should be put on helping the patient see all foods as safe and acceptable for them to eat. Using the right language with this population is key, and that is often acquired through experience, especially since it can sometimes contradict what is taught in school.

Refer to Appendix A for an extensive list of resources to help you begin your exposure to eating disorders, HAES®, IE, and weight-inclusive care. As there are a plethora of resources provided, know that you don't have to explore all of them at once. Start broadly when first jumping into this world of nutrition and then narrow your search once you gain some understanding and experience. It may even be helpful to focus on one aspect of this field for a certain period of time and then move on to another topic once you feel comfortable with the information. You'll also begin to figure out what types of resources best suit you with regards to learning style, time availability, cost, etc.

The Essentiality of Supervision

Supervision provides numerous functions. It allows you to work with an experienced RD for case consultation and skill development, but also gives you the opportunity to discuss your own hardships that come up while working. While supervision is not a model typically explored by RDs, it holds high value in the field of eating disorders. If you are aiming to obtain your CEDRD, supervision from an iaedp™ approved supervisor (CEDRD-S) is already required. Even if you are not aiming to get the credential, supervision is still essential when working with eating disorders, especially when first starting out. With general supervision, you can ask any RD or therapist that has more experience than you do or has a niche that you want to explore to be your supervisor.

There are two types of supervision, group supervision and individual supervision, which can be in-person or virtual depending on the supervisor. Group supervision involves receiving supervision in a group setting with fees that can range from free to $25 per session. Individual supervision involves receiving one-on-one supervision with fees that can range from $120-$150

per hour. Both individual and group supervision have their own strengths and limitations and deciding which one to pursue depends on your own goals, preferences, and availability. As it has been noted that supervision is vital, there are two important questions an interviewee could ask when applying for a job: "Does the company offer supervision to employees?" and "Does the company provide employees stipends to receive clinical supervision if it is not provided in-house?" As a dietitian just starting out in this field, don't be afraid to advocate for supervision as it will help you grow as a professional and provide evidence-based care in a safe and effective manner.

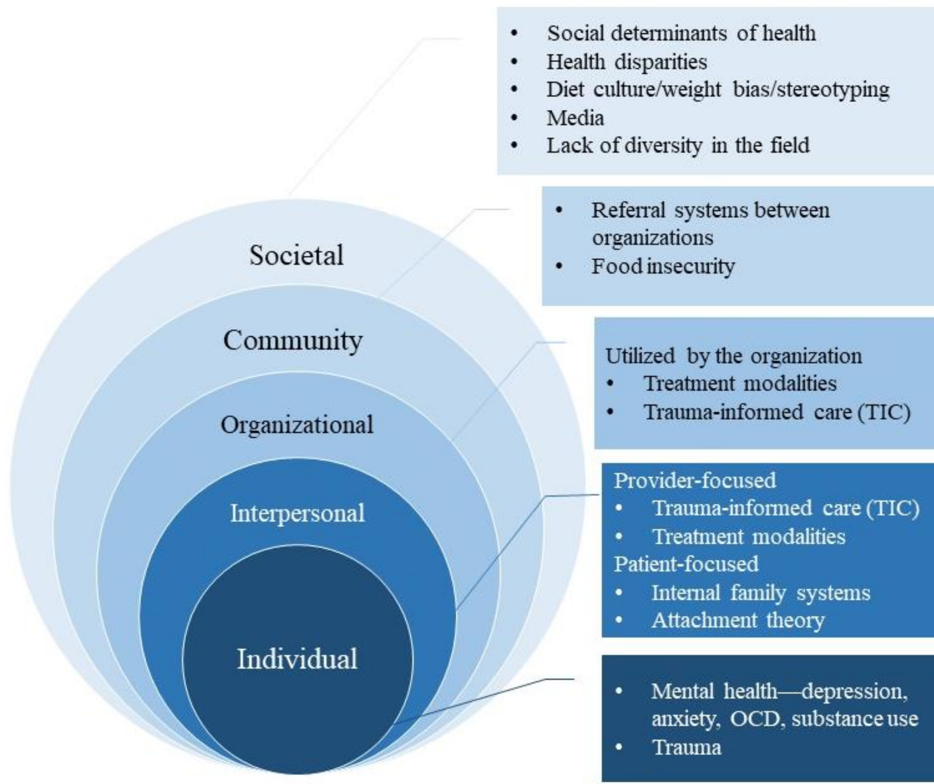
The Importance of Exposure to Interdisciplinary Knowledge

As eating disorders are complex, mental health disorders with biological and environmental determinants, there were a multitude of topics expressed by the RDs as important to consider when working in this space. Because of this, I will apply the Social Ecological Framework (Figure 2) to eating disorder care in hopes of providing an expansive visual of possible subjects to explore as one dives deeper into this field.

Starting at the individual level, it's essential for RDs to have a general understanding of mental health as eating disorders often coincide with other mental health disorders such as depression, anxiety, substance use, and obsessive-compulsive disorder (OCD) (Treasure, Duarte, & Schmidt, 2020). Furthermore, being aware of the impact of trauma at the individual level can help you have a more in depth understanding of your patients. At the interpersonal level, this can include exposure to trauma-informed care (TIC) and different treatment modalities such as cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), motivational interviewing (MI), acceptance and commitment therapy (ACT), and exposure and response prevention (ERP) therapy. A professional's use of these modalities and approaches will affect the patient-provider relationship and the subsequent outcomes. When focusing on the client at the interpersonal level, consider exploring topics such as internal family systems and attachment theory. Moving up to the organizational level, support and encouragement from one's organization to train in these treatment modalities and approaches is an aspect to explore. As these modalities and approaches will affect the patient-provider relationship, having an organization that offers support via policies, opportunities, or financial compensation for professional training can be extremely helpful.

At the community level, consider exposing yourself to information pertaining to food insecurity and referral systems between eating disorder professionals and organizations. For example, understanding the referral system is important since treating eating disorders requires an interdisciplinary team at all levels. It's critical to know the resources in your local community and state to be able to refer when you identify signs of an eating disorder and/or need additional support. Lastly, at the societal level, factors to familiarize yourself with when working in this space include health disparities, social determinants of health (SDOH), media influences, weight bias/diet culture, and the lack of diversity in the profession.

Figure 2: Multi-level Topics Essential to the Field of Eating Disorders



Certified Eating Disorder Registered Dietitian (CEDRD) Credential

The decision to obtain your CEDRD is not a simple yes or no answer. There are pros and cons to obtaining your CEDRD and the decision can be based off your own personal aspirations and career path. See Appendix C for guidelines on obtaining the credential.

Attaching CEDRD to your name can be beneficial, especially if this is the main field you're dedicated to working in, but by no means is it required nor is it a determinant of your success. It is also important to remember that you don't have to quickly jump into getting your CEDRD. There is so much to learn initially, and you'll likely need some time to soak everything up. Valuable experience in the field can even outweigh the credential, therefore, it might be helpful to explore getting the credential once you have a strong foundation in the field. One RD even described this credential as the "cherry on top."

Pros	Cons
• The credential is of high value—it shows that you have done the work to be a dedicated and skilled healthcare provider that treats EDs, but also shows that you have enough skills, tools, and self-awareness to manage your own emotions in the room.	• Expensive—it is important to ask if your employer can support you in the process in any way. • Time intensive, especially if you're not in a setting with daily exposure to EDs. • The expense and time commitment creates a larger gap and less opportunity

• Can help fellow RDs feel safe sending their patients to you, as harm can be done by RDs who don't properly understand ED treatment. • Provides numerous CEU opportunities through the core courses. • Allows you to make connections and form a community across the world with RDs and a variety of healthcare professionals. • Lays out a plan of continuing learning once you become a RD.	for more marginalized colleagues, thus further adding to the lack of diversity among trained professionals.

Tips for the Job Search Process

Searching for a job in the field of eating disorders can be both a challenging and daunting task, especially since not all RDs have the same nutrition philosophies such as providing care through a HAES®, IE, and weight-inclusive lens. For this segment of the interview process, I asked the RDs to provide any information they may have on the following topics: 1.) Questions to ask employers during interviews, 2.) Factors to be mindful of when applying and interviewing for jobs, and 3.) Overall tips for interviewees. The goal of this segment is to provide RDs of all experience levels with some guidance when it comes to finding a job in this specialty of dietetics.

1.) Possible questions to ask employers during interviews:
   - "What is this company doing to prevent weight stigma?"
   - "What is this company's viewpoint on weight?"
   - "How do you handle individuals coming in seeking weight management?"
   - "How do you feel if I approach my work from a weight-inclusive perspective? Am I able to practice independently in a way that still provides evidence-based treatment?"
   - "What is your nutrition philosophy and how do you implement your interventions using that philosophy?"
   - "How does your nutrition philosophy transcribe into the dining room and meal plan design?"
   - "What is the role of the RD in the treatment of the patient?"
   - "What are you doing to honor the racial disparities in eating disorder treatment and how are you bridging that gap?"
   - "How are you promoting diversity and inclusion in your practice?"
   - "How does this facility treat individuals across the spectrum with regards to abilities/disabilities, race, body size, eating disorder diagnoses, etc.?"
   - "If I want to obtain my CEDRD, how can you support me through this process?"

2.) Factors to be mindful of when applying and interviewing for jobs.
   - What kind of language is used on their websites? Is it weight-centric vs. weight-inclusive? Are there hints of diet culture?
   - Does the company understand HAES®? Do they call it *Healthy* at Every Size?

- If you are applying for a job at an eating disorder facility, you want to be upfront and honest about your nutrition philosophies.

3.) Overall tips for interviewees
- Be able to adequately articulate your dietary philosophy. Every treatment center will have its own belief system and the way they implement things, so make sure to do your research beforehand.
- Be honest with what your philosophy is and if it truly aligns with the facility's. Your patients will notice if there is discord between the facility's philosophy and your own.

Promoting a Shift in Dietetics: Weight-Inclusivity & Diversity and Inclusion

As stated previously, eating disorders do not discriminate, meaning they affect people of all ages, genders, races, ethnicities, religions, sexual orientations, weights, and body shapes (NEDA, 2018c). However, there continues to be a pervasive stereotype that eating disorders only affect higher income, white women (A. Lutz, personal communication, February 19, 2021). How can we then, as registered dietitians, promote a shift in dietetics where weight-inclusivity as well as diversity and inclusion are brought to the forefront?

<u>Weight-Inclusivity</u>

Concerning weight-inclusivity, changes can be made through the initiation of grassroots movements by both students and employees. As students, one important way to initiate change is to request that curriculum be presented in a more weight inclusive and HAES® manner. While it is challenging to add a new class to a program's busy schedule, just getting enough voices to express interest in these topics could promote small changes. This could include shifts in the type of language used in the classroom, the inclusion of viewpoints that don't automatically view weight as the culprit, or even the addition of a new class competency dedicated towards weight-inclusivity. Furthermore, don't be afraid to ask the tough questions in lecture even if they may go against the grain. Outdated perspectives will never change if no one is willing to challenge such viewpoints. Third, make it a priority to talk to like-minded peers to form vital connections and a support system. Not only can you share resources among your peers but having a support system can be beneficial when faced with information contradictory to your beliefs. Lastly, as a student, take advantage of sending evidence-based articles about these topics to professors who may not see eye-to-eye with you. While not trying to forcefully change their opinions, sending evidence-based articles could offer professors an insight into a new world and allow them to see where you are coming from.

As an employee, you can advocate for time at staff meetings to educate colleagues about evidence-based, weight-inclusive care, and if you're working with a doctor who doesn't practice through a weight-inclusive lens, don't be afraid to send them evidence-based articles as well. By providing colleagues and doctors with all the evidence, they can make informed choices about which lens they want to have while providing care. Second, you can advocate for support in your practice by asking for paid supervision, allowing you to learn from an experienced RD who already practices through a weight-inclusive lens. Lastly, consider offering to be a preceptor.

Share your knowledge with students so that new generations of RDs will continue to be more familiar with and accepting of weight-inclusive care.

A crucial aspect of promoting a more weight-inclusive dietetics practice is to check your own biases. It is okay if you have any weight biases given that we grew up in a weight-centric society, but you can address and rewrite them if you acknowledge your own biases. We must look introspectively first before trying to promote any shifts in society or among other people. Jacqui Supplee emphasized that we must approach everyone the same way, and not only those in larger bodies but those across the spectrum of shapes and sizes. Consider what is impacting their quality of life, what are their behaviors around food, what foods are avoided. Pretend weight doesn't even exist because even without knowing the person's weight, we can still address a lot of things. Behaviors are often ignored because of weight. If the weight is deemed "unhealthy," it can almost invalidate everything else that is going on with the individual. We need to look at each patient as a whole person rather than only focusing on the number on the scale.

As RDs we must be crucially aware of the fact that being in a larger body prevents one from getting appropriate medical care, and that can be more dangerous than what their weight is. For example, individuals in larger bodies don't want to go to the doctor for preventive care because they know they'll get lectured about losing weight. They attempt to go on a diet, but when they "fail" at it, they feel ashamed creating this vicious cycle. Many studies don't speak to the ill effects of dieting, such as the metabolic stress that occurs under a restrictive state, and studies that associate higher weight to inflammatory diseases may not even account for the metabolic stress of dieting and weight cycling.

With all this information, RDs must challenge the paradigm and advocate that weight is not the culprit. At the end of the day, weight is a symptom of a system, it is not a behavior. If we take weight out of the picture and look at what else is going on, we can see the whole person more clearly.

Diversity & Inclusion

While much of the RD profession is made up of white females, it is not impossible to promote diversity and inclusion. First, you should have a deep understanding of what your blind spots are. You must acknowledge that you won't understand what a person of another race/ethnicity experiences, or if the RD has thin privilege, what a person in a larger body experiences. One resource that can be extremely helpful with starting to uncover implicit biases and blind spots with regards to weight and body size is Harvard University's Implicit Association Test (IAT; see Appendix A for the link to this website). Additionally, leaning in on social media accounts of RDs that are different from you and being aware of your thought processes can help you catch any biases that may be creeping in.

Second, being culturally humble is important. It's not about being an expert on your patient's culture or life experiences, but rather being open to a lifelong process of reflecting on your own biases and values while also being dedicated to learning where your patient is coming from. There is no need to be "the expert" of another person's culture, but you should make it a priority to listen fully to their experiences because if you don't, you are going to make

assumptions and cause harm. Additionally, be intentional about referring patients of color to other healthcare professionals of color or to those that have some of the same lived experiences. Finally, as a provider, seek supervision and consultation from other practitioners of color to better support your patients of color.

Top Piece(s) of Advice

At the end of each interview, I asked each RD to provide their top piece(s) of advice for RDs who aim to enter and succeed in this field. Below is what each had to say.

- "It's okay to question things. It's okay to go against the grain and say, 'Wait a minute' and to trust your gut instinct if something feels wrong or you just want more evidence or explanation. We don't have to do things just because that's the way they've always been done…at large, dietitians are kind of boxed in by the time we graduate of things we are supposed to do…and truly I want to see people break the glass ceiling. There is so much we can do as dietitians and we do not have to be boxed into that little box. It is okay to go outside of it."
  – Haley Goodrich, RD, LDN, CEDRD-S

- "Find a community of like-minded dietitians, which can be through a professional organization or through peers that meet once a month. Find that community so you feel supported."
  – Anna Lutz, MPH, RD, LDN, CEDRD-S

- "Look for ways to get experience even if you can't find something that's full-time eating disorder work. There are other ways to get that experience."
  – Anna Lutz, MPH, RD, LDN, CEDRD-S

- "I am a really big proponent of supervision if it's something that someone can do. So, understanding the importance of supervision and how it exists in the psychotherapy world…whether it be individual supervision or group supervision."
  – Anna Lutz, MPH, RD, LDN, CEDRD-S

- "Know that there will be a lot of learning ahead. There will be things that you hear and learn about that may be contrary to what you have believed or known, and that's okay, it is a totally different language. Even just knowing that we as dietitians do have the capability to do harm, so we really want to make sure that no matter who we work with, a lot of the principles used in the treatment of eating disorders are actually really affective for treating the general public. It's not just battling weight stigma, diet culture, and diet mentality with eating disorder patients, it's battling it with everyone to make the world a safer place for those who do have an eating disorder. Don't get discouraged if it takes a while to get the hang of how things run."
  – Jacqui Supplee, MPH, RDN, LD/N, CEDRD-S, ATC

- "Weight bias does impact all aspects of dietetics and our practice. We need to not perpetuate diet culture, but to think twice about how things are said as it relates to someone's body or as it relates to how we communicate about food because that can be really powerful in both positive and negative ways."
  – Jacqui Supplee, MPH, RDN, LD/N, CEDRD-S, ATC

- "If you are interested in this field, continue to apply for jobs and express interest because a lot of times treatment centers or programs do hire new grads. Find different symposiums or conferences to be a part of or immerse yourself in different trainings in eating disorders… I am a big advocate of LinkedIn and forming different connections so that way you can stay caught up with all the different things coming out…it shows your interest in the field when potentially being interviewed for a position."
  – Vanessa Garcia, MS, RDN, LDN

- "You are ready once you finish up your coursework from UNC and then do your final internship where you can get more client interaction. You are ready to go, you just have to know it's not going to be perfect, but it's going to be fine. Get involved in group supervision the second that you can and then if you want, make that next step into individual."
  – McKenzie Caldwell, MPH, RDN, LDN

Resources

There are a multitude of resources one can utilize to learn about disordered eating, eating disorders, HAES®, IE, and weight-inclusive care. In this section, I have organized a set of critical resources for RDs to consider utilizing. These resources were either mentioned by more than one of the RDs interviewed or that I found to be immensely helpful. The resources are organized into 6 groups: trainings, podcasts, websites, research articles, books, and interdisciplinary coursework. See Appendix A for an extensive list of resources.

Trainings

- Nutrition Counseling for Eating Disorders: A 5 Part Online Training with Marci Evans
- Jessica Setnick's Eating Disorders Bootcamp

Podcasts

- Food Psych by Christy Harrison

Websites

- Eating Disorder Registered Dietitians & Professionals (EDRDPro): https://edrdpro.com/
- International Association of Eating Disorders Professionals (iaedp™): http://www.iaedp.com/
- National Center of Excellence for Eating Disorders (NCEED):

https://www.nceedus.org/

Research Articles

- Bacon, L. & Aphramor, L. (2011). Weight science: Evaluating the evidence for a paradigm shift. *Nutrition Journal*, 10(1), 1-13, https://doi.org/10.1186/1475-2891-10-9

Books

- *Nutrition Counseling in the Treatment of Eating Disorders, Second Edition* by Marcia Herrin and Maria Larkin
- *Sick Enough: A Guide to Medical Complications of Eating Disorders* by Dr. Jennifer Gaudiani
- *The Eating Disorders Clinical Pocket Guide: Quick Reference for Healthcare Providers*, *Second Edition* by Jessica Setnick
- *Body Respect: What Conventional Health Books Get Wrong, Leave Out, and Just Plain Fail to Understand about Weight* by Lindo Bacon and Lucy Aphramor
- *Intuitive Eating: A Revolutionary Anti-Diet Approach, Fourth Edition* by Evelyn Tribole and Elyse Resch

Interdisciplinary Courses

- Social Work
  - Motivational Interviewing
  - Cognitive Behavioral Therapy
  - Dialectical Behavioral Therapy
- Psychology
  - Developmental Psychology

Summary & Implications

Eating disorders are pervasive mental health illnesses that can negatively affect all aspects of life. Registered dietitians play a crucial role in the treatment of eating disorders and their contributions to the interdisciplinary team is invaluable. Despite this knowledge, few dietetic programs provide sufficient education and training on eating disorders, leaving both aspiring and practicing RDs with limited skills in this important area. Therefore, the aim of this toolkit is to provide an applicable resource for dietetic students and current RDs to gain insight into this challenging yet highly rewarding field.

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Appendix A: Resource Table

<table>
<tr><th>Category</th><th>Resources</th></tr>
<tr><td>Websites</td><td>Academy for Eating Disorders (AED)
https://www.aedweb.org/home

Eating Disorder Registered Dietitians & Professionals (EDRDPro)
https://edrdpro.com/

Implicit Association Test (IAT) from Harvard University
https://implicit.harvard.edu/implicit/takeatest.html

InspiRD Nutrition
https://www.inspirdnutrition.com/

International Association of Eating Disorders Professionals (iaedp™)
http://www.iaedp.com/

National Center of Excellence for Eating Disorders (NCEED)
https://www.nceedus.org/

Weight Inclusive Nutrition & Dietetics
https://weightinclusivenutrition.com/</td></tr>
<tr><td>Organizations</td><td>Behavioral Health Nutrition Dietetic Practice Group (DPG)
https://www.bhndpg.org/home
A professional-interest group for Academy of Nutrition & Dietetics (AND) members to connect with others within their area of interest and/or practice.
Specifically, the Behavioral Health Nutrition DPG supports professionals in becoming the food and nutrition experts in the field of eating disorders, intellectual and developmental disabilities, and addictions and mental illness.
Students have the opportunity to become involved through the Facebook group, “BHN Students”
iaedp™ North Carolina Chapter
https://nciaedp.com/
This chapter of iaedp™ provides eating disorder professionals located in North Carolina with collaboration, education, networking, and support opportunities.
iaedp™ also has 35 additional chapters throughout the United States http://www.iaedp.com/chapter/</td></tr>
<tr><td>Webinars</td><td>EDRDPro
https://edrdpro.com/webinar-library/</td></tr>
</table>

	• Free for EDRDPro members
	• 1-2 webinars each month & access to EDRDPro's webinar library
	
	International Association of Eating Disorders Professionals (iaedp™)
	• Continuing Education (CE) Monthly Webinar Series http://www.iaedp.com/webinars-schedule/
	    o $15 per webinar and 1 CEU
	• iaedp's Institute on MemberSHARE https://membershare.iaedp.com/category/events/iaedp-events/webinars/iaedp-institute-webinars/
	    o Free recordings when you provide your name and email
	
	National Association of Anorexia Nervosa and Associated Disorders (ANAD)
	https://anad.org/webinars/
	• Free webinars provided through their website
	
	The Renfrew Center Foundation
	• Free for students, professionals, etc.
	• Sign up for their listserv at info@renfrewcenter.com or go to their calendar at https://renfrewcenter.com/resources/calendar

Trainings	*Jessica Setnick's Eating Disorders Bootcamp* https://www.eatingdisordersbootcamp.com/ • An extensive compilation of downloadable audio sessions, downloadable and printable handouts and materials, books via mail, and an individual Zoom or call workshop with Jessica Setnick. *Nourish Your Knowledge* https://nourish-your-knowledge.teachable.com/p/nourish-your-knowledge • An online course dedicated towards allowing nutrition students, dietitians, and healthcare professionals to explore intuitive eating, Health at Every Size®, and weight-inclusive care. *Nutrition Counseling for Eating Disorders: A 5 Part Online Training with Marci Evans* https://marcird.teachable.com/p/online-eating-disorders-training-rdns-17 • An online course consisting of video training with PowerPoint slides, patient ready handouts, research articles, master tips sheets, recommended reading, access to a private Facebook group, and 13 continuing education credits.
Internships	*Wondering if it is required to have an internship with eating disorders to get a job in this field? Read what RDs have to say about this question:* • Having an internship in this setting allows you to get your foot in the door, build connections, and market yourself as having hands-on

	experience on your resume, but it is not absolutely essential in order to go into this field. - *Anna Lutz, MPH, RD, LDN, CEDRD-S* • Does it help having an internship in eating disorders, yes absolutely, but by no means is it required. You still have the ability to go into the field if you are not able to get an internship. Some treatment centers will hire techs (e.g., diet techs and floor staff) where you can be on the floor with the patients supporting them during meal time or serve as an aid in the kitchen. You may not be working with residents one-on-one, but you're a part of their world, learning the language and learning how the treatment environment works. - *Jacqui Supplee, MPH, RDN, LD/N, CEDRD-S, ATC*
Research Articles	**Evidence-Based Guidance** da Silva, J., Seres, D.S., Sabino, K., Adams, S.C., Berdahl, G.J., Vitty, S.W., Cober, M.P., Evans, D.C., Greaves, J.R., Gura, K. M., Michalski, A., Plogsted, S., Sacks, G. S., Tucker, A. M., Worthington, P., Walker, R. N., Ayers, P., Parenteral Nutrition Safety and Clinical Practice Committees, American Society for Parenteral and Enteral Nutrition (2020). ASPEN consensus recommendations for refeeding syndrome. *Nutrition in Clinical Practice*, 35(2), 178-195. https://doi.org/10.1002/ncp.10474 Hackert, A. N., Kniskern, M. A., & Beasley, T. M. (2020). Academy of Nutrition and Dietetics: Revised 2020 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Eating Disorders. *Journal of the Academy of Nutrition and Dietetics*, 120(11), 1902-1919. https://doi.org/10.1016/j.jand.2020.07.014 **Health at Every Size®/Intuitive Eating** Bacon, L. & Aphramor, L. (2011). Weight science: Evaluating the evidence for a paradigm shift. *Nutrition Journal*, 10(1), 1-13, https://doi.org/10.1186/1475-2891-10-9 Hunger, J. M., Smith, *J. P., &* Tomiyama, A. J. (2020). An evidence-based rationale for adopting weight-inclusive health policy. *Social Issues and Policy Review*, 14(1), 73-107. https://doi.org/10.1111/sipr.12062 Tylka, T. L., Annunziato, R. A., Burgard, D., Daníelsdóttir, S., Shuman, E., Davis, C., & Calogero, R. M. (2014). The weight-inclusive versus weight-normative approach to health: Evaluating the evidence for prioritizing well-being over weight loss. *Journal of obesity,* 2014. https://doi.org/10.1155/2014/983495

	Bruce, L. J., & Ricciardelli, L. A. (2016). A systematic review of the psychosocial correlates of intuitive eating among adult women. *Appetite*, *96*, 454-472. https://doi.org/10.1016/j.appet.2015.10.012 **Weight Stigma/Weight Bias** Mensinger, J. L., Tylka, T. L., & Calamari, M. E. (2018). Mechanisms underlying weight status and healthcare avoidance in women: A study of weight stigma, body-related shame and guilt, and healthcare stress. *Body Image*, 25, 139-147. https://doi.org/10.1016/j.bodyim.2018.03.001 Rubino, F., Puhl, R.M., Cummings, D.E. et al. (2020). Joint international consensus statement for ending stigma of obesity. *Nat Med*, 26, 485-497. https://doi.org/10.1038/s41591-020-0803-x Sutin, A. R., Stephan, Y., & Terracciano, A. (2015). Weight discrimination and risk of mortality. *Psychological science*, 26(11), 1803-1811. https://doi.org/10.1177/0956797615601103
Books	**Medical Focused** *Eating Disorders: A Guide to Medical Care and Complications, Third Edition* by Philip Mehler and Arnold Andersen *Nutrition Counseling in the Treatment of Eating Disorders, Second Edition* by Marcia Herrin and Maria Larkin *Sick Enough: A Guide to Medical Complications of Eating Disorders* by Dr. Jennifer Gaudiani *The Eating Disorders Clinical Pocket Guide: Quick Reference for Healthcare Providers*, *Second Edition* by Jessica Setnick *Guidebook for Nutrition Treatment of Eating Disorders by* Academy for Eating Disorders Nutrition Working Group **Language Focused** *Anti-Diet: Reclaim Your Time, Money, Well-Being and Happiness Through Intuitive Eating* by Christy Harrison *Body Respect: What Conventional Health Books Get Wrong, Leave Out, and Just Plain Fail to Understand about Weight* by Lindo Bacon and Lucy Aphramor

	How to Nourish Your Child Through an Eating Disorder: A Simple, Plate-by-Plate Approach to Rebuilding a Healthy Relationship with Food by Casey Crosbie *Intuitive Eating: A Revolutionary Anti-Diet Approach, Fourth Edition* by Evelyn Tribole and Elyse Resch *Life Without ED: How One Woman Declared Independence from Her Eating Disorder and How You Can Too* by Jenni Schaefer *The Intuitive Eating Workbook for Teens* by Elyse Resch *The Intuitive Eating Workbook: Ten Principles for Nourishing a Healthy Relationship with Food* by Evelyn Tribole and Elyse Resch
Podcasts	*Food Psych by Christy Harrison* https://christyharrison.com/foodpsych *RD Real Talk by Heather Caplan* http://heathercaplan.com/rd-real-talk-podcast/ *Dietitians Unplugged with Aaron Flores and Glenys Oyston* https://dietitiansunplugged.libsyn.com/ *The Food Heaven by Wendy Lopez and Jessica Jones,* two black registered dietitians aiming to provide accessible and inclusive care. https://foodheavenmadeeasy.com/podcast/
Facebook Groups	*Nourish Your Knowledge* • Offers RDs, RDs-to-be, nutrition students, and health professionals a safe space to explore concepts of HAES®, IE, and weight-inclusive care. *#INSPIRDtoSEEK* • Offers a community for RDs, RDs-to-be, and health professionals who are working to challenge body image standards and practice using a non-diet, weight-inclusive approach.
Videos	*Poodle Science* https://www.youtube.com/watch?v=H89QQfXtc-k • Explores the limitations of current research on weight and health. Created by Association for Size Diversity and Health (ASDAH)

Appendix B: Registered Dietitian Contact Information

Anna Lutz, MPH, RD, LDN, CEDRD-S; anna@lutzandalexander.com

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McKenzie Caldwell, MPH, RDN, LDN; mckenzie@feedyourzest.com

Vanessa Garcia, MS, RDN, LDN; vanessa.garcia@veritascollaborative.com

Appendix C: Certified Eating Disorder Registered Dietitian (CEDRD) Credential Process

Checklist:

- Must be registered through the Commission on Dietetics Registration (RDN)
- iaedp™ Core Courses
  - Course 1- Overview of Feeding and Eating Disorders
  - Course 2- Treatment Modalities for Feeding and Eating Disorders
  - Course 3- Nutrition Therapy for Feeding and Eating Disorders
  - Course 4- Medical Treatment of Feeding and Eating Disorders
- Case Study
  - Completion of a case study that will be submitted with the application.
- Continuing Education (CE)
  - Completion of 20 hours specific to the treatment of feeding and eating disorders per the DSM-5.
- Supervised Experience
  - Completion of 2,500 documented practice hours treating eating disorders under the guidance of an iaedp™-Approved Supervisor (CEDRD-S)
- iaep™ Traditional Certification-Specific Curriculum Vitae (CV)
  - Inclusion of your current CV along with your application.
- Letters of Recommendation (LOR)
  - Obtain 3 LOR from a licensed or credentialed practitioner.
- iaedp™ Certification Examination
- iaedp™ Membership Requirement

Links: Check out these links for additional information on obtaining your CEDRD

- Certification Overview: http://www.iaedp.com/certification-overview/
  - Traditional Certification Application: http://www.iaedp.com/upload/Certification/Overview/Traditional/TradCertApplication_May_2019.pdf
  - A Guide to Your iaedp™ Supervision: Microsoft Word - Sup1 Guide to Supervision 4.15.20 (2).docx (iaedp.com)
  - iaedp™ Certification Examination Guide: Certification_Exam_Guide_2020.pdf (iaedp.com)
- The CEDRD in Eating Disorders Care Booklet: http://www.iaedp.com/upload/Certification/Overview/General/iaedp_CEDRD_Booklet2018_with_TW_.pdf