

[00:00:00] **Melissa:** Hello and welcome to the sound bites podcast. Today's episode is about eating disorders and disordered eating or dysfunctional eating behaviors. What they are, how to understand them and their origins better and how to better manage and treat them. This episode is for anyone who is interested in the topic for themselves, for a friend or a family member, or as a healthcare professional, who wants to be a better practitioner.

Now I do want to let you know that if you have had or have any kind of struggles with body image dieting or the like, I would like you to consider that the topic we're covering might not be in your best interest, if it leads to anxiety or other triggering emotions, we are trying not to share anything too specific or triggering today, but we aren't able to predict how different people will react to some of the information we discuss.

So just know that it's important for you to do what you need to do in order to take care of yourself. I also want to let you know that we are submitting this episode for free continuing education credits for registered dietitians, diet technicians, and diabetes educators. So be sure to check back at soundbitesrd.com/freeceus for updates on all of my free continuing education activities.

My guest today is Jessica Setnick. You may know her as the eating disorder nutrition expert behind eating disorders bootcamp, or as the author of the eating disorders clinical pocket guide. For nearly 25 years as a dietitian, Jessica has worked in all levels of eating disorders.

From private practice to large facilities. Welcome to the show, Jessica.

[00:01:43] **Jessica:** Thank you. Excited to be here,

[00:01:45] **Melissa:** You know, I actually interviewed you for my blog. You'll remember back in 2014 after we met I believe it was a dietitians in business and communications panel that we were on together. I remember! It was a long time ago though.

You're very memorable! So are you! I really enjoyed connecting. And we haven't really, our paths haven't crossed much since then. But that blog that I did, where I interviewed a lot of dietitians, it turns out it was the precursor to my podcast. That was unbeknownst to me at the time.

But, you know, we just kind of got reconnected recently through a mutual friend Neva Cochran. And I would love for you to tell us more about yourself and your background and the work that you do. Sure.

[00:02:34] **Jessica:** I'd be happy to. And thanks for having me. And, you know, I always tell Neva that technically she's a dietician, but her real job is connecting people.

So she did a great job this time. Always. So my path as a dietician is. Very accidental one. I took nutrition as an elective in college because a friend told me that it was an easy "A" which, by the way, it wasn't. But nevertheless, taking that nutrition class made me fall in love with nutrition, the idea of what happens to food once it goes inside your body, why you make the food choices you make, how the food gets to you in the first place.

All of it was so fascinating to me. And I was actually an anthropology major at the time. And couldn't quite figure out how it was going to make anthropology into a career. But if you're not familiar with anthropology, it's the study of human development on a macro scale, human cultures, human physiology.

And to me, nutrition was more of Human development on a micro scale, how we develop throughout life, how we develop the culture of eating in our own homes and in how we reflect the bigger culture with our eating, it was all just amazing to me. So I changed course there and went to get a master's degree in nutrition.

Even though I think that the whole psychology of eating or the anthropology of eating, or whatever you want to call it about the pieces of the puzzle, that aren't just the nutrition process inside your body. I felt like that should be important in every area of nutrition and dietetics. But at the time when I was at school in the 1990s, really the only area where it was kind of kosher to talk about that stuff was in the eating disorder field.

And so that became really my fascination, because it was where we were really looking into those things. And it took a while for me to realize that I was actually in recovery from my own eating disorder. I was one of those people that sort of looks at the diagnostic criteria and says, well, it wasn't that bad.

So I guess I didn't really have a problem. And it took me a long time to really accept that Yes, I had had an eating disorder. And even though I was able to get into somewhat of a recovery without professional help, I really needed a lot of

counseling and eventually medication to really actually get into what I consider remission, which is not having Not as many thoughts, and definitely no behaviors. And it just gave me such an important insight. Having gone through that process, myself, into what I brought into the field. So my work is now mostly educating other health professionals because I was in private practice. As you mentioned for a lot of years, I started in the hospital in an eating disorder program, went into private practice and then realized that there was so little education and this is going to make me sound really, really old, but you're going to remember this too. But when I started working in an eating disorder, Program at a hospital. This was sort of the Dawn of the internet. There was no Google. There was nowhere to look things up.

And so if you needed information, you had to get in touch with another dietician. And so for dieticians, who weren't specializing in eating disorder, It was really challenging because they would literally have to call information, asked for the phone number of a different hospital call a different hospital, ask for the nutrition department, ask if they had a dietician who specialized in eating disorders or who could advise them if the answer was no, they'd have to hang up the phone, call information, get the phone number for another hospital.

I mean, it was really a labor intensive process to try to find someone that could help you. And when the Dawn of the internet, happened there was one listserv for all of the academy. I don't know if you remember that – it was called the ADA at the time, but there was one listserv for every dietician. And so what would happen is the dietician could look on their census in the morning, see that there was someone with an eating disorder type into the list serve “Can anyone help me with this patient?” And by the time they came back down for lunch someone like me would have answered and said, Hey, give me a call. I can talk you through it type of thing. And so through that process, I became known as an expert in eating disorders. And so that's really where everything in my mind kind of began.

I don't know if it was right place right time, but also that willingness to help a colleague. And so over time, I was then asked to give talks on eating disorders. I came up with my own workshop, eating disorders bootcamp. And so that aspect of my career started to overwhelm the patient care aspect where I couldn't be traveling and presenting and also be there for my patients when they needed me.

So over time, I ended up closing my private practice and just doing the education piece, which is what I do now.

[00:06:57] **Melissa:** Okay. Excellent. Yes, I do remember all of that you know, before the internet, before we used email at work and, and things like that I think we're, we're pretty much contemporaries

[00:07:07] **Jessica:** there. We had email but pe printed out all the emails I don't know what we thought we were going to do with.

Well,

[00:07:17] **Melissa:** that is funny. I do remember doing that. Yeah. Or if you're going to a website, you would just print out the information because of course you didn't have a mobile device to look it up on the go. And, oh my gosh, you know, you, you called a restaurant and got directions on how to get there. You didn't, you know, use Google maps or anything.

But I digress and I've told this story on the podcast before I think, My very first TV segment was the first day of my second job, which was my outpatient dietician job, which was my favorite job. I loved it. And that first day on the job, my boss came to us at lunch and there was about 10, 12. I was the only outpatient dietician, everybody else was inpatient.

And she said, the TV stations coming, who's going to do the TV interview. Everybody said, I'm not doing that. I'm not doing that. And I was mortified that everybody was being so insubordinate. And I thought, well, I guess I'll do it. And it was on men's health. And of course like, well, I didn't know that much about men's health.

You know, it, wasn't my area of expertise. But we actually called the academy based here in Chicago. And I said, you know, I need some information and they faxed it to me. So that was in 1995. So yes, a lot has changed since then. And yeah, the good news is that the world has opened up in order for dieticians to be able to connect with each other and find resources like you.

But that's still, we're going to get into this. That's still a little bit of an issue. With dieticians in our field, not necessarily, you know, specializing in eating disorders or disordered eating and perhaps not feeling comfortable, you're still serving this wonderful role to help educate them and give them confidence and insight.

So we're going to talk about that today. So this topic, eating disorders, it can really be taboo. Yes. It can feel very daunting. It can be anxiety provoking. So

where should we start? You know, keeping in mind that we have a mixed audience, we have the general public, we have dietitians and other healthcare practitioners.

You know, where should we start? What do we need to know to set the stage for eating disorders and disordered eating.

[00:09:25] **Jessica:** Gotcha. Great question. And the place I would start is with a term that you used in your introduction, which is dysfunctional eating behaviors. I feel like when we say the words, eating disorders, everyone gets sort of a persona or an avatar in their mind of what that means the same way that I, who had had an eating disorder thought that I didn't have an eating disorder because I didn't meet XYZ picture that I had in my mind of what an eating disorder was or the diagnostic criteria.

I think all of that, we need to kind of set aside because what it has led to unfortunately, is a lot of missed opportunities to help people. And the diagnostic criteria, the research in our field so much is based on these biased ideas of who gets eating disorders that really, I feel like we need to use different terminology that sort of takes us away from that this is a very small group of people who have these very specific behaviors and enlarge it to everyone who eats can have dysfunctional eating behaviors. And there's no reason that someone couldn't or shouldn't get help just because they don't meet some criteria.

So part "A" is a lot of people don't get help because the having a problem is not recognized by the words, eating disorders. And another part of the problem is that sort of outdated treatment for eating disorders. We're really kind of thinking of eating disorders as one thing, based on the symptoms, the outward symptoms.

And we need to start looking at that idea of anyone who eats can have dysfunctional eating behaviors. They don't even have to rise to the level of an eating disorder to be an issue. And so I prefer the term dysfunctional eating behaviors because I feel like it sort of opens up this continuum of, yeah, we all have some, and my definition of dysfunctional eating behaviors is really, you know, does eating support your goals or not support your goals?

You can't really define it by someone's individual behavior. There's things we can all agree are detrimental to health, but for many people it's much more individual than that. So for example, someone might be eating a Turkey

sandwich for lunch and enjoying it. It's delicious. And someone else might be eating a Turkey sandwich for lunch because they're scared to eat anything else.

And so the same food can be functional or dysfunctional for two different people, or even for the same person in different situations. And so I felt like dysfunctional eating behaviors really opens up the window for us to look through and our own behaviors and include things like our motive for eating and the results of our eating and whether we feel regret after eating and things like that can sort of point to whether our behaviors are supportive to our lives or destructive to our lives versus the specific behaviors that we all know and associate with eating disorders.

[00:12:00] **Melissa:** Okay. Very good. And yes, this term dysfunctional eating behaviors is a phrase or a term that you came up with and shared with me. So, so that's why I used it. And I'm so glad that you explained that to me and to our listeners, you know, there there's a stereotype and a stigma and there's symptoms and behaviors.

And it makes perfect sense that if we have this narrow view of it, like you said, there's a lot of missed opportunities. People falling through the cracks, even, even in your situation, you thought, well, I don't look like that. And when I say, look, I mean, in my mind, like I'm not, I don't identify with that. So that's not, I don't have any detour because that's not what I'm seeing.

Even for ourselves, there can be missed opportunities there. Yeah. Very good. So then let's build on that. You know, we've adjusted our lens, we've opened up our minds and I'll tell you as a dietician working in the hospital setting, whether it was inpatients or outpatients, I worked with eating disorders and I found it very challenging.

I felt frustrated and anxious that I couldn't, I felt that I couldn't help my patients better, but also kind of had this epiphany leading back to this term, dysfunctional eating behaviors where gosh, you know, eating disorders aside, most people that I was seeing had some disordered eating. And like you said, it didn't necessarily rise to the level of, you know, like a formal diagnosis or anything.

And this is just what people were telling me. Lord knows what they weren't telling me. It can be a lot. So let's build on this. Is this a good spot for us to talk about there's four origins.

[00:13:45] **Jessica:** Yes, but first let me say that I am totally with you and the statistics support what you say. I think statistics about eating disorders are very unhelpful in many, many cases.

Because again, as I said, they're kind of based on this very biased thinking that's baked into the field, but one of the things I think we can trust, or it may be even worse than the statistic is that only about one in 10 individuals with an eating disorder is ever going to get specialty care. So that means nine out of 10 people with eating disorders - and we're not even talking about dysfunctional eating - We're just talking about truly diagnosable eating disorders. Nine out of 10 are going to be in your care. They're going to be in the diabetes clinic. They're going to be in the oncology service. They're going to be on the med/surg floor. And so obviously not, everyone's going to see a dietician, but those that do are not very likely to see an eating disorder dietician just there's 30 million people with an eating disorder and less than a thousand dieticians that identify as specializing in the eating disorder world. So yes, if you're a dietician that doesn't specialize in eating disorders, that's not gonna shield you from having patients in your care whenever your service is that also have eating disorders.

And so, yeah, I think it's really important to have a working knowledge of what to do to help. And that's why I actually came up with eating disorders bootcamp. It wasn't meant to be for specialists. It was meant to be for generalists or dieticians in other areas to really help them when they encounter individuals with eating disorders in those other areas.

So I agree. And when you look at the four different paths to eating disorders, you can see how they can affect everyone. It's not just this small sort of subgroup that we've been led to believe. So there's four major groupings of paths toward eating disorders. There's probably 30 million different paths to eating disorders since there's 30 million people.

Well, that's just in the U S actually you may have listeners in other countries. So there are millions of people with eating disorders, but I've tried to sort of narrow down the origins of them into four major paths. So yes, we can go over those. And I have a handout on this that we can put in the show notes if you'd like to. Great! Because I'm going to say a lot of words and you won't be able to write it all down.

So the first grouping is the biologically based, dysfunctional eating behaviors. And I use the word biology to describe this rather than genetic, because I think genetic is one of those words that has very specific meanings, right. Inherited.

And that's not what I mean. Yes, there are probably some eating disorders that are inherited, but there are also a lot of biological factors that are not inherited that can influence an eating disorder.

A great example is concussions, right? Nothing inherited about that, but someone could get a concussion and that can lead to the development of dysfunctional eating behaviors because of the effects on the brain, right? It's traumatic brain injury. And even though it's a closed head injury, you still have effects on appetite effects on perception, all different kinds of things.

And so that's just one example, other biologic behaviors or biologic factors that affect eating behaviors are things like hyper or hypothyroidism, anything pretty much that has a hormonal component. So any kind of diabetes, polycystic ovary syndrome, and then you have the psychiatric illnesses like depression and anxiety, obsessive compulsive disorder, all of these are biological conditions that can influence eating behavior.

So it's much more than just the genetic piece, which there probably is a genetic piece to a lot of eating disorders, but that's definitely not the whole picture. So that's type one. Type two of the path to eating disorders would be addiction related. So there's sort of a chicken and egg cycle that can happen with addictions and by addictions I mean everything from substance abuse or chemical dependency to behavior, process, addictions things like compulsive gambling, et cetera, you have a situation where, you know, someone who's trying to recover from an addiction has, you know, the addiction is not to the substance as much as to the chemical changes that the substance or the behavior produces.

Right. And so food is a mood altering chemical. People don't often identify it that way, but if you've ever been hangry and you ate and you felt better - not as cranky, you know, right. Food affects your mood. And so when someone is dependent on a different substance and they're trying to not use that substance or abuse that substance, it can be really easy to turn to food.

You can also have a situation where someone develops an addiction because of their dysfunctional eating behavior. So where someone turns to a certain type of substance in order to let's say, keep their weight down and prevent them from eating or prevent them from having an appetite. So there's a lot of connections between addiction and eating and that's another path.

The third path is stress and trauma related dysfunctional eating behaviors. And this is such a huge category. I'll give a few examples, but basically it breaks down into two major groups. I guess, to me, the difference between stress and trauma is simply a traumatic event might happen one or more times.

Stress is something that could be low lying and may not even be identified as traumatic, but it is traumatic because it occurs over time. So something like food insecurity to me is stress that becomes a trauma because it keeps occurring over time. And so you've got two major groups here. You've got traumatic events that have nothing to do with food, but that are just a shock to the system.

They exceed someone's ability to cope, probably anyone's ability to cope. This is things like, you know, and here's where I hate to trigger someone, but something like a death, a divorce, your house burning down - things that are just so shocking that they affect your body chemistry and that can then affect all the things I mentioned when we were talking about concussions. That can affect your appetite. It can affect your mood. It can affect your ability to procure food for yourself, your desire to eat. So many different things can be affected by a single traumatic incident. And if someone has multiple traumatic incidents even more so. Then there's a group of stressful, traumatic incidents and events that are related to food.

So that is something like if you were in hurricane Katrina, sitting on your roof for three days, not knowing if anyone was going to rescue you and you had no food. Or someone who was in a refugee situation, someone who went through the great depression. And we're all descended from individuals who experienced some kind of food-related insecurity at some point.

And so we have this kind of food related trauma that then becomes even more difficult to untangle because we have to deal with the food related rules and thoughts and feelings that we develop based on that. And also whatever the traumatic stressful incident was as well. So, you know, almost everyone has something in their life that they remember or recall that happened related to food.

For me, it's that I ate life cereal and I threw it up and I can't even stand to look at the, those colorful letters of the word life. When I walk in the store, all I can think of is how I threw it up. For my husband at the time, he had to sit overnight with the mashed potatoes on the table that he didn't want to eat.

And he fell asleep on the table. So, you know, those are in the grand scheme of life. It's so easy to say, like that's no big deal that happened so long ago that wasn't really that bad. It didn't affect me, but Melissa, I'm telling you that stuff that happens when you're young, it really does continue to affect you throughout life.

So we can't just discount those things, even if they don't rise to the level of what the therapist call a big T trauma. They still were less than nurturing, let's say. And so they felt traumatic to us as children and, and can definitely be still affecting us. So that's a third path. And then the fourth path is, is learned behavior.

And this is caused by the environment, by society, whatever names you want to call it by, you know, everything from diet culture to the thin Ideal is what it used to be called. You know, appearance culture, consumer culture. This is caused by, you know, filters and the fact that we never see celebrities looking like humans, we only see them all glammed up.

There's so many factors this can come from just learned behavior in a family. I remember seeing on TV, a woman talking about her eating disorder development and that her whole family would eat dinner and then they would go move into the room with the television and order pizzas. And everyone in the family would get their own pizza to eat while they watch TV.

And this was after dinner. So, you know, to me, some of these behaviors that are learned are not perceived as dysfunctional at the time, but if we're still doing them later in our lives, they may now have become dysfunctional behaviors. Another example would be something like sort of food rules, like a lady doesn't eat blank or doesn't weigh blank or, you know, different kinds of messages that we get that, you know, the solution is not necessarily an easy solution just because it's not biological. It might be very difficult to untangle these messages, but it's important to sort of try to find the source of dysfunctional eating behaviors because that's going to lead to the appropriate treatment.

[00:22:38] **Melissa:** Right? So each of these four different types in and of themselves there's a variety, like you said, there's millions of reasons. Cause there's millions of unique individuals. Yes. But to your point, the goal is to try to find the right treatment for the right person. And if you're trying to treat somebody with addiction related behaviors.

And you're just talking about diet culture, you kind of missing the point and vice versa. Right?

[00:23:07] **Jessica:** Exactly. Exactly. And I do feel like that's the dilemma that a lot of people who have tried to find treatment for their eating disorder have encountered that people are grouped together based on their outward symptoms.

So here's three people who don't eat enough to sustain life. They're going to get the same treatment. Here's three people who use compensatory behaviors after they eat. They're going to get the same treatment. But if you put someone who had a concussion in a group with someone who has had food insecurity in their life.

I'm not saying they don't have lots of things in common, but they don't necessarily have the same condition. And so therein lies the story of three bears that I often tell the three bears and Goldilocks, which is that the three bears were all coughing and Goldilocks came along and gave them each a cough drop.

And Papa bear said, oh, thanks, Goldilocks. I feel much better. And mama bear said in between coughs, Well, that didn't do anything for me and baby bear, didn't say anything and just started turning blue and passed out and they had to call 9 1 1. Well, they were all coughing. They all got the same treatment. Well, Papa bear, he had a sore throat.

So a cough drop was great – solved his problem. Mama bear had tuberculosis, so a cough drop isn't going to do anything for her. It's just going to cough it right out. Probably. And baby bear was already sucking on a cough drop. And two cough drops was just too much for his little trachea. And so he actually started choking because it blocked his airway.

So if you don't look at what is the root of someone's outward behavior, then, how do you know you're giving them the right treatment? And unfortunately, in a lot of cases, not all, but in a lot of cases, that's what traditional eating disorder treatment is. It's, let's look at your outward sign of behavior and then let's give you a treatment based on that.

And some treatment is even based on what someone weighs, which has nothing to do with the origin of their dysfunctional eating behavior. So a lot of missed opportunities, as we said before.

[00:24:59] **Melissa:** And you had mentioned, just because something might have happened to you long ago, or it might seem just a long ago, memory doesn't mean it's not affecting you today.

And I can appreciate the challenge here to kind of connect all the dots. And help people do that for themselves as well. How, you know, I remember thinking when I was working as an outpatient dietician that, gosh, you know, I can't, I need a degree in psychology to help these people, or I need to work closely with a therapist.

Where are things at with that today regarding dieticians and therapists working together? I mean, I know like tele-health has probably helped a lot of that because you know, just the logistics involved. Where are things at with that?

[00:25:43] **Jessica:** Well, there's a big difference between our training, right?

Dieticians are trained to work in a team approach. Therapists are often trained to work very independently. Everything is confidential. So you can't really make a generalization about dieticians and therapists. I think there is a group of or, you know, many therapists who really respect and value the input of dieticians and are really good at working together.

I know I found that when I was working, there were, you know, certain therapists that, you know, a patient would say to us, wow, did you talk to Suzy? Because she said the same thing, you know, where we're really kind of sharing a wavelength. And then there are other therapists who don't want anything to do with the dietician, or they are sort of one modality therapist.

They really are very strongly into whatever that modality is, whether it's FBT or CBTE and those modalities don't involve dieticians. So that's fine, but it's not going to be a good working relationship if a patient wants to see a dietician and one of those therapists. So I think it just depends. As far as what is the dietician's role there?

You know, first of all, let me just mention that I did do a workbook called Food Fairytales, which is about delving in on your own for someone who isn't really ready to talk about it with a professional to just start delving in, on your own, on what are those childhood messages and experiences that you had.

And so we can put a link to that in the show notes and even put a discount code for people if they're interested. Great. As far as what is the dietician's role versus

the therapist role? I think it's really easy to me to say what the difference is. And I will say, this is the number one question that dietitians always ask during eating disorders Boot camp is how do I know that I'm not being a therapist? And the easy answer is if you didn't sleep, walk to school and go become a counselor, you're not accidentally being a therapist.

Dietitians and therapists both use counseling skills. But to me, the biggest difference is what the topic is. So we might all use motivational interviewing or mirroring or active listening or unpacking or all these different things redirecting, reframing, but what makes the difference is that a therapist is using those tools on things that are separate from what the dietitian does. So the dietitian's scope of practice is anything related to food and eating. And then there's, you know, some aspects of body and body size and things like that.

And then the therapist is using those exact same tools sometimes but to delve into things like adverse childhood experiences and future dreams and aspirations and career goals and time management and family relationships. And it becomes really easy when you think about it that way to realize that as a dietitian, I'm only talking about family relationships as far as they relate to someone's food and eating. Once I realize this isn't about food and eating, then it's real easy to say, you know what? I'm a good listener, but I don't think I'm the right person to advise you on this. Do you have a counselor? Or a best friend or who helps support you when you have this kind of dilemma.

So it becomes really easy as a dietitian to sort of you know, draw that line gently, but for us and for the client and say, oh, you know what, this isn't my area of expertise. Now it might be different if you're talking to a friend, but when you're talking as a dietitian, your area's really the food and nutrition aspects.

And so it becomes really I think obvious once you get there, but sometimes you don't get there until you've gone down a bit of a rabbit hole. So I'll give the example of someone who let's say is talking to a dietitian about their specific way that they like to eat. And they mentioned that they went to someone's wedding and that person did not accommodate their eating style and they just felt very left out.

And so the dietitian is kind of going along this conversation, thinking, okay, we're talking about how they manage their eating and what did they do in this situation? But over a few minutes, you realize, wait, this is not about food and

eating. This is about feeling insulted. This is about their relationship with that person.

And when you realize that that's when you can say, oh, you know what? I thought we were talking about your eating, but I realized this is really more about your relationship with that person. So I think this might be better addressed with your counselor, and then you bring the topic back to eating. And the easiest way to do that is to say, how did that affect your eating?

Right. We can always bring it a - almost always there's exceptions to everything. We can almost always bring a conversation back to food and nutrition and be right there in our scope. And just to comfort those dietitians that worry, sometimes I'll say this, what a client or patient brings to you and says to you does not make you in or out of your scope.

It's what you say back. So if someone tells you something, that's not really a dietician's area, you just simply say. Oh, you know what? That's not really my area. Is there someone else in your life that you could talk to about that? And that's all you have to say, just because someone told you about some experience or something that isn't related to food doesn't mean you've done anything wrong.

And I know as a new dietician, I thought that sometimes I thought, why is this person telling me about X, Y Z. This isn't about nutrition. And I realized that it's not the patient's role to determine what is, and isn't about nutrition. It's my job as a dietician to sift through it and find out where the nuggets that I need to take and help with nutrition related advice versus which are the nuggets that are not in my area.

And sometimes that does take practice, but like I said, it's not ever wrong to talk through something with someone, as you think you're going towards food and eating, and then they realize, oh, you know what? That wasn't about food and eating after all. And as a hospital dietician, this is another question you mentioned that we haven't really talked about yet, but that idea that I don't know what to do with this person to help this person in a short term situation, there isn't a lot you can do. You don't have to figure out the origin of someone's eating behavior. Really the key in a short-term situation is to figure out, is there anything that can nourish that person that you can provide?

So is there anything that they can keep down? Is there anything they can tolerate? Is there anything they're willing to eat? And even if that's not the most

nutritious combo then, can you provide that in a safe environment for someone to eat? And that's really the key to the whole operation. And I do remember many times recommending things that I thought, oh, my internship director would not be impressed with this meal plan that I just gave someone because it wasn't balanced at all, but it wasn't about balance, right?

It was about, is there something that this person can use as sort of a starting point for practicing nourishing themselves?

[00:31:46] **Melissa:** Thank you so much for illuminating the therapist aspect, the scope of practice, because I can imagine that that's a huge barrier for dieticians and that reassurance and that those guidelines are very helpful.

[00:32:01] **Jessica:** People often say to me, well, how do I know I won't make their eating disorder worse? And I always just think, you know, what? If they're in the hospital with an eating disorder, it's already pretty bad. So you having some compassion and listening and trying to find a way to help is already a step in the right direction.

There's not, I mean, again, there's exceptions to everything, but there's not a lot you can do to make someone's eating disorder worse when it's already in that place. I would say that the number one thing you can do, and unfortunately this does happen, hopefully not by dieticians, but that can make someone's eating disorder worse is to say, well, your eating disorder really isn't that bad.

Or, you know, based on your weight, you don't really have an eating disorder. Those are things that can make someone's eating disorder worse in a sense that they can discourage someone from getting the care that they need. But other than that, trying to help is a great service. And then the other piece is trying to get them to the appropriate care that can help them more.

And that often falls to the social worker. But sometimes as a dietician, you may have, you know, a network where you can ask, you know, where would be a good place to recommend for this person or who would be a good dietician to see them for the longterm.

[00:33:06] **Melissa:** Wow. That's a powerful concern. How do I know I'm not, not just not helping, but making it worse.

What are some other common pain points or concerns that you hear that I assume we could talk about your eating disorder bootcamp in a little bit about

like, you know, what you cover and what, what you really feel like most dieticians who just want to be better practitioners, like you said, I think it's a really important point that you don't have to want to specialize in this.

We need more practitioners to just be comfortable with this. Like I'm a certified diabetes educator, but a lot of dieticians will talk with patients about diabetes, you know, it's going to happen and what can you do to improve and increase their comfort level?

[00:33:48] **Jessica:** There's a couple of things that I would say to dieticians that, you know, I sort of learned the hard way and maybe I can save you some time.

One is that people who find it easy to change, aren't seeing a dietician, right? They just did it. They just changed. Or they saw a dietician one time got some advice changed or they read a book and changed. The only people who end up seeing a dietician usually are people who find it difficult to change and need support and help.

And so there's that aspect of what you had mentioned. I think at the beginning of like, am I really helping? Or this is so frustrating. Well, yeah, if you're frustrated, believe me, that person who's trying to change is frustrated too. And so a lot of times my soundbite in that situation is something like, you know what, you're bringing a lot of work to the table.

I know I'm a good dietician, but it seems like the skills that we each bring to the table are not adequate to manage this situation. So who can we bring in that might be able to help us? Or who can we bring in that might have more information and through that sort of involving family members, or maybe even someone like a roommate.

Anyone that might be able to help support someone or provide more information. I'm a big believer in getting more people on board. That could be someone who's a specialist in time management or in learning disorders. There are so many different aspects that food intersects with that it's really okay to say as a dietician, I'm bringing my best to this situation.

And yet there doesn't seem to be a lot of progress in the way that the client is hoping for or that I'm hoping for. And so to bring more people on board, we don't need to feel ashamed - the same way someone, an individual shouldn't feel

ashamed about their eating. We, as dietitians don't need to feel ashamed that we're having difficulty helping someone.

We don't even know what cures eating disorders. We don't have a set protocol. So a lot of it is creativity on the part of the dietician, trial, and error, seeing what will help. And it's really important not to judge yourself as a dietician. On the other hand, if you feel like you're outmatched, you can always get consultation from another dietician who is a specialist in eating disorders.

And ultimately to me, I would rather coach someone who already has a good relationship. So if you're someone's diabetes, dietician, and they need help with an eating disorder I would rather coach you on how to help them because you already have the relationship with them rather than sending them to me or to another eating disorder dietician that they have to start over with.

Because to me, the relationship is so much of the de-shaming and the freedom to talk about the things that are going on that I don't want to disrupt that, but at the end of the day, if someone listening feels like this is just not my bag. I get too frustrated or I really feel like, I don't know how to help no judgment on that either.

It's good to know yourself. And you can always simply say, you know what, based on this new information or based on these symptoms that you're sharing with me, I'm really glad and honored that you shared, but I may not be the right dietician for you. I'd like to help you find someone who specializes in that area.

And that's okay, too. So there's really no right or wrong, staying with a patient and getting consultation to help you or saying I'd like to refer you on to someone else. It's really a decision that, that you have to make for yourself. And I would say in consultation with a colleague, you know, our ethical guidelines I have to say are very vague, but for the most part, what I take away from our dietician ethical guidelines is the ethical dietician will consult with knowledgeable colleagues when they have a dilemma.

And so it might make sense to talk it through with someone on your team and say, you know, I'm not sure if I'm the right person, should I get consultation or should I send them onward to someone else? I think that those are some of the, you know, you kind of were asking about sort of pain points, but I think that's a lot of what I hear from dietitians is just that worry of, you know, am I abandoning someone if I recommend someone else? And I don't think that's the

case at all. You're actually bringing someone else on board the team in order to help in a way that's different from the skills that you have.

[00:37:35] **Melissa:** Oh, this is very interesting. And I can see, as you're talking for me, there's some parallels with diabetes. I continue to learn with new patients and new medications and new situations. And I find that invigorating. I find that very interesting. I don't find it daunting. I don't feel insecure about that, but with eating disorders, I can see that like some dietitians might find that continual learning and growth in that particular cope very exhilarating as well and very fulfilling. So I'm really glad that you're bringing people into the fold..

[00:38:33] **Jessica:** Well, and that's why there's different specialties, right? Yeah. But I do think a lot of people in school got the message that there is no role for dietitians and eating disorders, or it's a very rare job and that's just completely wrong.

We need more dietitians in the eating disorder field. If it's an area, you have a passion for. Absolutely. Let's get you specialized in it. If it's an area you don't want to specialize in. That's great too, because we need dietitians in the other areas too. It's just helpful to have some knowledge of eating disorders, because as we said before, just because you don't specialize in this area, doesn't mean, I mean, maybe if you do research studies with, you know, rats, but that's the only situation I can think of anyone who's doing any kind of counseling with humans is encountering people with dysfunctional eating behaviors, but there's a difference between being an expert and having a working knowledge.

[00:39:20] **Melissa:** And I think that's the most powerful thing that I've learned from you, besides of all, all the interesting intricacies about like the different types of eating disorders, but just the point that we can have more dietitians have that comfort level and confidence. And that, that way we can help that many more people. You just published an article I'd like you to tell us about - you surveyed some dietitians.

[00:39:43] **Jessica:** Yes. So Paula Quatromoni and I surveyed 182 dietitians responded. We asked questions about job satisfaction. And what's your workload like and where did you get your education on eating disorders? And one of the biggest findings that we had when looking at the results was that most dietitians who, and this is dietitians working in the eating disorder field, most of those dietitians did not get any training in school related to eating disorder care.

We, and I include myself in this group, we got our education from continuing education that we did separately. I mean, there's some on the job training in some cases, but for the most part, it seemed like dietitians were paying for their own supervision and consultation with more experienced dietitians paying for their own conferences and other kinds of continuing education.

There wasn't a lot of support on the job either. And so what we found was that the most acute patients are being seen by the least experienced dietitians. And we thought that that might have an impact on patient care, which isn't something that we studied, but it was one of our sort of possible items for future research.

And to me, every dietitian should have, like we said, some education on eating disorders and not just that one paragraph in a nutrition textbook that sort of gives the diagnostic criteria, but it could roll into all counseling skills. And one of the comments on our survey, which I thought was so crucial that we included in the article was that they said that some level of eating disorder knowledge is important for people working everywhere from corporate wellness to any other, you know, area of dietetics. And I think that's true. That really supports what I think also. Simply because eating disorders – I've had conversations with people who are sort of high up in different dietitian organizations.

And they say, well, you know what? Eating disorders is just never going to be in our top 10 of priorities. And when I look at the top 10 of priorities, every single one of them overlaps with dysfunctional eating behavior, food insecurity, overlaps, dysfunctional eating behavior. Hunger and environmental nutrition overlaps with dysfunctional eating behaviors, diabetes care, renal disease, every single thing that's in the top 10 is going to intersect with dysfunctional eating behaviors in some way, whether it's caused by them, whether it promotes them.

And so to say, it's never going to make it into our top 10. I sort of laugh at that and say, you're right, it's an umbrella over all of your top 10, but I haven't quite been able to get that message to the large organizations. That's why I actually ended up starting my own organization for eating disorder, dietitians or eating disorder, interested students.

And we have a thousand members. So obviously there was a need for an organization just for eating disorder dietitians.

[00:42:35] **Melissa:** Wonderful. Is that the eating disorder bootcamps or is that's something else?

[00:42:38] **Jessica:** No, no. That's the international Federation of eating disorder dieticians, and we can put a link to that in the show notes.

[00:42:45] **Melissa:** Perfect. Wonderful. Well, I will say the diabetes world hears you loud and clear. We've long known that diabetes and disordered eating can very much go hand in hand more typically with type one because they tend to be younger going through adolescence and puberty and everything, but certainly with type two as well, you know, anytime that you have to, I shouldn't say, have to, but you're called to change your eating habits and you're monitoring all of this stuff and your blood sugars and everything. It's just, it can be a lot and it can trigger a lot of things.

[00:43:18] **Jessica:** Well, sure. Because it triggers anxiety and anxiety can influence food and eating behaviors. So, yeah, absolutely. I agree. And I'm not talking about dieticians in the field.

I do think dieticians in the field, absolutely in many areas recognize the need. It's more of the organizations that are in charge of what students learn that I feel like have not gotten the message.

[00:43:40] **Melissa:** Connecting those dots for sure. Well, you know, and I could say the same thing about communications, but I do think that's improving.

Gosh, you know, communications should be an integral part of everything that dieticians do on every level. But I think that that's improving.

So we talked about the four different origins and I would like to take an opportunity to have you talk a little bit more about that fourth origin, the external environment, diet culture because it's, it's just such a hot topic right now, and I have not addressed it much on the podcast.

So I would love to kind of hear your little brain dump on what's going on with that origin and any insights you can share with us, whether, you know, we're a person struggling with this. And I think, I mean, I think everybody is impacted by what we see in diet culture, from our own personal perspective, all the way to a healthcare professional.

[00:44:29] **Jessica:** Oh yeah, absolutely. We are. Yeah. Well, we're recording this during eating disorders awareness week. I just gave a talk last night to a college kid. And, you know, a big piece of what we're sort of seeing with the rise in eating disorders during COVID has been building for a long time. So

there have always been aspects of the culture that have promoted you know, your body isn't good enough. And therefore you need a product. Whether that product is a diet, whether that product is shampoo for your frizzy hair or razors to shave your legs, right? There's, there's so many economies, industries that are based on the idea that your body isn't good enough as is. There's products to make your body bigger, products to make your body smaller, products to make different parts of your body bigger or smaller.

Right. And so it's really important to keep in mind that this is not new. And something that was new for me was to learn that racism is a big factor in that. And that the ideal of whiteness is a big factor in some of the things that we sort of imagine to be you know, that appearance ideal. So like I said, you know, frizzy hair, less body hair, you know, having pale smooth skin, like there's so many things in sort of our cultural beauty ideal that are based on racism and based on separating people into categories. And so it's so not new. The only thing that's new is the difference in sort of technology in distributing those messages. So where in order to look back at the messages, let's say from the 1920s, you're going to have to look at newspaper and magazine ads for products. That's where you're going to see the beauty ideals of that era. Now you look at Instagram or, you know, by the time this recording comes out, there probably will be 10 new platforms. Right? You look at Tik TOK, you look at social media and that's where we're getting our information about the body ideals or the beauty ideals that supposedly we're supposed to conform to.

And the bottom line is they're all about things that we don't even realize. We've internalized them as being our own desires or we've even been, you know, sort of lied to and told that these are sort of biological genetic constructs, like it's normal for, you know, let's say men to be attracted to women with big boobs and things like that.

We think we've been taught that's in our genes and really it's just a preference! And it's a preference we've been taught, you know, so that kind of thing, it's just, I wish we could look at bodies and just say, you know, basically there's a diversity of bodies, just like there's a diversity of everything else. And I heard a really good example.

I didn't make it up. I wish I did, but it was something. You know, you don't burn a Picasso just because it's not the Mona Lisa. Right. You can admire both of them and think they're both beautiful. And so it's really about expanding our minds to accept that even if we all ate the same foods and exercise the same

amounts and got the same haircut, we would still all look different and that's normal and that's okay.

And so that is such a hard concept though, when you're looking at yourself in the mirror and whatever parts you don't like seeing emphasized. It's so important that we recognize that we are being influenced by so much more than our own beliefs. That's what food fairytales is really about is looking back and trying to figure out what messages you got.

And unfortunately, some of the messages conflict, and that's because they're not real, right. If they were real, there's only one truth. Right. But if, sometimes you feel too big and sometimes you feel too little, neither one of those could possibly be true. Right. If sometimes your hair's too curly and sometimes it's too straight, you know, neither one of those is true because it can't be the same thing.

If you're in a bad mood and suddenly you look down and your body seems to have changed, that can't be right. But we tend to think, we believe in our own thoughts, let's say. And so another sort of touchstone that I go to sometimes is don't believe everything you think. And maybe that will help someone who is listening to this, you know, just very simple, write it down.

Don't believe everything you think. Thoughts are just chemicals in a way, you know, sort of like leaves floating down a river and you get to pick which one to believe. So if your, your thoughts are equally not factual, why not pick the one that says instead of the one that says I'm never good enough? And you know, it's not that easy to change, you know, I'm not saying it's simple, but I think that you know, accepting that diet culture or appearance culture or racism or genderism or sizeism or ableism are all factors that are affecting us, whether we realize it or not. I think that's a first step, at least in untangling ourselves from, we cannot untangle ourselves from culture unless you go live in a cave, but untangling yourself from being so impressionable by the culture.

[00:49:10] **Melissa:** Very good. Very good. Yeah. I touched on the racism aspect a little bit back on an episode, I believe it was called the science and culture of obesity and it's a two-part series. And I believe it was part two with Noel Theodosiou. I will link to that in my show notes as well. If anybody's interested a little bit more, she's a behavioral scientist you know, kind of just looking at the origins of you know, some of the, what you mentioned, like thin ideal or you

know, the pale skin and, and all of that. And what culture says is attractive. So just wanted to mention that.

As we're wrapping up here, I want to hear any just general takeaways you have or specific takeaways that you have for people who might be struggling with disordered eating body image issues, and then also some takeaways for healthcare professionals.

[00:50:03] **Jessica:** Sure. So for individuals who are struggling, which by the way might also be healthcare professionals, right? It's not two distinct groups. Exactly. But anyone who is thinking, you know, well, my problems are so minor, no one wants to hear about them or they don't rise to the level of, you know, you can't see my finger quotes, but an eating disorder.

It's not that big of a problem. I would just encourage you to think about the way that what I learned from the college speakers when I was on a college speakers bureau, they talked about alcohol abuse and they speak about it in a different way that I remember when I was you know, that age and I, it's not about how much you drink.

It's not about what you drink is not about which kind of alcohol you drink. It's not about how early in the morning. It's about do problems happen when you drink? That is the key issue with food as well. Do problems happen when you eat or don't eat? Because like I said, the same person could eat the same six corn dogs and they'll really fueled for their marathon.

Whereas there's another person can eat six corn dogs and feel like they don't deserve to live. And not sure why I thought of corn dogs. I must be craving corn dogs, but my point is, don't worry about how you compare to others or how you compare to even to yourself at a different time when maybe you did feel like you had an eating disorder, think of it as do problems happen when you eat and whether those problems are mental or physical or anything else, social.

Do you feel like you have to eat by yourself, you have to eat alone because you're embarrassed of your eating? I mean, these are things that are problems, even if, you know, we don't recognize them as a society as problems. And so I would encourage you to meet with an eating disorder dietician, even if you don't feel like you identify with the word eating disorder.

Because that eating disorder dietician is going to be the person who can help you sift through and see what is nutrition related and what isn't. Because if

you're trying to solve problems with food or with not eating, that aren't really food related, it's going to be very discouraging. And so I really encourage you to talk with someone, if not a dietician, then a counselor, if not a counselor then a best friend or someone supportive, that can be a good listener.

[00:52:04] **Melissa:** I want to just jump in. And you mentioned a couple of times about kind of realizing, and these are my own words, but it's kind of paraphrasing what you're saying. I think. when you realize your behaviors are not really connected to the problem, or like, it's not about food, I think that that's really powerful.

I remember learning that and that was like a really light bulb moment for me. And I talk a little bit about my eating journey. I'm not going to say eating disorder - my disordered eating issues a little bit. In an, in an episode that I did with ballerina dietician. And I'll link to that in my show notes as well.

But when I made that connection, it just like, it was a light switch. It just really flipped everything for me. So I think it's really powerful to reinforce that idea when it just sort of helps kinda take a step back and reassess everything. I don't know if that's, if that makes sense.

[00:53:00] **Jessica:** Yeah, I agree. And I had that kind of epiphany too - realizing what I was doing with my eating wasn't really about food.

It was about my feelings, about a particular person I had a crush on. So, you know, absolutely. I think. There are lots of ways that dysfunctional eating behaviors are not about food, but I think there are ways that they are too. And I think that it's easy for a dietician sometimes to say, well, I have no role here because if this isn't really about food, but I think it's so important that there's both roles because no, it's not about food, but when someone has been doing behaviors with food or believing things about food, they don't just change just because they may solve the underlying issues.

Let's say someone's depressed and it's affecting their eating. Maybe in a very few cases, solving the depression, solves the eating – hooray! But in a lot of cases, someone's going to need help with their depression and help with their eating. And so that would be the message that I would leave with the health professionals listening is that, you know, there is a place for a lot of different pieces of the puzzle, someone who is struggling with their eating, maybe compensating for some kind of medical issue, that's been undiagnosed.

We need to get a doctor involved, right? Sometimes an endocrinologist. Sometimes a cardiologist. Don't feel like you have to be the person who is doing this alone. It's, it's actually, in my opinion, not appropriate to be doing it alone. And so, you know, the same way I would say to an individual who's struggling.

Try if you can to remember my words that, you know, whatever you're doing, it may be causing problems, but it's nothing to be ashamed of. It doesn't mean there's anything wrong or broken about you. Same thing with a health professional that feels outmatched by someone's eating disorder. It doesn't mean you're wrong or broken, or you missed that day in school, you're dealing with a very difficult issue.

And I've said many times, you know, sometimes we only realize later that your eating disorder is more severe than what we wanted it to be, or it's more tricky than what we wanted it to be, because if it wasn't, you would have solved it a long time ago. And so that's why we need to bring someone else on board onto the team.

So I guess my biggest message that goes to both individuals who are struggling with their eating and professionals is simply, you know, don't try to do it all yourself. It's not a DIY project. I know nutrition is sort of promoted out there as something you can wrangle yourself, but to me, you can't solve a problem with the same mind that created it.

You've got to get at least one additional pair of eyes, maybe sometimes more than one with different skillsets. And it's okay if those people don't agree, but it's really important to get other people helping you. It, it just, I think eating disorders thrive in isolation and we need to sort of open the doors to individuals to get care.

And there's a lot of barriers and I hope you will not let shame be your barrier.

[00:55:34] **Melissa:** Thank you so much. You're saying so many powerful things. I'm sitting here going. Oh wow. So thank you, Jessica. Where can people find out more information? I know you have a website and your social media handles, and also if you want to just share like what people can find in the eating disorders bootcamp too.

[00:55:52] **Jessica:** So my umbrella homepage website is Jessicasetnick.com.

That's where you can go to, you know, bring me to your campus to speak or anything like that, schedule a consultation and then eating disordersbootcamp.com is where the information on eating disorders bootcamp is. And it's really comprehensive. There's three audio workshops. There's books that come with it. I mean, it's really more than I can say right now, but you know, you're welcome to check it out on the website.

I just rerecorded a new introduction to eating disorders bootcamp, and that is available as a free download with the slides for anyone who wants it, whether you've taken eating disorders bootcamp before or not. You can listen to that new introduction if you'd like to. Okay. But, yeah, I mean, I feel like there's also other people's courses and I have a list of other resources on my site.

There's a lot more out there than there used to be. And we can put a link to that list of resources, even in your show notes, for someone who's more advanced that might be looking for something more advanced. I'm happy to help in any way I can, you know, I wish that I could say I foresee the end of eating disorders in my lifetime, and I could just retire and talk about it as like this thing that we used to deal with, like polio, but I don't see that happening. So we're just going to need lots more people who want to help.

[00:57:05] **Melissa:** And hopefully talking about it more helps remove some of the mystery and stigma and barriers to access. So thank you so much for the amazing work that you're doing and for coming on my show and sharing all of this important information. I'll have people check out your website, but like you said, we'll have links in my show notes as well at soundbitesrd.com.

And I hope to see you in person sometime soon.

[00:57:29] **Jessica:** Yes. Same. Thank you for the platform. I really appreciate the opportunity to spread the word and yes, I hope we get to see each other in person as in-person meeting starts coming back.

[00:57:38] **Melissa:** Absolutely. Thank you again. And for everybody listening as always enjoy your food with health in mind. Till next time.