

P.O. Box 640
Naperville, IL 60566

Working Together



Let's Move!

In February of 2010, First Lady Michelle Obama made obesity an imminent national issue. She launched the Let's Move! campaign to eliminate childhood obesity in one generation, and President Obama established the Task Force on Childhood Obesity to consider how this might be done in communities across the nation. Childhood obesity has certainly reached epidemic levels – with about one in three children considered overweight or obese¹ – and we believe Let's Move! has the potential to improve the health of the next generation. But this can only happen if children are taught the importance of physical, emotional and psychological health and how these three are intimately integrated; then they can live healthy, not just obesity-free, lives.

Unhealthy relationships with food, whether restricting or overeating, can be symptoms with deep, emotional

origins. And just as we know that forcing someone to eat will not resolve their disordered eating, forcing children to lose weight will not make them healthy.

To avoid causing body image dissatisfaction, diminished self-esteem and eating disorders, obesity prevention should not focus on weight, but on establishing sound eating and exercise



habits. Weight is not the sole indicator for health and wellness. Current research maintains that when schools focus on healthy living instead of weight, rates of disordered eating decrease.²

"Wellness, not weight, should be our aim."

BMI testing can be a dangerous instrument in this regard. Telling children to lose weight when they are in a period of growth and development is neither logical nor healthy. Children should be taught in adolescence that weight is not a fixed attribute. BMI testing assumes rigid ranges for weight and may initiate weight and body fat competition among children and lower self-appreciation. For all children, BMI comparisons can lead to teasing and bullying, of which low self-esteem and anxiety over weight and body image can be a result.

Cont. on page 5

Trauma and Eating Disorders: Tracing the Roots

by Patricia Santucci, MD

Editor's note: This is the first part in a three part series on the relationship between trauma and eating disorders.



A traumatic event has been defined as something horrible and scary that you see or that happens to you. During this type of event, you think that your life or others' lives are in danger and you have no control over what is happening. It creates fear, helplessness and horror.

Trauma is a common part of everyday life. Each year, 7% of the U.S. population will experience trauma with a lifetime occurrence of 51% in women and 61% in men. The most common traumatic events include: witnessing someone badly injured or killed, disasters, life-threatening accidents and combat exposure.

Common experiences, like the breakup of a significant relationship, an unexpected death of a loved one, a humiliating or deeply disappointing situation, sexual harassment, or discovery of a life-threatening illness, can also be traumatic. Sometimes secondary trauma develops from the fact that no one was there to protect or care for a person after a traumatic event.

Not everyone who experiences trauma is traumatized. Initially, fear and distress are experienced by almost everyone. This wide range of reactions – from intense emotionality to a shock-like "numb" state – can be very frightening. Survivors are often relieved to hear that for the most part, these are considered

of trauma. Care must be taken NOT to prematurely label these responses as severe psychiatric disorders like PTSD. With time, and often without mental health intervention, most people's feelings will return to a more manageable level. A smaller number of people, however, do not cope well and show behavioral changes. Increased use of alcohol, drugs, eating too much or too little, withdrawal, irritability, difficulty with trust and/or intimacy can create distress. While they may not merit a psychiatric diagnosis, they often negatively impact daily life and perpetuate even more distress.

Only a significant minority will actually develop long-standing psychiatric disorders, like PTSD, depression, etc. These are serious disorders and need treatment. Dr. Robert J. Ursano, a leading expert in the field of trauma, noted, "The acute form of PTSD is like the common cold – experienced at some time in one's life by almost all. Some colds progress to pneumonia and may create substantial illness and impairment."¹

Why do some people do well and others do not? Unfortunately, some traumatic experiences are just more horrific than others. The risk of developing problems increases with the severity of the trauma. Key factors include the type of trauma (terrorism with intentional harm to the innocent creates the most psychological impact), witnessing death or grotesque scenes, or being physically injured.

Having a previous psychiatric disorder, having prior trauma, or just being a female places one at risk. The female gender is a robust predictor of PTSD (10% in females versus 5% in males) and of depression

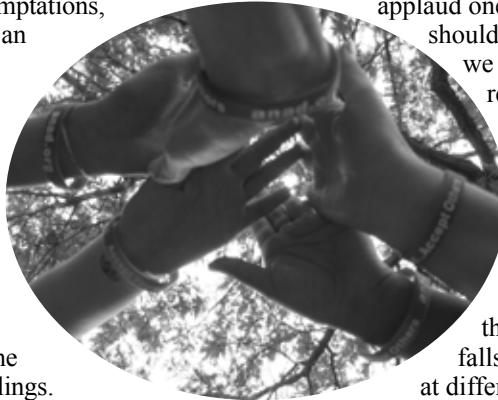
Cont. on page 4

State of Mind

Just a few weeks ago, ANAD held a Candlelight Vigil in Naperville, IL at with over 400 supporters present. At one point, Dr. Maria Rago (ANAD Board Member) asked anyone who had been recovered for one year to stand up. Applause and cheers filled the auditorium as they rose from their seats.

Recovery is a powerful word, but is also an abstract word and therefore many people have difficulty defining it. Some think that recovery is a point in time where all temptations, feelings, and struggles associated with an eating disorder completely disappear. Others assume recovery is something that can be scientifically measured, and they determine that they are recovered when they reach an ideal number on a scale or body mass index test. Both of these approaches are misunderstandings of recovery. The first ignores the fact that recovery is developmental. The second focuses on outward behaviors and disregards the importance of inward attitudes and feelings.

True recovery is developmental, meaning that it is a growing process characterized by stops and starts, setbacks and celebrations, periods of stagnation and periods of quick, immense maturation. True recovery is also inward and cannot be measured by any number. When someone struggling with an eating disorder returns to a healthy weight, this is only the beginning of recovery. The weight is the tip of the iceberg, the part which is visible to everyone, but the part we don't see under the water are the attitudes and feelings that are the continued



focus of recovery. People who accept themselves as they are and have a healthy state of mind are not concerned with numbers because they understand that healthy looks different for different people. Someone who is recovered from an eating disorder does not deny that they had an eating disorder, but neither do they establish their identity in their struggle.

Does that mean we shouldn't stand and

applaud one year of recovery? Of course not. But we shouldn't celebrate only because one year has passed; we should take the time to celebrate every step of recovery. The person who has developed a healthy body and mind while allowing for continued growth should be praised.

Recovery from an eating disorder can be scary and intimidating because one's identity has been wrapped up in the eating disorder. The first step in recovery is making the decision to recover, and then to explore one's identity outside the dimensions of the eating disorder. Recovery falls along a continuum and we know that people are at different places in their individualized journeys. Their families and loved ones must go through their own healing process separate, but in tandem, with the individuals struggling to recover. And this is the most important truth we must remember about recovery – it doesn't happen in isolation. Recovery happens in community with those who can strengthen us and those whom we can strengthen. Let's celebrate each individual's recovery process and their support system.

*Laura Discipio, LCSW
Executive Director*

Serving the needs of adolescent girls and women with eating disorders, substance abuse, mood disorders and co-occurring disorders, Timberline Knolls offers a safe and serene setting for those who desire to make real life changes.

Rooted in the principles of recovery and emphasizing spiritual growth, Timberline Knolls combines clinical services, education and expressive therapies to enhance the continuum of life-changing care. Striving to provide the most effective and highest quality individually tailored treatment, Timberline Knolls gives its residents hope again.

Timberline Knolls is a residential treatment center located on 43 beautiful acres just outside Chicago, offering a nurturing environment of recovery for women ages 12 and older struggling to overcome eating disorders, substance abuse, mood disorders and co-occurring disorders. By serving with uncompromising care, relentless compassion and an unconditional joyful spirit, we help our residents help themselves in their recovery.

While there's life, there's hope.



TIMBERLINE KNOLLS

RESPONSIBILITY SPIRIT CONFIDENCE HOPE

www.timberlineknolls.com
email: info@timberlineknolls.com 1.877.257.9611

"I'M JUST TOO FAT"

Self-esteem should not be measured on a bathroom scale. To someone struggling with an eating disorder, reality becomes stretched.

She sees herself as overweight even as she risks wasting away. An eating disorder is a control issue that has become an obsession. It is a serious medical illness that can produce life-threatening complications.



Alexian Brothers Behavioral Health Hospital provides effective treatment strategies to help eating disorder patients overcome obsession and regain health.

Alexian Brothers Behavioral Health Hospital
1650 Moon Lake Boulevard • Hoffman Estates, IL 60169
800-432-5005



ALEXIAN
BROTHERS

Behavioral Health Hospital

A Healthy Community Begins with Alexian Brothers.

www.abbhh.org

© 2009 Alexian Brothers Health System

Rogers Memorial Hospital Your Trusted Resource

PROVEN

Nationally recognized, not-for-profit provider, offering evidence-based treatment for eating disorders.

EFFECTIVE

We provide separate programs for children, teens, men, women and those with co-occurring anxiety disorders.

SPECIALIZED

Inpatient, partial hospitalization and residential treatment programs are available for every age group.



800-767-4411

www.rogerseatingdisorders.org

Body Image Across the World

We are sorely aware that in America the ideal body image, especially for women, is grossly unreal. But how do non-Western countries evaluate women's bodies? This is the question that prompted the International Body Project (IBP-I), a survey of 7,434 people in 10 major regions across the world that asked for participant's ideas of the ideal female body type and measured female dissatisfaction with their bodies. The researchers (from 47 universities around the world) conducting the study found that despite cultural differences, body image problems are not just Western; they are global.

Previous research, like the often-cited study of Fiji culture (1999), confirms that while Westerners favor thin or underweight body types, non-Western cultures defy this trend. In Fiji, more body fat was associated with being well-provided for and healthy.

There is good science behind this trend. The researchers noted that in terms of



evolutionary instinct, where resources are not as prevalent, higher body fat indicates a resource-secure area and becomes desirable. So why are body issues an international problem?

IBP-I found that the division of Western and non-Western was practically irrelevant. The true division in beliefs about desirable body type was socioeconomic status (SES). Across the world, there was greater continuity between SES brackets (whether Western or non-Western) than between participants of the same country. This fits appropriately with our instinctual desire to be in an area with secure resources. The authors cite previous research suggesting an "inverse relationship between socioeconomic status (a covariate of resource security) and ideal body weight" (10), meaning that where resources are truly abundant, the ideal body weight plummets. Additionally, higher SES "results in changes to the role of women in society, greater opportunities for mate choice and birth control, and the legitimization of overweight stigma, all of which have been argued to intensify the preference for thin bodies" (11). Moreover, globalization through technology has opened Western media up to the rest of the world, especially in affluent areas. The study noted that the more participants were exposed to Western media, the thinner their ideal body type.

One of the more practical issues this study raises is the relation between women's dissatisfaction with their bodies and men's ideal body type. Using a series of line drawings (of a woman's body) along a spectrum of body sizes, women and men were asked to rate their ideal body type. Across all world regions besides East Asia, women chose smaller ideal body types than men. The researchers concluded that this misinterpretation should be an area of further study.

The IBP-I reveals that there is an international body image crisis and "societies now face the urgent task of promoting more realistic and healthier body weight ideals, and challenging associations between extreme thinness and femininity, success, and health."

Swami, V. et al. 2010. The attractive female body weight and female body dissatisfaction in 26 countries across 10 world regions: Results of the International Body Project I. *Personality and Social Psychology Bulletin*. 36: 309-325.

Trauma and Eating Disorders *Cont. from page 1*

(14% in females versus 6% in males)². Whether women are at risk because of their biological, genetic or specific sociocultural factors, such as prior sexual trauma, is unknown. Women tend to report more rape, sexual abuse, harassment and domestic violence. Two-thirds of the 3 million attacks on women in the U.S. are carried out by someone they know.

A strong link exists between eating disorders and various forms of trauma. Frequently, eating disorder patients report an “adverse life event” prior to the onset of their illness. Childhood sexual abuse (CSA) appears to be a specific risk factor for bulimia with one study reporting CSA 20% higher in eating disorder patients than in the general population. 30-40% of ED patients have reported sexual trauma. A representative sample of 3,000 women from the U.S. were extensively interviewed. Over half (54%) of the subjects who met the criteria for bulimia nervosa were raped, molested or assaulted. Among these women, 37% met lifetime criteria for posttraumatic stress disorder (PTSD) and 22% met current criteria for PTSD³.

While every eating disorder patient has not been traumatized, it is important to assess for the possibility. There is a common modality of shame and secrecy. Individuals will often not share these issues unless there is a compassionate, non-judgmental and safe environment. Helping patients build adaptive coping mechanisms while working through the process is essential. Delayed intervention often allows maladaptive coping and comorbid psychiatric illness to complicate the picture.

Post-trauma support and resources become key factors in determining outcome. Social support is one of the most therapeutic interventions. There is substantial evidence that it can buffer effects of stress and may even offset genetic vulnerability.

Support may be offered by many people – not just mental health professionals. Making sure that survivors actually seek support is vital. We need to remove the barriers that create

shame, guilt, blame, and fear. Years ago, cancer and HIV were “unmentionables.” Today, with awareness, education and prevention programs, people are seeking help.

Interventions must also be safe and easily accessible. Knowing how to give support is important. The first rule is always DO NO HARM. Understanding that survivors may not be able to speak about the trauma, supporters must not push individuals into talking about the event until they feel comfortable. To do otherwise may re-traumatize the person. Just being there and being a compassionate listener is often sufficient for the time being.

In part two of this three part series, we will look at Psychological First Aid™ and the supportive interventions that can be used in the immediate aftermath of trauma.

Dr. Santucci is the Executive Vice President of ANAD and has had extensive experience in treating eating disorder patients who have had a history of trauma. After 9/11, her interests expanded to helping survivors of disasters and terrorism. She served as co-chair of the mental health committee for the Medical Reserve Corps, a national organization of volunteers under the Office of the Surgeon General that responds to disasters. Working with the National Center for PTSD and the National Child Traumatic Stress Network, she assisted in the development of a manual, Psychological First Aid™, which is presently being used worldwide as the gold standard for intervention. She recently completed a chapter on psychological outcomes of trauma which will soon be published.

1 Ursano, Robert J., L. Zhang, H. Li, L. Johnson et al. 2009. PTSD and traumatic stress: From gene to community and bench to bedside. *Brain Research* 1293: 2-12.

2 Kessler, R.C., A. Sonnega, E. Bromet, M. Hughes, et al. 1995. Post-traumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*. 52: 1048-1060.

3 Dansky, B.S., T.D. Brewerton, and D.G. Kilpatrick. 2000. Comorbidity of Bulimia Nervosa and alcohol use disorders: Results from the National Women's Study. *International Journal of Eating Disorders*. 27:180-190.

Candlelight Vigil

On Monday, May 17 over 400 supporters attended the 7th annual ANAD Candlelight Vigil at Linden Oaks Hospital in Naperville, IL to commemorate the lives lost to eating disorders and to encourage those in recovery. Among the speakers were Miss Indiana Nicole Pollard, filmmaker Darryl Roberts, and the Executive Vice President of ANAD, Dr. Patricia Santucci. “I’m here because I believe in recovery,” Dr. Santucci said forcefully, to remind everyone that though Anorexia is the deadliest mental disorder, recovery is possible. Marilyn and Darriel Clark, whose daughter Aubrey lost her ten-year fight with an eating disorder, spoke with sadness about the loss of their daughter but were adamant about expanding education about eating disorders. The vigil was a rally cry to Mrs. Clark and her family – “We leave this place armed for war” she said, as reported in the Naperville Sun.

ANAD’s National Candlelight Vigil Program remembers those who have passed away, celebrates those who have recovered, and supports those who are recovering.



Pictured from left to right: Dr. Steven Prinz (Board member), Laura Discipio (Executive Director), Nicole Pollard (Miss Indiana), Dr. Maria Rago (Board member) and Dr. Patricia Santucci (Executive Vice President).

The Unthinkable

by Chris Ganis, PsyD

We all know the statistic: 5-20% of individuals with Anorexia Nervosa die¹. As group leaders, clinicians, family members, and friends, we all live with the harsh reality that the illness is unforgiving of who we are, but draws on other factors—some outside of our conscious and unconscious control (like genetic history).

And, so it was with Nicole. She came to our ANAD group about two years ago. Nicole moved to the big city (Harrisburg, PA) to pursue her dreams. She had Bachelor's degrees in Psychology and Pre-Medicine, and was an accomplished musician. Nicole was working on her Master's degree in Social Work when the eating disorder reared its ugly head. She felt very much like a battle was raging within, and that she was being pulled between the promise of losing more weight "to feel better about myself," and the recovery promises of "having a better life" and "building a future" for herself.

Nicole went off for treatment. In fact, she had to fight for treatment. Nicole identified with that fight for the right to treatment so much, that with the precious little energy she had, Nicole became an activist for the cause of the FREED (Federal Response to Eliminating Eating Disorders) Act to work hard to ensure that others would not have to fight to get treatment. The very week that we lost her, Nicole was organizing a road trip to take fellow ANAD members to lobby with her at Advocacy Days in Washington, D.C. At the same time, she was

trying to get group members involved in becoming advocates for individuals with eating disorders who had to go to the emergency rooms at local hospitals to seek treatment at a time when they might not have the strength to fight for themselves.

Then, the unthinkable happened. Nicole's roommate found her unresponsive in bed. It appeared as if she was still sleeping. The sad reality is that Nicole had gone to the emergency room two days prior with chest pains. At 30 years of age she had heart pathology—maybe from birth, maybe from what the eating disorder had done to her body. Her father was undergoing heart bypass surgery, which was just one of the many stressors she was under at the time of her passing. Did the eating disorder take Nicole from us, or was it the heart disease? Did one contribute to the other? We know that the eating disorder affects the whole body, with all of its systems.

Regardless of what it was that took Nicole from us, much too soon, we have been left with holes in all of our hearts. We still wait for this beautiful, vivacious young woman to walk into our Wednesday night ANAD group, trying to light a fire under all of us to stand-up and make a difference, if not for ourselves or our current patients, then for future generations of individuals with eating disorders.

1 Neumarker, Kläus-Jürgen. 1995. Mortality and sudden death in anorexia nervosa. *International Journal of Eating Disorders*. 21: 205-212.

*Nicole's advocacy efforts were featured in the summer of 2009 issue of *Working Together*.

Let's Move! *cont. from page 1*

Ultimately, the authority of these tests becomes arbitrary, dubious and discriminatory when accommodating for differences in ethnicity and body types. The "ideal" weight is simply an illusion.

So what should be the mission of Let's Move!/? Its mission should be to provide healthy food and opportunities for physical activity in schools. It should also promote healthy lifestyles, and most importantly, tell children that they are valuable and good independent of their weight. Our weight does not define who we are or how healthy we are, and our children need to hear that over and over again.

Let's Move! is in its infancy, meaning we still have time to influence the Task Force and Mrs. Obama, encouraging them to consider the larger issues at hand. After receiving suggestions, the Task Force's report to the President did acknowledge that obesity can be linked with eating disorders. But it isn't enough just to acknowledge this link. ANAD has supported programs like Planet Health, which integrates school curriculum with healthy living, and Kidz Bite Back, which teaches children about the influences of media on body image and eating habits. ANAD's own School Guidelines is a comprehensive resource for school teachers and health staff that prepares them to educate students on

eating disorders and help those struggling. The more resources available to schools, the better equipped they will be to help their students.

Parents, school administrators, teachers, coaches and school health staff are responsible for implementing wellness. They set the tone for acceptable treatment of those struggling with health issues. Mandatory, targeted programs that aim to fix certain overweight populations mistake a symptom for the disease, and school officials need to be prepared to create programs that develop the wellness of the whole person. Wellness, not weight, should be our aim.

1 Denoon, Daniel J. WebMD. WebMD Health News. Michelle Obama's plan to end childhood obesity epidemic. <http://children.webmd.com/news/20100511-michelle-obama-plan-to-end-child-obesity-epidemic>.

2 Austin, S.B., A.E. Field, J. Wiecha, K.E. Peterson and S.L. Gortmaker. 2005. The impact of a school-based obesity prevention trial on disordered weight control behavior in early adolescent girls. *Archives of Pediatrics and Adolescent Medicine* 159: 225-230.



Please send inquiries, comments, and submissions to the editor, David Warren, at newsletter@anad.org.



Woman Wins Insurance Battle

UnitedHealthcare (UHC) recently settled outside of court after a suit was filed alleging their misconduct in denying necessary eating disorder treatment to a Wisconsin college student. Amanda Conrad had sought to enter Anna Westin House, a residential treatment program in St. Paul Minnesota. Even with the support of her psychiatrist, and after a year of trying to persuade UHC of the critical nature of her case, Amanda was forced to put herself \$50,000 into debt to pay for treatment. Not only did UHC neglect to follow the guidelines for denying her treatment, they repeatedly delayed the process and blatantly disregarded her doctors as they discussed the urgency of her case. With the settlement, Conrad can finally pay off her debt. She has recently completed college and is continuing in her recovery.

The Emily Program. United Healthcare settles federal lawsuit by Wisconsin woman denied critical treatment for life-threatening eating disorder. <http://theemilyprogram.blogspot.com/2010/06/united-healthcare-settles-federal.html>

An ANAD Reminder

With the warm weather upon us, we may become more conscious of our bodies and our physical appearance. Let's be just as conscious of the words we use to describe ourselves and others. When speaking about ourselves, we should focus on the unique aspects of our personalities, skills and talents. If you hear someone criticize their own weight or appearance, or worse, someone else's, please remind them to appreciate what's on the inside. Let's make this summer about healthy lifestyles for our bodies, minds and hearts.

Remember: Accept Yourself...Accept Others.

Write a Letter, Be an Advocate!

In April, the Eating Disorders Coalition (of which ANAD is a member) hosted a lobbying day to support the introduction of the FREED Act to the Senate. The FREED Act is the Federal Response to Eliminate Eating Disorders, and it is the first eating disorders legislation ever introduced into the Senate. The Eating Disorders Coalition (EDC) is asking for 1000 letters voicing your concern for those struggling with eating disorders. Inadequate funds for research, unequal treatment, and the need for more public awareness are issues that need to be addressed. Tell your personal story as a family member, friend, or person struggling to recover. Let your representatives know how important this legislation is to overcoming the inequities in health care treatment for eating disorders.

For more information about the letter writing campaign, including detailed instructions on how to address your representatives, please visit the website of the EDC: <http://www.eatingdisorderscoalition.org>

help

WE'RE FOR PEOPLE WHO NEED IT

Linden Oaks at Edward is known for its comprehensive Eating Disorders Program. Led by a team of exceptional psychiatrists, we offer the latest techniques and programs to help adults and adolescents who are struggling with anorexia, bulimia and related eating disorders.

We are also home to Arabella House – one of the few centers in the country which offers residential care for eating disorders.

For more information, call the **Linden Oaks Help Line** at **(630) 305-5500** or visit us at www.lindenoaks.org

LINDEN OAKS
at
EDWARD

Dear Friend,

I'm sure as you opened this most recent issue of *Working Together*, you noticed some changes. The ANAD logo now has a "reflection"! The reflecting ANAD, which is the mirror image of the red-lettered ANAD, encourages people to see themselves as they truly are; it is without distortion. Also, there are no more envelopes, donation cards or inserts. Streamlining our newsletter and offering a tear-off contribution form (below) are just a few ways ANAD is reducing costs and using your contributions to efficiently support those who need our help. It has been repeated all too often that economic conditions have forced everyone to budget carefully. In the world of non-profits, giving has gone down markedly. ANAD's contributions are around 60% of what they were just one year ago. We know these facts are reality for many of you. We repeat them only because we want you to know that this reality has sparked our creativity and ingenuity.

Our mission of offering free programs and help to those struggling has not changed. In fact, we have become even more committed to looking for new ways to serve you. We are always examining the most effective way to communicate with our members and volunteers, and reach out to those who are just beginning to feel comfortable seeking help. We have found that improving our social media presence on Facebook and Twitter and, in June, launching a renovated website, are essential to reaching our goals. On our website, look for a parent connection link, a place where parents can find fellowship and encouragement from other families across the nation. Look for other interactive features designed to make it easier to participate in ANAD's work and benefit from our support. We want our members to be more involved and to share with each other and ANAD staff. By taking advantage of the web, we not only make our services cost-effective, we also reach more people than ever before.

ANAD has found creative solutions to maintaining a significant presence in the eating disorder community. And while support from foundations and grants have been down, we are confident that you can rise to the challenge. Look for creative ways to save for and contribute to ANAD and the people we serve. We depend on your donations. Take the time right now to sustain ANAD's work. **Please join us, as you have in the past, by making a tax deductible contribution.**

ANAD deeply appreciates any contribution to continue fulfilling our mission. You can make a donation by calling 630-577-1333, visiting www.anad.org, or tearing off the donation card below.

With humble thanks,

Patricia Santucci, M.D.
Executive Vice President

Laura Discipio, LCSW
Executive Director



EVERY DONATION IS SINCERELY APPRECIATED

ANAD P.O. Box 640 Naperville, IL 60566

Yes – count me (us) in! I (we) would like to help those struggling with eating disorders and work to alleviate this illness. Please make checks payable to ANAD. This is my (our) gift for \$ _____

Please Circle (if applicable): In memory of **OR** In honor of _____

Name (Printed) _____ Address _____ City _____

State _____ Zip _____ Phone _____ E-mail _____

Credit Card Number _____ Expiration _____

Signature _____

Now available! If you would like to support our cause and receive a free ANAD awareness bracelet for your donation, please check here

The National Association of Anorexia Nervosa and Associated Disorders



P.O. Box 640
Naperville IL 60566

RETURN SERVICE REQUESTED

NON-PROFIT ORG.
U.S. POSTAGE PAID
NAPERVILLE, IL
PERMIT NO. 4091

A non-profit dedicated to the prevention and alleviation of eating disorders since 1976.

 **rader**
programs

A PROGRAM FOR LIFELONG RECOVERY

800-841-1515 | raderprograms.com

Specializing in the highest quality treatment of
Anorexia, Bulimia & Compulsive Overeating

It's not your fault... You're not alone... We can help.

Our mission: Save the lives of those suffering from devastating eating disorders

- We assist affected individuals and their families
- We treat the emotional, physical and nutritional symptoms
- We understand the social and family components

Multi-disciplinary team
• Physicians • Psychiatrists • Psychologists • Therapists • Family & Exercise Counselors • Dietitians • Nurses

Over 25 years of Acute, Daycare and Outpatient Experience
Nationwide locations including California (near Ocean & Marina)
Most Insurance Accepted
JCAHO accredited