BEHAVIORAL INTEGRATIVE TREATMENT & EVALUATION (BITE)
FOR ANOREXIA NERVOSA IN ADOLESCENTS

by
Tara Deliberto, Ph.D. & Dina Hirsch, Ph.D.
BEHAVIORAL INTEGRATIVE TREATMENT & EVALUATION (BITE)

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**OUR MISSION**

Anorexia nervosa is a deadly illness that must be halted and treated by any means necessary. When trying to save a life, allegiance to a singular evidence-based approach must be substituted for whatever works. As a scientific community, we must pool our resources to treat and eradicate the terrible illness of anorexia nervosa, not waste time divided by deference to opposing theories. There is so much untapped wisdom to be harnessed in every single evidence-based treatment. Integrating this knowledge has tremendous potential.

Sharing this stance, we set out to explore how different interventions could be used to help our patients. We began by examining components of family-based therapy, continued by acceptance and commitment therapy, behavior therapy, cognitive therapy, cognitive behavioral therapy-enhanced, parent-child interaction therapy, dialectical behavior therapy, compassion focused therapy, appetite awareness training, mirror exposure therapy, and cognitive remediation therapy - to name a few. And it still wasn’t enough. Even when considering all of these treatments, there were many more clinical problems specific to the treatment of anorexia nervosa that were left to be solved. So when looking to other treatments for answers was not meeting our patients’ needs, we created interventions. We worked under the assumption that if a hole existed, a way to patch it must be devised. Over time, a cohesive treatment with three integrated modalities began to emerge. In this way, the approach we now call Behavioral Integrative Treatment & Evaluation (BITE) was conceived.

Considering the massive integration of information involved, such a treatment starts to sound extremely complex, and consequentially, off-putting. Quickly grasping this, we decided that BITE must be experienced as simple – for the sake of malnourished patients, distressed families, and clinicians in the trenches. As such, our number one goal became presenting clinical information and heady concepts in a crystal clear way. For guidance and inspiration, Dr. Deliberto looked to books by Edward Tufte on a topic rarely discussed in science: the art of information design. Information design is the practice of fostering understanding by presenting data both efficiently and aesthetically. Using information design techniques, we went to great lengths to make BITE content easy to understand for patients, parents, and clinicians.

Specifically regarding patients: it can be particularly difficult for people in the throes of anorexia nervosa to grasp and process information because malnourishment interferes with normal brain functioning. Consequentially, adolescent patients are often overlooked in treatment because it is all too easy for us to just communicate with the parents. But why wait to directly work with the patient until weight-restoration? Rather than seeing decreased cognitive functioning as an insurmountable obstacle, we should seek to overcome it. In part, we attempted to do this in BITE by creating handouts with fun graphics and clearly displayed information. Further, we found ways to make mindfulness exercises more concrete. For example, patients record their internal experiences on organized handouts during mindfulness practice. As another example, during the classic leaves on a stream exercise, the therapist plays nature sounds from a freely available app to help refocus the patient’s attention. In short, rather than bypassing the patient as a participant in treatment until weight-restoration, the BITE material is specifically designed to meet the patient where they are both emotionally and cognitively.

Concurrently, parents of patients often have understandable difficultly processing pertinent treatment information. In the context of having a sick child and monumental treatment responsibilities, parents
are often very distressed. Therefore, it seems inefficient to rely on verbal communication alone to convey important clinical information and concepts. In BITE, parents are given clear handouts, often with enumerated lists, to guide them through treatment. Rather than recommending a whole book to read, smaller amounts of relevant information is presented across multiple sessions in a way that can be referenced and reviewed as needed. We hope this to be one contribution to a growing movement of mindfully supporting parents in treatment.

BITE is also designed with the needs of clinicians in mind. We aim not only to make clinical information and concepts more understandable for parents and patients, but to improve communication among members of the patient's treatment team as well. If you have worked with adolescents with anorexia nervosa, you know how time-consuming the task of coordinating with a multidisciplinary team can be. Never having met them, you must communicate regularly with medical doctors, school psychologists, school nurses, school guidance counselors, and/or nutritionists for every patient. Plus, the outpatient therapist is charged with the task of onboarding each professional the patient brings to the treatment team. In other words, long before seeking your help, the patient has had a medical doctor - who may or may not be familiar with anorexia nervosa – now overseeing the patient’s potentially dangerous weight gain process on a weekly basis. The patient also attends a school whose staff members now need training in how to get their student with anorexia nervosa to finish eating a huge lunch five days a week. This is no small feat! In an effort to assist the eating disorder specialist, we created handouts not only meant to facilitate the communication with patients and parents, but with collaterals as well.

We also hope that BITE will be useful to non-specialists. To many mental health professionals, the treatment of anorexia nervosa remains daunting and mysterious. Only a minority of clinicians receives formal training in the treatment of eating disorders. Consequentially, the lack of professionals willing and able to treat anorexia nervosa translates into countless cases of people left suffering alone from this dangerous illness. A goal of ours is to help close this treatment gap by making treatment more approachable. With clearly defined behavioral treatment targets and practical suggestions on how to shape behavior, we hope that BITE makes the treatment of anorexia nervosa more manageable to those who otherwise would shy away from it.

We want to make BITE accessible in more ways than one. In part, we decided to self-publish the BITE manuals and handouts so they can be easily accessed from any place the internet works. Rather than waiting for a paper book to be shipped or figuring out how to print material from industry published e-books, BITE is available in the familiar format of a PDF. Our decision to self-publish also gives us complete control over the BITE material so that it can be a living, breathing, evolving treatment. We want you to contact us with any helpful ideas about how to alter, administer, or grow the treatment. For instance, you might have an idea that can be quickly transformed into an additional handout and posted online for everyone's use. When piloting BITE, we were able to craft and tailor additional handouts suggested to us in under a week. Over time, we hope that your feedback will lead to fundamental improvements in BITE. In short, with the content of BITE completely in our hands, it can organically grow over time with your help. We consider the ease of administration, access, and adaptability of BITE to be great strengths.

[Note: Because we intend to evolve BITE bit by bit over time, we will demarcate different versions of BITE after reaching a critical number of revisions for research purposes.]
How You Can Help!

We see self-publishing - considering our aim of making BITE a living, breathing, evolving treatment - as a fantastic option for making BITE available to users. There are, of course, several downsides to this approach. The most notable potential problem is distribution. Publishing through the traditional route would allow this treatment to be available in brick and mortar bookstores like Barnes & Noble. Unfortunately, the cost of allowing BITE to be an ever-evolving treatment is that it doesn't have this kind of visibility. Word of mouth is the only channel of distribution that we have. For this reason, if it turns out that BITE is helpful to you and your patients, please let everyone know! Let us know, let your colleagues know, and let people on your social media accounts know. After all, not only are we putting out a new treatment into the world, but the method by which we are publishing and planning to evolve this treatment is also new. Of course, this is very exciting! But like most things that have the potential to be truly exciting, it is also pretty scary. The extensive toiling over the design of each handout could all be in vain if no one knows about BITE... or it all could be part of effort inherent in creating something big. You, the reader, will make the difference.

At the same time, you will also help BITE by letting us know if you find any errors, disagree with a particular stance BITE takes, or discover that this treatment is ineffective for some patients. We absolutely need this feedback. The only way to improve care for people with this deadly illness is to continue improving the treatments that we know work and put to rest those that do not. If you find that parts of BITE are a bust, we want to know.

Our Mission Statement

Our mission is to optimize the treatment of anorexia nervosa in adolescents by:

- integrating interventions that have been shown to work
- thoughtfully ordering and arranging these interventions into a comprehensive treatment
- executing the BITE treatment manuals & workbooks in such a way that clearly communicates complex concepts to patients, parents, eating disorder specialists, collaterals, and novice therapists alike
- making BITE material accessible and printable from anywhere the internet works
- seeking feedback from parents, patients, and therapists alike that will be used to direct the evolution of BITE
- evolving BITE as an evidence-based treatment for eating disorders

So... What is BITE?

So, what is BITE? Behavioral Integrative Treatment and Evaluation (BITE) is a new comprehensive behavioral approach to the treatment of anorexia nervosa in adolescents. We consider BITE “integrative” in three main respects: 1) it comprehensively integrates multiple evidence-based treatments, 2) it integrates tailored evaluations with treatment, and 3) it is pragmatically designed for easy integration into your current practice. In short, BITE is quite true to its name. When administered in full, Comprehensive BITE includes family, group, and individual treatment modalities. This manual - the BITE Family Therapy manual – describes one of the three core modalities that comprise the Comprehensive version of BITE.
INTRODUCTION TO COMPREHENSIVE BITE

Across the family, group, and individual treatment modalities that comprise Comprehensive BITE, different components from a variety of evidence-based approaches are integrated along with novel interventions. As such, BITE is intended to be administered by clinicians with training in evidence-based treatments. Prior training in the specific approaches from which the BITE model draws is beneficial; however, it is not necessary. Although the process of tying a large body of work together into BITE was admittedly complicated, this manual is intended to explain and depict BITE as simply as possible. Because of this, you may find it unnecessary to receive formal training in implementing this BITE manual before administering it (especially with prior Maudsley Family-Based Treatment training). Of course, if you are interested in training in any of the BITE modalities, please contact us. We would love to hear from you!

Comprehensive BITE is influenced by all of the following evidence-based treatments:

- Maudsley Family-Based Treatment (FBT; Locke, LeGrange, & Russell, 2013)
- Acceptance and Commitment Therapy (ACT; Sandoz, Wilson, & Dufrene, 2011)
- Cognitive Behavioral Therapy (CBT; Beck, 2011)
- Cognitive Behavioral Therapy - Enhanced (CBT-E; Fairburn, 2008)
- Parent-Child Interaction Therapy (PCIT; Bodiford-McNeil & Hembree-Kigin, 2010)
- Dialectical Behavior Therapy (DBT; Linehan, 1993, 2014a, & 2014b)
- Compassion Focused Therapy (CFT; Gilbert, 2009)
- Appetite Awareness Training (AAT; Craighead, 2006)
- Intuitive Eating (IE; Tribole & Resch, 2012)
- Health at Every Size (HAES; Bacon, 2008)
- Mirror Exposure Therapy (Hildebrant, Grief, et al., in preparation)
- Cognitive Remediation Therapy (CRT; Tchanturia, Davies, Reeder, & Wykes, 2010)

Comprehensive BITE also includes the following novel components:

- Weekly evaluations that assess the frequency of BITE-specific behavioral treatment targets for both the patient (e.g., eating disorder behavior, recovery behavior, skill usage, etc.) and parent
- A simple way to code both adaptive & unhelpful parental behavior during in session family meals or snacks
- Guidelines on sharing that feedback with parents to promote adaptive meal-time behavior
- Structured family sessions that include the use of BITE Handouts (e.g., a list of treatment rules, suggestions for ways to manage difficult behavior, how to shape recovery behavior etc.)
- Easy-to-use food and behavior logs for the parent to complete
- Clearly written BITE Handouts on “Earned Freedoms,” or food responsibilities a patient may earn over time
- A systematized protocol for giving Earned Freedoms back to the adolescent once weight is restored
- Adolescent friendly group exercises aimed at accepting parental control over food
- Adolescent friendly group exercises that encourage adaptive recovery-oriented behavior in early treatment
- Adolescent friendly CBT group exercises that teach patients to identify & dispute eating disordered thoughts
- Adolescent friendly CBT group exercises aimed at coping with fat talk and thin ideal messages
- Individual session guidelines to giving patients a replacement behavior to the restriction and avoidance of food: regular and appetitive eating (RAE), the practice of eating three square meals per day (with snacks) and according to one’s own hunger and fullness cues
- Individual session guidelines for novel body image exposure exercises (conducted once the patient is weight restored & equipped with skills)
- And a lot more!
THE STRUCTURE OF COMPREHENSIVE BITE

BITE is organized into three different modalities: family, group, and individual therapy. While the implementation of all three BITE modalities is referred to as Comprehensive BITE, the selective administration of certain modalities is referred to as Modular BITE (guidelines for choosing between Comprehensive and Modular BITE are provided later in the manual). For implementation of Comprehensive BITE, all three modalities will available in one manual by 2016. Considering the needs of the Modular BITE therapist, however, the following Modular BITE manuals will be sold separately: 1) BITE Family Therapy, 2) BITE Group Therapy, and 3) BITE Individual Therapy. BITE Individual Therapy is comprised of both a) Regular and Appetitive Eating (RAE) and b) Body Acceptance and Exposure (BAE) treatment components. In Comprehensive BITE, the three different modalities are collectively administered across three stages as follows:

<table>
<thead>
<tr>
<th>Stage 1: EATING FOCUSED</th>
<th>Stage 2: SKILLS &amp; BODY IMAGE</th>
<th>Stage 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>Group</td>
<td>Individual RAE</td>
</tr>
<tr>
<td>Individual RAE</td>
<td>Individual BAE</td>
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</tbody>
</table>

In Comprehensive BITE Stage 1, BITE Family Therapy and BITE Group were thoughtfully created to complement each other. During Stage 1 BITE Family Therapy, the therapist teaches parents to take control of food responsibilities. Parents also learn to coach the patient in eating meals/snacks and help them through difficult eating disorder urges. Stage 1 BITE Family Therapy terminates when the patient has reached weight restoration and stabilization. Although this is likely to improve the patient’s cognitive and emotional functioning, the addition of Stage 1 BITE Group is intended to expedite this process. Stage 1 BITE Group has been designed to specifically facilitate acceptance of parental control over food, provide skills training, and increase recovery behaviors (as defined in the BITE Handouts) early in treatment.

With improved physical and psychological health at the completion of BITE Stage 1, the timing is ripe for the introduction of CBT coping skills to support the patient’s process of reclaiming independence. Stage 2 BITE Family Therapy is focused on gradually and systematically handing over food responsibilities to the patient. Especially for patients scared of the eating disorder returning, this process can be very anxiety provoking. As such, Stage 2 BITE Group is administered alongside Stage 2 BITE Family Therapy to impart coping skills. While Stage 1 BITE Group primarily focuses on traditionally “third wave” acceptance and mindfulness strategies, Stage 2 BITE Group focuses mostly on the development of CBT skills (e.g., thought disputation). Skill building in Stage 2 BITE Group also lays the necessary groundwork for exposure exercises in Stage 3.

After the patient’s weight is stable, eating disorder behaviors have significantly decreased, and coping skills are in place, a transition to BITE Stage 3 is made. In this crucial final stage of BITE, the patient receives individual therapy twice per week. One type of session fosters self-directed eating, while the other aims to improve body image. In the former type of individual therapy, patients are guided to eat regularly (three meals and two snacks) and according to their own appetitive cues of hunger and fullness. We call this Regular and Appetitive Eating or "RAE." Alongside RAE, the patient receives Body Acceptance and Exposure or "BAE." BAE includes a series of body size/shape/weight acceptance and exposure exercises (e.g., imaginal exposure of seeing a weight a few pounds higher on the scale) that facilitate anxiety reduction. This type of body image work is saved until Stage 3 because the patient’s weight has been restored and stabilized at this point in treatment. Lastly, throughout both RAE & BAE in Stage 3, self-sufficiency and relapse prevention are underscored.
COMPREHENSIVE BITE TREATMENT OBJECTIVES

STAGE 1 BITE

BITE Family Therapy Objectives:
- Provide psychoeducation about the medical dangers of anorexia nervosa and this treatment
- Teach parents to effectively supervise eating by increasing skillful behaviors (i.e. TABLE Skills) and decreasing maladaptive behaviors (i.e. ED WINS Habits) during in session snacks and with psychoeducation
- Teach parents to decrease the patient's eating disorder behavior with the skillful implementation of rules
- Teach parents to increase the patient's recovery behaviors by providing recovery-specific positive attention (e.g., expressing gratitude to their child for eating, smiling, showing warmth, etc.)
- Eradicate the eating disorder behavior of food restriction (i.e. limiting overall caloric amount) via refeeding
- Foster the patient's sense of responsibility in recovery over time

BITE Group Therapy Objectives:
- Increase acceptance of parental supervision of meals and snacks
- Encourage patients to help decrease their own eating disorder behavior and increase recovery behavior
- Increase adaptive coping skill use
- Identify "thinness" as an invalid value and foster the healthful reprioritization of current values
- Increase self-compassion
- Increase mindfulness skills
- Increase psychological flexibility, as defined in Acceptance and Commitment Therapy
- Increase cognitive flexibility with Cognitive Remediation Therapy aka "Brain Games"

STAGE 2 BITE

BITE Family Therapy Objectives:
- Appropriately and therapeutically increase the patient’s Earned Freedoms (i.e. food responsibilities) over time
- Increase the patient’s self-sufficiency through the adaptive management of food responsibilities
- Target the eating disorder behavior of food avoidance (e.g., avoiding cupcakes) via exposures
- Restore the quality of the parent-child relationship likely to have been damaged by the eating disorder
- Prepare the parents for termination by providing psychoeducation about the patient’s new treatment goals

BITE Group Therapy Objectives:
- Decrease cognitive distortions
- Decrease eating disorder behavior
- Increase adaptive coping skill use to manage environmental triggers
- Increase relapse prevention skills
- Increase the patient’s self-sufficiency through the practice of coping skills

STAGE 3 BITE

BITE Individual Therapy - Regular & Appetitive Eating (RAE) - Objectives:
- Continue to implement regular eating (i.e. eating three square meals and two snacks)
- Establish regular self-directed eating
- Increase awareness of appetitive cues (i.e. one’s level of hunger & fullness) via mindfulness and monitoring
- Behaviorally, increase the use of appetitive cues to guide eating (i.e. according to hunger & fullness)

BITE Individual Therapy - Body Acceptance & Exposure (BAE) - Objectives:
- Increase the patient’s acceptance of their healthy size/shape/weight
- Increase tolerance of negative emotions through in vivo & imaginal exposures targeted at fear of weight gain
- With the implementation of both RAE & BAE, eradicate eating disorder behaviors
SAMPLE BITE MATERIAL
A List of Stage 1 BITE Family Therapy Handouts

Handout 1 - BITE: Not the type of therapy you’d expect
Handout 2 - FAQ: Why Family Therapy?
Handout 3 - 5 Roles & Expectations in BITE
Handout 4 - TABLE Skills (i.e. adaptive parent meal-time skills)
Handout 5 - ED WINS Habits (i.e. maladaptive meal-time habits of parents)
Handout 6 - 12 Treatment Rules for Parents
Handout 7 - 10 Reasons Kids Despise Supervised Eating
Handout 8 - 12 Eating Disorder & Recovery Behaviors
Handout 9 - Introduction to Stage 1 BITE
Handout 10 - Selfies, and Twitter, and Websites - Oh My! (i.e. how social media influences ED behavior)
Handout 11 - Recovery Delaying Behaviors
Handout 12 - "What Do I Do When...?" 12 Smart Parent Responses to Tricky ED Behaviors
Handout 13 - The Siblings’ Role in BITE
Handout 14 - What Foods are "Unhealthy" in Treatment?
Handout 15 - Separating the Eating Disorder & Your Child
Handout 16 - Presenting a United Front as Parents
Handout 17 - Three Tricky Ways Eating Disorders Disguise Themselves
Handout 18 - Be a Detective
Handout 19 - The Dieting Parent
Handout 20 - Stop the Fat Talk
Handout 21 - How Eating Disorders Work
Handout 22 - Improving the Relationship with Your Child
Handout 23 - Shaping Your Child’s Behavior
Handout 24 - Giving Recovery-Specific Positive Attention to Your Child
Handout 25 - 7 Roadblocks to Giving Your Child Recovery-Specific Positive Attention
Handout 26 - Strict or Soft?
Handout 27 - Flipping Eating Disorder Beliefs to Recovery Beliefs
Handout 28 - Are we There Yet? And Other Concerns: Like “When Can I Stop Gaining Weight?”
Handout 29 - ED or Teenage Angst
Handout 30 - Eating Disorder & Recovery Spirals
Handout 31 - Comprehensive BITE Treatment Stages
Handout 32 - Keep on Trucking
A List of Stage 2 BITE Family Therapy Handouts

Handout 1 - The Earned Freedoms List (i.e. a list of food responsibility the patient may earn)
Handout 2 - Earned Freedom Levels
Handout 3 - Forever-Nevers, Even After Treatment Ends
Handout 4 - The 10 Treatment Rules of Stage 2 BITE
Handout 5 - Welcome to Stage 2 BITE!
Handout 6 - Five Roles & Expectations in Stage 2 BITE
Handout 7 - How to Implement Earned Freedoms
Handout 8 - FAQs: Rewards v.s. Earned Freedoms
Handout 9 - 3 Wise Expectations about Recovery
Handout 10 - 3 Tricky Ways Eating Disorders Disguise Themselves in Stage 2
Handout 11 - Setback Triggers - Look Out!
Handout 12 - Earned Freedom Road Map
Handout 13 - Planning Ahead for Eating Disordered Urges in Stage 2
Handout 14 - Stage 2 ED & Recovery Behaviors
Handout 15 - Giving Recovery-Specific Positive Attention to Your Child in Stage 2
Handout 16 - The Importance of Confronting Fear of Foods
Handout 17 - Fear Food List
Handout 18 - Repairing the Relationship with Your Child
Handout 19 - Improving the Relationship with Your Child
Handout 20 - Belly Signals (i.e. paying attention to hunger and fullness bodily cues)
   Belly Signal Log for Patients
Handout 21 - The Body Checking Downward Spiral
Handout 22 - The 15 Commandments of Recovered Eating
Handout 23 - Sticking with It!
Handout 24 - Supporting Your Child in the Future
Handout 25 - Be a Detective in Stages 3
Handout 26 - Stage 2 BITE Cheat Sheet
3 TRICKY WAYS EATING DISORDERS DISGUISE THEMSELVES

Eating disorders can be very tricky, so it is important to be on your guard. Many times, an eating disorder can masquerade around like some sort of professional or expert nutritionist. But do not be fooled! The eating disorder will twist and turn the information around and use it to hurt your child. Look out for these tricky types of eating disorder manifestations:

The 3 tricky ways eating disorders can disguise themselves:

1. The Self-Proclaimed Diet Guru - Seeming Like a Nutrition & Health Expert
   Your child may have a lot of information on nutrition, dieting, and exercise. This does NOT mean, however, that they are correct or that they are implementing that information well. Remember that your child is not an expert, but a victim of a ruthless eating disorder. By definition, if a person has an eating disorder, they are not healthily implementing nutrition rules in a physically or mentally healthy way. No matter how armed your child’s eating disorder is with "nutrition" or "health" information, they are not correct. You & the treatment team know best, not your child with an eating disorder. Even though the eating disorder may think it knows better than both you & the treatment team, your child must comply. Beware of the Self-Proclaimed Diet Guru.

2. The Perfect Child - Seeming Put-Together
   Kids with eating disorders can be very bright and seem like they have it all together. They can be meticulous, well spoken, and seemingly rational... but watch out! Just because your child seems to have it all figured out, doesn’t mean that they do. Especially if your child has the ability to present a good argument against having to eat/ being sedentary/ going to treatment: beware that the eating disorder is trying to win. Be on your guard for skillful arguments against complying with treatment rules. Even though your child seems to have a solid argument, they still must comply. Beware of your child seeming like the Perfect Child.

3. The Recovered Patient - Seeming Physically & Mentally Healthy
   Especially after gaining the first several pounds back, your child may look relatively physically healthy and even tell you that they do not have an eating disorder anymore. This does NOT mean they are healthy. Especially considering growth curves (more on this in Handout 26), your child may need to gain even more weight for their height than would be recommended for a child without a history of an eating disorder. Only your child’s team of experts have the knowledge to decide when they must stop gaining. Even though your child seems physically & mentally healthier than at the start of treatment, they must still comply. Treatment is not over until the treatment team says so. Beware of your child seeming like the Recovered Patient.

Bottom Line: No matter how skillful the eating disorder is, treatment compliance is mandatory.
You Have to Be a Detective: Eating disorders cause otherwise honest and trustworthy kids to engage in sneaky behaviors. Parents need to be aware of eating disorder tricks and signs in order to effectively monitor their child and battle the eating disorder.

Types of Sneaky Behaviors:
- Altering weight on the scale by putting on heavy jewelry or having extra weight (e.g. batteries) in pockets.
- Purging in the shower, garbage, plastic bags, buckets
- Hiding vomit
- Hiding food – in socks, pockets, under table/chair, backpack/purse, or feeding the dog
- Drinking water to feel full and/or superficially increase weight during weigh ins
- Using “thinspiration” or “thinspo”
  - pro Ana (anorexia) websites/blogs
  - pro Mia (bulimia) websites/blogs
  - collecting pictures representing their ideal body
  - joining online groups for people with eating disorders
  - “fitspiration” from exercise and/or diet focused websites and magazines
- "Marker" clothes (keeping old skinny jeans to compare body against)
- Chewing gum to hide breath odor (or is this to keep full?)
- Moving/shaking/fidgeting to burn calories
- Chewing and spitting food
- Complaining of feeling too sick or full to eat
- Laxative/diuretic/diet pill/caffeine use
- Liquid cleanses or fasts

Signs of Purging:
- Eating marker foods (eating nuts, carrots, Doritos, etc. at beginning of meal to signal that they’ve vomited everything they’ve eaten)
- Disappearing after meals
- Drinking milk to reduce burning in throat after vomiting
- Puffy, red eyes
- Puffy cheeks
- Clogged toilet, shower, or sink drains from vomit
- Vomit-soiled toilet, shower, or sink

Bathroom Monitoring:
- Have your child sing Row, Row, Row Your Boat or count while going to the bathroom within one hour of eating. This will ensure the child is not vomiting in secret, as they will be singing or counting the whole time.
- Another option is to not allow your child to turn on the faucet or flush the toilet unless you are present.

Exercise Monitoring
- Take your child’s pulse to assess for compulsive exercising. Make sure you know your child’s typical resting heart rate.
BITE FAMILY THERAPY STAGE 1 PATIENT EVALUATION

Directions: Answer all BITE Questionnaire items with the 0-4 scale below. If an item does not apply, write “NA.”

0------------------1------------------2------------------3------------------4
Never            Rarely           Occasionally      Usually           Always

1. EATING DISORDER BEHAVIOR - (Parent Supervised)
   This week, how often did your eating disorder lead you to:
   1 _______ negotiate about the type of food being served.
   2 _______ negotiate about the amount of food being served.
   3 _______ "refuse" to finish a meal or snack after starting to eat.
   4 _______ completely "skip" having an afternoon or evening snack.
   5 _______ have an emotional outburst that resulted in not having to eat (i.e. got you "off the hook").
   6 _______ openly (i.e. not secretly) measure or prepare your own food.
   7 _______ openly eat reduced calorie / diet foods.
   8 _______ openly eat without a parent present.
   9 _______ openly exercise more than is currently recommended by your doctor.
   10 _______ easily view pro-ED content online / use weight loss apps without parental interference.
   11 _______ openly refuse to take prescribed medications (if not applicable, write "NA").
   12 _______ be alone in the hour after you ate (even if you did not engage in an ED Behavior).

2. EATING DISORDER BEHAVIOR - (Patient Directed)
   This week, how often did your eating disorder lead you to:
   1 _______ hide food.
   2 _______ have emotional outburst to try to avoid eating.
   3 _______ eat in secret / eat alone.
   4 _______ take non-prescribed pills in an attempt to alter weight (i.e. laxatives / diuretics / diet pills).
   5 _______ secretly exercise without a parent knowing.
   6 _______ secretly measure food / demand to know calories or ingredients in food.
   7 _______ seek out pro-ED content online or use weight loss apps despite parental monitoring & controls.
   8 _______ secretly compensate for calories after meals or snacks.

3. RECOVERY DELAYING BEHAVIOR - (Patient Accountable)
   This week, how often did you:
   1 _______ purge prescribed medication (if not applicable, write "NA").
   2 _______ attempt to trick the scale / alter weight (e.g. wear heavy jewelry).
   3 _______ secretly not take prescribed medication (e.g. hiding pills).
   4 _______ refuse to participate in therapy (e.g. being weighed, talking to therapist, skipping, incomplete HW).
   5 _______ take mood altering substances (non-prescribed).
   6 _______ misrepresent the truth about your compliance with treatment (e.g. not reporting purging).

4. BEHAVIOR OF YOUR PARENT – E.D. WINS Habits
   This week, how often did (or was) your parent:
   1 _______ Escalate: argue or express anger during meal/snack time.
   2 _______ Disagree with Each Other: one parent had a different rule than the other
   3 _______ Waiver on the Rules: for example, say you had to eat something & then take it back.
   4 _______ Impatience: tell you to hurry up your eating in a frustrated way.
   5 _______ Nag You to Eat: complain about your eating & ineffectively ask you to eat.
   6 _______ Sarcastic: make sarcastic or snide remarks about your eating or eating disorder.
Directions: Answer all BITE Questionnaire items with the 0-4 scale below. If an item does not apply, write “NA.”

0------------------ 1------------------ 2------------------ 3------------------ 4------------------
Never Rarely Sometimes Usually Always

6. BULLYING BEHAVIOR & VICTIMIZATION
This week, how much:
1_______ were you bullied online? [What were you bullied about?_____________________]  
2_______ were you bullied in person? [What were you bullied about?_____________________]  
3_______ did you bully others online? [What did you bully others about?_________________]  
4_______ did you bully others in person? [What did you bully others about?_________________]  
5_______ make negative comments to another person's about their body size / shape / weight?   
6_______ make negative comments about an immediate family member's body size / shape / weight?

7. BODY IMAGE BEHAVIOR [Eventually Stage 3 Individual Therapy Targets]
This week, how often did your eating disorder lead you to:
1_______ body check (e.g. touch stomach to assess weight).  
2_______ avoid your body (e.g. avoiding mirrors).  
3_______ hide parts of your body with clothing (e.g. tying sweater around waist).  
4_______ weigh or measure yourself (i.e. on your own, not at appointments).  
5_______ compare your body to another person's.  
6_______ make negative comments about your own body.  
7_______ make negative comments about another person's body.  
8_______ count calories in order to have control over your body's size / shape / weight.  
9_______ take pictures of yourself ("selfies") to examine your body.

8. BEHAVIOR OF YOUR PARENT - TABLE Skills
This week, how often did your parent(s) use the following skills:
1_______ Together Eating & Distraction: eat with & distract you during meals.  
2_______ Appreciate Your Struggle: show they understand that eating is hard for you.  
3_______ Break it Down & Be Positive: encourage you to take bites of food in a positive way.  
4_______ Limit Set: make a rule about eating and stick to it.  
5_______ Externalize the Eating Disorder: show they don’t blame you for the eating disorder.

9. RECOVERY BEHAVIOR
This week, how often did you:
1a_______ eat the type of food being served.  
1b_______ eat the type of food being served without negotiating.  
2a_______ eat the amount of food being served.  
2b_______ eat the amount of food being served without negotiating.  
3_______ finish meals.  
4_______ finish snacks.  
5_______ have negative emotions and still eat.  
6a_______ eat food that you have not prepared.  
6b_______ eat food that you have not prepared without negotiating.  
7_______ eat full-calorie and full-fat foods.  
8_______ eat meals and snacks with adult supervision.  
9_______ adhere to restricted exercise guidelines from your doctor.  
10_______ view/use only the websites, apps, & accounts approved by your parents and therapist.  
11_______ take prescribed medications as recommended (if not applicable, write "NA").  
12_______ wait one hour before using the bathroom after a meal or snack.