Questions Asked During Live Webinar Broadcast on 4/22/20

Practical Recommendations in the Treatment of Eating Disorders

Presenter: Alyssa Kalata, PhD

Hello, everyone! I wanted to extend a big thank you for everyone who attended the webinar and for the feedback that you provided! I've done my best to provide answers to the questions we did not get to in the live question and answer portion of the webinar. I really do value ongoing dialogue with colleagues, so if the answers below are not sufficient or you've thought of new questions you may have since attending the webinar, please don't hesitate to reach out! The best ways to contact me are via e-mail at akalata@veritascollaborative.com or via telephone at (919) 908-0353. I look forward to continued discussion with you all! -Alyssa

I have a significant amount of miscellaneous training in ED treatment, but no formal certification, etc. Is there a way to have this specialization more formally that you recommend?

A: Yes! The International Association of Eating Disorders Professionals (iaedp) provides certification for providers of all sorts of disciplines. You can learn more about certification here: http://www.iaedp.com/certification-overview/.

Do you have any specific suggestions regarding working with inmates experiencing ED/SUD in a correctional environment attending a program within the corrections system

A: Sadly, the research on working with inmates diagnosed with eating disorders is incredibly limited. Here are links to the only two articles on the subject that I was able to find: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5395751/ and https://www.tandfonline.com/doi/abs/10.1080/21662630.2013.742968. As such, my recommendation is a broader one that applies across a variety of settings – if you are someone who is working with patients diagnosed with eating disorders, it is critical to ensure you have adequate training and that you seek supervision and consultation as appropriate. When I first began doing work with individuals diagnosed with a primary eating disorder, even though I had been a fully licensed psychologist for a number of years, I made arrangements for weekly individual supervision with an experienced, CEDS certified eating disorder professional. I would argue that the supervision and consultation piece is all the more critical when working with a highly specific population, like individuals who are incarcerated, as the degree of nuance involved in treating individuals diagnosed with an eating disorder is likely heightened by the context in which they are living.

Talking of disordered thinking, I have a patient that has been hospitalized three times for suicidal attempts, stated he has eating disorder problem. He is overly anxious about being over weight. Secondly, he is abusing both alcohol and different types of drugs. What are the best strategies for intervention ?

A: Although I don't have the full clinical picture for this individual, I would imagine he might be an excellent candidate for a full model Dialectical Behavior Therapy program. You can learn more about comprehensive DBT here: https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/. Many of the strategies that we discussed in the webinar, like diary cards and chain analyses, are components of DBT and certainly would be helpful for an individual like your patient. However, full model DBT has many other elements that we did not discuss that I suspect your patient might find of benefit.

Are harm reduction strategies to address SUDs contraindicated for people who have a co-occurring eating disorder?

A: Really excellent question! I combed through the research literature on this subject, and wasn't able to find and research that speaks to this topic specifically. Without research to guide an answer, I'll share my thoughts based on my clinical experience to date. From my perspective, I wouldn't say this approach is contraindicated. Whether it is the appropriate approach to take will depend on both your patient, including their goals (both short-term goals and life worth living goals) and their stage of change, as well as you as a provider. I think it's important to note that

harm reduction strategies are not necessarily appropriate for every provider (for an eloquent summary of this perspective, I'd encourage you to read the "Research Summary and Clinical Practices" section of an article by Logan and Marlatt that you can access here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928290/pdf/nihms552569.pdf), however if it is an approach you are comfortable working with, I think it can be helpful with patients diagnosed with a comorbid eating disorder and substance use disorder, particularly early in the course of treatment. It can be helpful to remember that patients are often ambivalent about making change around their eating disorder behavior, substance use, or both. If you approach these patients with a heavily change-focused angle, with an emphasis on immediate abstinence from all behaviors, you may not see that patient come back through your doors, which shuts down any possibility of you helping them to make change in the future. That being said, there are some important questions I would want to revisit regularly if I was taking a harm reduction approach in my work with a patient. First, when I reflect on my patient's life worth living, is the harm reduction approach getting them closer to this? I can imagine a situation in which a harm reduction approach helps a patient to make good progress initially in treatment, in that it is a way of meeting them where they are at and setting reasonable goals for change, however as treatment progresses that patient stagnates at a point that is short of their life worth living because continued behaviors are getting in the way. I think in a situation like this one, it would be important to revisit whether the harm reduction approach is the best route to go. The other question I might consider is, "Is my patient using substances in lieu of engaging in eating disordered behaviors or vice-versa, and what does this mean for their long-term prospects for recovery and having a life worth living?" I've worked with many patients where behaviors of varying topographies served a similar function (e.g. reducing anxiety) and I think there are a couple of risks with taking a harm reduction approach when this is the case. First, as one set of symptoms (e.g. substance) improve, you often will see a worsening of another set of symptoms (e.g. eating disorder behaviors). Second, if a patient tends to turn to a rotating array of maladaptive behaviors as coping mechanisms, they never get the opportunity to truly focus on how to manage difficult situations skillfully. As an overarching take-home point, I do think there is value in finding routine pause points in your work where you evaluate how your interventions are working with a patient and whether changes to your interventions as warranted. And when you do pause, I also think it's important to consider whether you've given an intervention sufficient time to work, keeping in mind that the pace of change for patients with complex comorbidities is often going to be slower than for patients with a less complicated clinical picture.

Do you recommend the App DBT Diary Cards and Skills Coach, especially because it costs $5?

A: If you or your patient has a preference for doing a diary card via an app, I think this is worth the $5 investment. For capturing diary card information, it is customizable, and it also has functionality built in for skills coaching and skill reminders. I admittedly have a preference for the diary card format that was used in the webinar, so in my own personal clinical practice, I use that in conjunction with Recovery Record with most of my patients. For those of you who are totally new to diary cards, I'd recommend experimenting with what works best for you in terms of how you take in and process information, as well as what honors your patients' preferences. Even though I have a prefererence for the diary card and Recovery Record combination, I've used other diary card formats based on patient preferences, and would be willing to use Recovery Record on its own with certain patients.

What advice can you give to me as a clinician to advocate for my program/agency to include more treatment/education/assessment of eating disorders?

A: Excellent question! I think there are a couple of different angles you might consider taking. Something that I think mental health professionals tend to shy away from talking about is the business aspect of providing mental health services. As much as it is uncomfortable to think about, any time you are advocating for change, it's important to consider how your change could impact the bottom line. There tend to be costs associated with expanding the scope of services you provide (e.g. costs associated with staff training), however there are questions to consider that might help you to figure out if that cost could be offset or if your proposed changes could actually lead to positive changes for the bottom line. Some questions I might consider pondering include, (1) Is there a lack of eating disorder services in the area my agency serves, such that having the capacity to provide high-quality eating disorder services at our agency might draw in patients we wouldn't otherwise treat, thus creating a new source of revenue?, (2) Is there a strong possibility that providing eating disorder training to staff would have a direct impact on patient retention, which decreases lost revenue due to patient drop-out?, (3) Would staff training or changes to programming around eating disorders improve patient outcomes and/or reduce the likelihood of adverse patient events (e.g. medical emergency associated with an eating disorder, suicide attempts), which might help you

to use good outcomes to help drive future business? Another interesting financial angle to consider is that with DBT specifically, I've seen examples of providers successfully advocating for increased reimbursement rates for those services (Koons, et al (2013) do a nice job of outlining that process in an article that can be accessed here: https://statacumen.com/pub/2013_KoonsErhardt_NegotiatingDBT.pdf). Taking off the finances hat and putting on the clinical hat, I think there are some compelling arguments that can be made from that angle as well. Opioid Use Disorder recently overtook Anorexia Nervosa as the most lethal psychiatric illness, and the risks of lethality and other adverse conseqeunces of eating disorders are not to be underestimated. It's critical that if you are going to work with such a group of psychiatric illnesses that have a high risk of lethality and adverse medical outcomes that your staff are properly trained to do so and that the programming you have in place is appropriate to meet these patients' needs. Eating Disorders and Substance Use Disorders are part of a small subset of psychiatric illnesses that I believe truly require additional specialized training beyond the generalist training that many of us are exposed to in graduate school. Assuming that you work in a program that is a primary Substance Use Disorders setting, another angle I think you could take is that these disorders commonly cooccur and when treatment does not address both disorders concurrently, you may see an improvement in symptoms of one disorder while the other disorder worsens, which will ultimately impede someone's overall recovery process. I'm a firm believer in the importance of treating our patients holistically, rather than trying to treat individual disorders, symptoms, and other life challenges in isolation. Finally, I think you could take the approach of coming up with small changes in terms of assessment, treatment, or education, with the goal of advocating for larger changes over the course of time. For example, incorporating the SCOFF (the screening tool we discussed for eating disorders) is an incredibly low-cost, low-effort intervention that could improve your ability to identify patients who meet criteria for an eating disorder who otherwise might have been missed using your standard screening and assessment procedures. If this change leads to your organization finding that you have many more patients who meet criteria for an eating disorder than initially thought, what does this data suggest would be an appropriate next step? I think data like that could make for a compelling argument to consider at least a brief staff in-service on working with patients diagnosed with eating disorders. My take-home point with this is think about incremental, data-driven changes.

Could you help me to understand 5-7 under "How were skills used" on the Diary Card?

A: Sure! I will share that a lot of folks (both patients and providers) find this scale to be confusing, so it's important to remember that with diary cards, function is more important than form. So if this scale doesn't work for you or your patient, feel free to adapt it accordingly. That said, here is an explanation for each of the numbers. 5 (Tried, I Could Use Them, THEY HELPED!!!): This describes a situation in which a patient made an intentional choice to use a skill, had the knowledge and abilities necessary to use the skill, and found that it was helpful. For example, if a patient decided that they wanted to use the DEAR MAN skill from DBT (this is a skill that can be used to make a request of someone in a skillful manner) to ask a family member to refrain from talking about dieting in front of them, used DEAR MAN to make the request of their family member, and they had a successful outcome with using DEAR MAN, this would be a "5." 6 (Didn't try, used them, didn't help) = This would be a situation where a patient used a skill without intentionality behind their skills use and they didn't find the skill to be beneficial. For example, if a patient started listening to music prior to a meal they were anxious about in a manner that was almost reflexive or habitual and found that listening to music didn't decrease their anxiety and/or help in completing their meal, this would be an example of a "6." At least in my experience, 6's come up in situations where a patient is "going through the motions" of using a skill, but not using the skill in a mindful or intentional manner. 7 (Didn't try, used them, THEY HELPED!!!) = This is a situation just like a 6, except for the outcome is a favorable one. Using the same example above, if the patient found that listening to music decreased their anxiety and/or helped in completing their meal, this would be an example of a "7." 7's usually show up in one of two ways; either a patient finds themselves using a skill by "accident" and is pleasantly surprised it is helpful or a patient is far enough along in treatment that skills use has become "second nature" and they don't have to think through skill use in each and every difficult situation.

What is the differnce between binging and purging ?

A: Binge eating, as defined by the DSM-5, involves eating in a discrete amount of time an amount of food that is definitely larger than what most individulas would eat in a smaller period of time under similar circumstances coupled with a sense of lack of control over eating during that episode. Purging encompasses a number of behaviors, including self-induced vomiting, misuse of laxatives or diuretics, and excessive exercise. These behaviors are usually thought of as compensatory behaviors intended to prevent weight gain.

What are your thoughts on people having an eating disorder and trauma?

A: This could be an entire training in and of itself, however here are a few things I think are important to know. Prevalence rates of histories of traumatic events in individuals diagnosed with an eating disorder range from 37% to 100% in individual studies, and Childhood Sexual Abuse (CSA) appears to a significant risk factor for development of an eating disorder. Prevalence rates of Posttraumatic Stress Disorder (PTSD) have ranged from 4% to 52% in individual studies. There is also some interesting summary information here (https://www.nationaleatingdisorders.org/learn/general-information/trauma) about Bulimia Nervosa, Binge Eating Disorder, and Binge Eating as they relate to PTSD prevalence rates. Like I mentioned a few questions above, I think it is important that we take a holistic approach in conceptualization and treatment of our patients. In other words, it's important to assess for trauma and trauma-related symptoms, and if present, consider how your patient's trauma history and symptoms and their eating disorder interact, as well as how addressing trauma-related symptoms will fit within your overall treatment plan. With this piece, timing is important. For a patient who is early in their treatment and recovery process with regard to their eating disorder, interventions like providing psychoeducation about trauma and teaching skills-based methods for managing trauma symptoms are appropriate interventions. Interventions aimed at processing trauma (like Prolonged Exposure, Cognitive Processing Therapy, Eye Moment Desensitization and Reprocessing) tend to be interventions that occur later in treatment, once a patient has established a period of abstinence from eating disorder behaviors. Lastly, like with eating disorders and substance use disorders, I do think it is critical for therapists wanting to work with patients on trauma-related concerns to have specialized training in this area.

One of the differences I've observed between substance use and eating disorders is that eating disorders are often addressed in persons in their teens and twenties. What happens to eating disorder clients in their 30s, 40s, 50s, and beyond? Do they improve? Cross-addict (move to substance use)? Do they give up on treatment?

A: There is actually an excellent article on this topic that was just released in the Journal of Abnormal Psychology on this very topic (Brown, et al (2020) – A 30-Year Longitudinal Study of Body Weight, Dieting, and Eating Pathology Across Women and Men From Late Adolescence to Later Midlife)! It's a very rich article, and I'll do my best to summarize key findings that address some of your questions. Although eating disorders may be more common in midlife than originally thought (this article discusses how the majority of new diagnoses in midlife are OSFED, which suggests that late onset eating disorders are atypical in their presentation), the data suggest that the majority of individuals recover over the course of their lifespan and that women in particular tend to "age out" of their eating disorder. This particular study found that DSM-5 eating disorder diagnoses decreased over the course of 30 years for women, however remained stable for men. Drive for thinness also decreased for women as well over the course of time, whereas drive for thinness increased for men during the same time period. Finally, symptoms of bulimia for both women and men decreased over time. What little literature I was able to find did not suggest that improvements in eating disorder symptoms over the lifespan are typically are accounted for by the emergence of a substance use disorder that serves a comparable function. The take-home point from all of this is that the majority of people diagnosed with an eating disorder do recover, even if that process takes a considerable amount of time and effort.

If a patient is pregnant and has SUD, does that change recommended level of care? And Could eating disorders present differently in pregnant patients?

A: Because of the medical risks to the fetus (and newborn infant) as well as the mother, pregnancy status may influence recommended level of care. I think this underscores why multidisciplinary collaboration is so important – if you are not a medical provider, it is critical to have input from that discipline about medical risks the patient and fetus are facing. The research literature on pregnancy and eating disorders is fairly limited and doesn't suggest that eating disorder presentation is different in terms of behaviors, however how pregnancy status interacts with an eating disorder has some additional layers of nuance. For someone who struggles with body image distress like someone diagnosed with Anorexia Nervosa, weight gain associated with pregnancy and increased comments made by others about body shape and size can increase the likelihood of eating disorder behaviors. Conversely, for some expectant mothers, the desire to make improvements with regard to eating disorder behaviors and actions aligned with this desire increased in the context of pregnancy, due to worries about adverse effects on the fetus.

Are bulimia, diabulimia, and binge common eating disorders in America ?

A: The lifetime prevalence rate of Bulimia Nervosa in the United States is about 1% and the lifetime prevalence rate of Binge Eating Disorder is 2.8%. In terms of diabulimia, there are a couple of statistics that I think are worth noting. Research over the last 25 years on eating disorders and insulin restriction in people with diabetes has found that 30-35% of women restrict insulin in order to lose weight at some point in their life. Relatedly, a more recent study found that 1/3 of female patients and 1/6 of male patients with Type 1 diabetes reported disordered eating and frequent insulin restriction. Even though these numbers may seem small, when you think of the population of the United States as a whole, these numbers translate to millions of people being impacted by these disorders.

Has anyone studied the connection between unresolved/unintegrated grief to due any source of loss and eating disorders? And has anyone studied "resistance" to treatment as a mis-match between what the patient needs vs. what is available as treatment? (i.e. could it be that if very base-level problems such as the sense of loss and the usual sense of emptiness that comes with it needs to be treated first, as the place to start and if not, then natural resistence to mentally-focused treatment appears?)

A: Really interesting questions! I'm not sure I fully follow, however I'll do my best to respond, and feel free to contact me directly if I miss the mark and you want to chat further! Grief and loss are certainly things that patients with eating disorders experience, both in ways that are common across all people (e.g. grief over the loss of a loved one), as well as some ways that are unique to eating disorders (e.g. grief over lost time and life experiences due to time spent in treatment at higher levels of care, grief over the loss of their eating disorder). I tried to find research that talks about the intersection of grief and eating disorders and came up empty in terms of empirical research, but nothing turned up on that topic. That being said, my colleague and I are presenting at the upcoming iaedp Virtual Symposium on targeting a patient's eating disorder indirectly by targeting a patient's symptoms of depression directly. Patients are often ambivalent or even actively opposed to targeting their eating disorder symptoms, however if they experience comorbid depression, they are almost always motivated to feel less depressed. Many of the interventions one might use to directly target depression can have impacts on a patient's eating disorder and/or their willingness to directly target eating disorder symptoms, so that can be a consideration if you are working with a patient who is willing to work on their depression but not willing to work on their eating disorder symptoms. The one caveat that comes to mind for me is that if I was an outpatient provider (I currently only do clinical work at higher levels of care), I would have some personal limits about the degree of severity of eating disorder behaviors I would be willing to tolerate while targeting grief first. For example, if I was working with a patient who met criteria for partial hospitalization, residential, or inpatient level of care, I wouldn't be comfortable targeting continuing to treat them on an outpatient basis, particularly with a primary focus on their grief over their eating disorder symptoms. If you found any of this to be of interest and would like to learn more about our upcoming presentation on this topic, or the iaedp Virtual Symposium more broadly, you can learn more here: https://iaedp.confex.com/iaedp/2020/meetingapp.cgi/Session/4528

Where does one find a list of "skillful behaviors" - strategies to use for the solution analysis?

A: The DBT Skills Training Manual (Second Edition) and the DBT Skills Training Handouts and Worksheets are the most comprehensive resources outlining skillful behaviors that can be incorporated into a solution analysis. Both can be purchased here: https://behavioraltech.org/store/product-category/books/. I also have a "cheat sheet" that I created and am happy to share that summarizes the majority of the skills in these books in a couple of pages. Feel free to e-mail me at akalata@veritascollaborative.com if you'd like a copy!

I would like to have some information about resources for Spanish speaking population?

A: There are a few resources I can link you to as starting points! NEDA has many parts of their website translated in to Spanish, which you can access here: https://www.nationaleatingdisorders.org/neda-espanol. This is a good resource for both patients and families. F.E.A.S.T. has a few of their resources also translated into Spanish, which you can access here: https://www.feast-ed.org/family-guide-series/. This is a resource that is more for families of loved ones struggling with an eating disorder than it is for patients. Finally, iaedp has a number of webinars for professionals that have been conducted in Spanish that you can access here: http://iaedp.netromedia.com/Webinars-Spanish.

The one client that I continue to work with that has knowingly been diagnosed with an eating disorder, is seeing me for Gambling Addiction. I understand all addictions have similar behaviors, but I am wondering if you have any specific pointers for those with gambling addiction and eating disorder?

A: I took a peek at the limited research about comorbid eating disorders and gambling addiction and one of the primary themes that emerged across the studies is that patients with this comorbidity tend to struggle with poor impulse control. If this description seems to fit your patient, I'd be inclined to provide a bit of psychoeducation around impulse control in eating disorders and gambling addiction, and explore if you and your patient can get on the same page that working on improving impulse control is a worthwhile treatment goal. Assuming this is a treatment goal that your patient is agreeable to working on, I think the chain analyses and solution analyses that we discussed during the webinar can be a helpful tool in gaining a detailed understanding of factors leading up to and consequences following a target behavior and then figuring out targeted and specific interventions for various links on the chain. Skills drawn from the Distress Tolerance module of DBT are particularly helpful in targeting impulse control, so I'd take a peek at those if you're not already familiar with them. In particular, the STOP skill and Burning Bridges are two that immediately come to mind as being potentially helpful. Related to Burning Bridges specifically, when I think about targeting poor impulse control, I think a lot about how to slow down the process of acting impulsively. For example, if I'm working with someone who has a tendency to make impulsive purchases online, can they delete all of their stored credit card information out of their online shopping accounts? Or if they have difficulty with making impulsive purchases while they are out on the town, can they store their or purse in the trunk of their car in a box that has the word "STOP" written on top of it? Obviously, neither of these interventions eliminates the possibility of engaging in an impulsive behavior, but it does make that process more difficult and opens up the possibility of the patient considering more skillful options.

Would you give us more information on the card sort and writing exercises?

A: Sure! You can find a link to the personal values card sort here: http://www.motivationalinterviewing.org/sites/default/files/valuescardsort_0.pdf The writing exercises are not available online, as best I can tell, however if you send me an e-mail at akalata@veritascollaborative.com, I'm happy to send them along to you!

Would you briefly describe gender differences in eating disorders and substance use disorders?

A: I'm assuming that your question is asking about differences in rates of eating disorders and substance use disorders across genders, but if I missed the mark, please feel free to reach out to me via e-mail at akalata@veritascollaborative.com and I'm happy to provide additional information! Lifetime prevalence rates of Anorexia Nervosa appear to be between 0.9%-2% for females and 0.1%-0.3% for males. ARFID is one of the new diagnoses that came along with DSM-5 and this diagnosis appears to be more common in males, although prevalence rates in general as well as among specific populations is an area of ongoing study. Lifetime prevalence rates of Binge Eating Disorder appear to be between 0.2%-3.5% for females and 0.9%-2% for males. Lifetime prevalence rates of Bulimia Nervosa appear to between 1.1%-4.6% of females and 0.1%-0.5% for males. Finally, it is important to note that transgender individuals are at particular risk of developing an eating disorder. For example, one study of transgender college students found that 16% of individuals in the study had been diagnosed with an eating disorder, which is considerably higher than the lifetime prevalence rates of eating disorders seen here. In terms of gender differences in substance use disorders, I thought this information provided through the NIH gives a wonderful summary: https://www.drugabuse.gov/publications/research-reports/substance-use-in-women/sex-gender-differences-in-substance-use

Many patients/clients are strugling with eating disorders AND another adddiction that hide the ED. Do you think it is better to get clean/sober AND abstinent at the same time?

A: Yes, I do believe eating disorders and substance use disorders as a comorbidity are best treated concurrently, rather than sequentially. The rationale for this is that often if the symptoms of one disorder are being treated and are improving, you'll see a worsening in symptoms of the other disorder. For example, if you are working with a patient who engages in purging and alcohol use as a way to regulate their anxiety and that individual is successful in achieving abstinence from alcohol use, you are likely to see an increasing in purging behavior unless this is being targeted directly as well.

Recovery Record

Presenters: Jenna Tregarthen, CEO, MA

In regards to the app. I am a counselor at a high school. is this an app I can recommend to a student or does it need to be utilized alongside with a clinician?

A: Absoltuely, a large scale study found the app to be effective even when used in a self-help capacity. As a free, HIPAA compliant and research validated tool, it is a great resource to share with your community. Eating disorders are of course serious and debilitating conditions which should be treated clinically, but resources such as Recovery Record can be valuable to students who are not yet ready or able to receive clinical treatment, or have sub threshold eating disorders. Please feel free to utilize the Recovery Record logo etc. for health promotion, and this flyer, if helpful: https://d3e0vp65sneg3n.cloudfront.net/flyer5.pdf

Can this app be used for people JUST with substance abuse issues?

A: If a client of yours has substance abuse issues and does not have a comorbid eating disorder, I recommend referring them to the Recovery Path product for addiction recovery. This is an evidence based and HIPAA compliant tool that your clients can use either independently or linked with you to help motivate and engage them in the day-to-day work of addiction recovery. See: www.recoverypath.com

Is this app in AppStore and Google Store?

A: Yes, the app is available on iPhone (via iTunes app store), Android (via the Google Play store) and also on desktop for those who do not have a smartphone (see: www.recoveryrecord.com)

How much is the Recovery Record app?

A: The app is free to patients, and the first patient link is free for providers, after which there is either a monthly or yearly fee, starting at $19 per month, depending on size of caseload using the tool.

What is the name of the alternative to recovery record?

A: The addiction recovery product is Recovery Path (www.recoverypath.com) and the product for mood and anxiety disorders is Mood Links (www.moodlinks.com)