

NAADAC

Practical Recommendations in the Treatment of Eating Disorders

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>> MODERATOR: Hello everyone and welcome to today's webinar on Practical Recommendations in the Treatment of Eating Disorders presented by Dr. Alyssa Kalata. My name is Samson Teklemariam the director of training and professional development for NAADAC the Association for Addiction Professionals. I will be the organizer for this training experience and an effort to continue clinical business with a professional NAADAC is fortunate to a welcome webinar sponsors.

As our field continues to grow all of the things important to remain informed of best practices and resources supporting addiction and recovery. Especially, in times like these where we are quickly realizing the importance of how technology connects us. The app which been evaluating clinical trials and engage in patients and best practice treatments. Any questions we don't get to.

[Technical difficulties]

You will notice in the go to webinar control panel another tab labeled handouts. Click on these if you not download of those handouts and the company the presentation. The presenter will discuss each of the handouts during the presentation so you can find them on the website that you use to register for this webinar and see the website link in the chat box. The webpages dedicated permanent webpage for everything you need to know about this webinar and it includes those additional resources and handouts. Nate and how to find them in two places.

Let me introduce you to today's presenter Dr. Alyssa Kalata is a licensed psychologist in the State of North Carolina. After receiving both her masters and doctoral degrees in clinical psychology from Western Michigan University in Kalamazoo, Michigan and a bachelor's degree in Psychology Women's Studies from the University of Michigan, she completed her pre-doctoral internship at Duke University Medical Center with a focus on cognitive behavioral therapy. Alyssa has served in various roles during her professional career including clinical supervisor, research and program development associate, associate clinical director and clinical trainer working with patients diagnosed with primary substance use disorders and primary eating disorders in settings that provide services at a variety of levels of care.

Alyssa has a passion for the dissemination and implementation of an empirically supported treatment spoke generally, the third areas of expertise include treatment of borderline personality disorder, eating disorders, substance use disorders, mood disorders and posttraumatic stress disorder and other trauma related concerns and symptoms. We have been honored to have Alyssa on before at regional conferences and NAADAC is delighted to bring you this webinar. Alyssa, if you're ready I will hand it over to you.

>> ALYSSA KALATA: Thank you so much, Samson. Hello and welcome everybody. I'm excited to spend the next hour and a half or so with you today. I have three primary objectives that I would like to get to for today's webinar. First, want to give you talk about effective methods for assessing eating disorders and substance use disorders and direct importance of using this information to make recommendations for an appropriate level of care.

After this webinar I hope you're able to describe at least a couple of strategies for increasing and sustaining motivation for change and hope you'll be able to describe three strategies to treat disorders concurrently.

We will cover a lot of ground today in terms of assessment and treatment strategies and I'm a firm believer you cannot do good eating as disorders work unless you've taken time to examine police you may hold about eating disorders and beliefs you have about food and body weight and shape.

The Academy for Eating Disorders is a wonderful resource for persons wanted to learn about eating disorders and put together the nice if a graphic that will be helpful to review. Their main points I want you to take away.

It is important to understand the eating disorders are biologically and genetically influenced illnesses rather than choices and families do not cause eating disorders. It is important that eating disorders affect all individuals with identities and backgrounds and you cannot tell if someone has an eating disorder simply by their outward appearance.

Before we get into discussing how to go about assessing for an eating disorder, I want to get a sense how frequently you encounter patients diagnosed with an eating disorder in your work. This is appalling question we will do.

>> MODERATOR: Thank you, Alyssa. You will see the polling question pop up in your screen in a moment. The question asks approximate what percentage of the patients with whom you work or diagnosed with an eating disorder? There are five options. Please select one that is closest to your experience.

As a reminder answering that question, you can continue to send in questions for our presenter in the questions box of the go to webinar control panel and have a live Q&A towards the end of the webinar and ask your questions in the order they are received. If you're curious how to get your continuing education hours and certificate hours, stay tuned for the end of the webinar after brief note from our sponsor RecoveryRecord.

Almost 30 seconds have passed and 70% of answered. I will give you five more seconds to answer this poll. I will show the results and turn it back over to Alyssa.

>> ALYSSA KALATA: I'm looking at the poll results. Some folks are working with eating disorders and not a lot of your caseloads are made up but we see some folks see people more frequently. This will be interesting when you look at the data on the next slide to get a sense how common eating disorders and substance use disorders occur.

Give me just a second. My slide might be frozen. When we look at individuals who present with primary substance use disorder, 35% will meet criteria for an eating disorder. Something important to note about these folks is they present with a greater severity of substance use. When we look at individuals diagnosed with an eating disorder, 50% meet criteria for substance use disorder and they present with worse eating disorder symptomology. Part when we look at specific comorbidity, these folk tend to have more severe medical complications and additional and more severe psychiatric co-morbidities and high rates of suicide and suicide attempts.

Given that eating disorders and substance use disorder coworker so frequently it is important when working with a patient diagnosed with a disorder you're taking time to screen for the other group of disorders. When we look at eating disorders the two most commonly screeners are the SCOFF and ESP.

For alcohol use disorders, GAGE, AUDIT and TWEAK are more well known in the screening was developed by the health organization.

Since you may not have seen what a screen for eating disorders look like want to give you a chance to speak at the SCOFF. It is a five question screener you can identify people who meet criteria for anorexia nervosa or bulimia. When you take a look at that psychometric properties of SCOFF and some answers to two more questions and has 100% sensitivity for identifying individuals with anorexia nervosa or bulimia but 12.5% of false/positive. You have a sensitive tools that is quite accurate and something you can incorporate into your practice.

In addition to some screening tools we took a look at, there are more elaborate quantitative measures you can use as part of your assessment process. Put these tools help with making a more specific diagnosis but assessing local severity of symptoms and providing you with more information about severity of specific symptoms. It is important to note when we look at substance use disorders there are a couple of scales you can use to assess severity withdrawal symptoms that are associated with alcohol use and opioid use.

Additional measures you can incorporate as part of your assessment process. Labs another form of quantitative assessment that can be helpful and identify both present and severity of eating disorders and substance use disorders. The labs recommended will depend on your patient's clinical presentation. Eating disorders includes a urinalysis and toxicology screening, blood chemistry studies and EKG. Other types you can use like stool samples or imaging. Here is a link to the practice guideline for the treatment a patient with eating disorders and is excellent resource you can access for free that summarizes all the different lab test you may administer and what conditions you administer them.

The substance use disorder will vary and lab tests that are liver tests as well as tests for infectious diseases like HIV or hepatitis C. Quantitative assessment is important first step when we talk about assessing co-morbid this you orders and substance use disorders. The most effective tool is your standard clinical interview. It gives you a chance to gather competence of information including information you used to inform level of care as well as giving you a chance to explore potential functions that different behaviors might serve.

If you do not work with patients with an eating disorder before, it can be challenging to know what questions to ask. You see a list of the different behaviors you might want to assess if someone walks through your door and trying to explore the diagnosis of an eating disorder. There is a star next to purging.

The reason is the presence of purging behavior regardless of what the specific eating disorder diagnosis is increases likelihood your patient is potentially using substances.

There are a couple important things to remember when conducting a clinical interview. It is important to recognize eating disorders and substance use disorders our company with great deal of guilt and shame. It is important as a provider your being direct with your patient and nonjudgmental in your assessment process.

The other thing to know in addition to the shame and guilt the patient experience they experience ambivalence about treatment and recovery initially to secrecy or reporting of symptoms. Whenever possible if you get your patient's permission and release of permission, it is helpful to obtain collateral information for family or support to help you round out your assessment of the patient.

I want to highlight the importance of both multidisciplinary assessment and treatment. When working with patients diagnosed with an eating disorder particularly, those complex comorbidity like substance use involve. Typical treatment because of the level care they are seen at should consist of individual therapist, dietitian, psychiatric provider and primary care provider although you might want to include family or couples therapists, group therapist, case manager or dentists as part of the team and some support groups are clinically indicated.

There are both overlapping and distinct elements of what each member of the treatment team is doing which is the importance of ongoing collaboration and care for your patient.

Once you have conducted a comprehensive assessment, use the information to inform what level of care is appropriate for your patient. The practice guideline I mentioned earlier provides a number of criteria you want to take into consideration when China forgot what level of care is good for your patient. Things like the patient's medical status, suicidality, percent of healthy body weight, motivation for recovery, co-occurring disorders, structure needed to eat or gain weight, ability to control compulsive exercise, purging behaviors, environmental stress and geographic availability of treatment.

I imagine many of you on the line are familiar with ASAM for recommendations of level of care and there are similarities between domains used as the ASAM in making your assessment appropriate level of care for a patient with an eating disorder.

You see a slide that summarizes all the different levels of care available for patients diagnosed with an eating disorder. Many of the levels of care parallel levels of care for individuals diagnosed with substance abuse disorder. Something important I highlight and talk about levels of care is a common error that happens is people try to treat patients with an eating disorder at lower level of care when higher level of care is indicated.

This sometimes happens because folks are not aware the guidelines exist that can guide decision-making and sometimes providers do not want to disrupt the patient live or have fears that if they make the recommendation, the patient may not resources to access the appropriate level of care.

Those are real and legitimate concerns. I like to highlight when treating a patient who needs higher level of care and a lower level care, it can prolong suffering and hopelessness about the ability to recover and put them at greater risk for death or significant medical complications as a result of their disorder. No matter what a patient decides about whether they are willing and able and having resources to seek treatment at higher level of care, it is important to provide you give accurate information about the recommendation for the treatment based on the clinical picture.

For the remainder of today's presentation we will periodically revisiting a patient named Alice who is described in the case vignette. You can read along but I will give a brief summary.

[Reading slide]

This is a typical presentation of the type of patient you might see you as both an eating disorder and substance use disorder. Will not review specifics of the criteria for assigning level of care based on your gut instinct, I'm curious what level of care you may guess would be recommended for this patient and then talk about what I recommend and why.

>> MODERATOR: Thank you, Alyssa. I got some messages in question box having trouble accessing the polling question. Something that is not the case because 20% have voted. If you have any other questions including tech questions like difficulty accessing the poll, send that question into the questions box.

We will collect any questions for the presenter and post those to the presenter towards the end of the webinar after a brief demo from our sponsor RecoveryRecord. I will give you five more seconds to answer the poll you should see on your screen. Thank you everyone for your participation in this poll. I will close the poll and show the results in turn this back over to your presenter.

>> ALYSSA KALATA: I think you're probably going to be surprised by the answer to this question. For this patient when I took a look at the level of care guidelines and look at her vignette I would recommend the patient for inpatient level of care. The reason is her blood pressure is low enough that it falls into the category for the recommendation. She had a really significant acute weight decline occurring in a very short period of time. She is not motivated to recover and motivation factors into what level of care you might be recommending.

It is clear she has difficulty meeting her nutritional needs without some additional support and does not access to a support system. She is working a different shift than her roommate which would get in the way of her having adequate support.

Interesting stuff and good to peek at the level of care guidelines. Now that we have talked about how levels of care be determined for patient diagnosed with an eating disorder want to talk through other important considerations when thinking of level of care and appropriate treatment placements for patients with comorbidity.

The first thing is when treating eating disorders and substance use disorders you treat them concurrently whenever possible. With sequential treatment, when disorder it is improving the other disorder is hindered. There's times when you cannot get concurrent treatment and the idea is essential able to progress of patient related have concurrent treatment, do so.

Because of the elevated medical risk that accompany both eating disorders and substance use disorders when occurring together, it is important the treatment of these disorders is multidisciplinary and regardless of the nature of care. It is critical that comorbidity eating disorders and substance use disorders are treated appropriate level of care and duration of time.

We didn't look at the ASAM criteria is what you used to make level of care recommendation for an individual diagnosed with a substance use disorder. The way I think about is use both tools when you are making assessments for level of care for somebody who has comorbidity and I would recommend going with highest level of care recommended by either tool.

As a patient is progressing through levels of care, you want to use those tools to guide decision-making around when it is appropriate for them to transition. As an example for why treating the appropriate length of time is so critical, for individuals diagnosed with anorexia nervosa your discharge from treatment at less than 90% of the estimated body weight the risk of relapse doubles. When you discharge them either at their expected body rate or above it you see the risk for relapse diminish and something to keep in mind.

We have talked about assessment and want to talk about case conceptualization is the next piece in the treatment process. I will present on case conceptualization from behavioral or oriented framework but there are other frameworks you can use.

The idea when using behavioral framework is we're trying to understand what the function or purpose is up the patient's eating disorders behaviors and substance abuse. Sometimes you will see behaviors of different topographies that serve a function. Purging and alcohol use both serving the same function of decreasing anxiety.

Across patient, the same behavior might be serving a different function. Weight loss is one function that both eating disorder behaviors and substance use disorders can serve. They lead to weight loss through mechanisms.

[Reading slide]

These behaviors are maintained and strengthened by negative reinforcement. The patient feels unpleasant emotion, engages in a behavior and intensity of the emotion decreases. This will increase the likelihood that engage in that behavior again in the future. Eating disorder behaviors and substance use so the function of increasing positive emotions. Calmness, contentedness, joy and pride. This is a circumstance where behaviors are maintained and strengthened through positive reinforcement.

The immediate positive consequence makes it likely the behavior will occur again in future. It is worth mentioning with cyclical patterns of behavior like bingeing and purging and restricting cycles, there may be multiple functions that are at play simultaneously. There is a lens for what do you think about eating disorders and substance use disorders. We you think about them as being conceptualized on a picture of under control to overcontrol.

[Reading slide]

Craving and loss of control and repeated attempts to stop behaviors or commonalities you see across all three disorders. When talking about anorexia, this is thought of more as a disorder of overcontrol where treatment includes emotional expressive and behavioral flexibility.

We will spend the remainder of today's webinar focused on treatment interventions and strategies. I wanted to get a sense of the orientation of everyone in the room.

>> MODERATOR: Thank you, Alyssa. You will see the polling question launch. What is your theoretical orientation? There are five answer options. It looks like the majority of our audience has been and will access the poll and if you are having technical issues. It may be showing up in a part of your screen. Take a moment and make it larger so you can see the full question and then you can answer that question.

Continue to send in your content related questions and thank you for those who have. Questions for Alyssa on this topic, we will ask in the order in which they have been received in live Q&A. I will give you five more seconds to answer the polling question you see on your screen.

>> MODERATOR: We will close the poll and showed the results in alternate back over to your presenter.

>> ALYSSA KALATA: What we covered today will resonate to a lot of you giving the overall clinical orientations in the room. For some folks it will be new information. A good to have a sense who is here.

To highlight what we're covering for the remainder of today's presentation, we will talk mostly about interventions that are drawn from DBT. The reason we are focusing on DBT is one of only two innovations today and that is therapy that shows efficacy in treating eating disorders and substance use disorders as a comorbidity. It is important to know that DBT has demonstrated equity and treats the disorders independently.

When we talk about eating disorders and substance use disorders as comorbidity they are incredibly complicated comorbidity and providers have struggled to forget how to treat these two

disorders when occurring together. A lot of what we're doing is forging new territory in terms of treatment.

Everybody is familiar with therapeutic relationship and psychotherapy broadly but there specific aspects that warrant special consideration when talk about working with patients diagnosed with it eating disorder and substance use disorder. What I found fascinating is there little research done on therapeutic relationship in the treatment of eating disorders. If you work with a patient diagnosed with an eating disorder, you've seen a number of interpersonal dynamics come up like lack of social connectedness and comparing themselves to others, problems with assertiveness in general interpersonal discord.

Is a variation on dialectical therapy called radically open Dialectical Behavior Therapy developed for the treatment of disorders of overcontrol which include anorexia.

There are number of recommendations made in terms of therapeutic approach taken by a provider when working with people who are more over controlled in nature. There is emphasis on actively and properly responding to alliance ruptures. And DBT encourages their phytic style that is relaxed and playful and responsive.

There is conscious attention to the patient being treated equal. part of what we're trying to do is providers is model the same behaviors we want the patient to develop of the course of time. Will look at substance use disorders there are two primary researchers in the DBT world and they spoke more specifically to challenges associated with establishing and strengthening therapeutic relationship with the individual diagnosed with those disorders.

The way they do it is like butterflies. They described them as patients who flit in and out of treatment which look like missed therapy sessions, unanswered phone calls or dropping out of

treatment entirely. They have a number of recommendations for working with the butterfly patients. Openly discussing the butterfly attachment problem is a potential concern and coming up with just in case plan that outlines who the therapist can contact to reengage the patient in the event they were falling off the radar.

Increasing in between session contact through phone calls or emails. If it is clinically appropriate and okay in the treatment setting to meet with patients for the session outside of the office.

As part of the process of establishing a therapeutic relationship, one thing important is being curious about your patient as a person and help your patient to define what they consider to be their life worth living.

Our patients need compelling why to begin to consider how when it comes to making these incredibly painful and anxiety provoking changes we ask them as providers to make in their lives. This is where values come in.

From eating order disorder standpoint values are helpful and including number and significance of different domains for self-evaluation which helps your patient develop an identity outside of their eating disorder.

From substance use disorder standpoint, helping our patients clarify values and structure their time and activities in alignment with their values can address key triggers for substance abuse like boredom and loneliness. In doing work with the patient, can help with process of developing discrepancy between what their stated values are in their current behaviors are and help them explore ways they're eating disorder of substance use might be preventing increased alignment with behaviors and values.

There are a number of ways I like to explore values with patients. I like a writing exercise you have patients describe who they want to be in relation to other people as a family member, friend and who they want to be in terms of their career and education, personal growth, spirituality, citizenship, leisure and personal well-being. It is a great way to get a rich picture of your patient was to be as a person.

Another useful activity is the personal values card sort. It has a patient place different qualities like adventure or comfort or contribution to different qualities they want to define their life. It's three different categories. Very important to me, important to me and not at all important to me. Patients that I want to do card sort there's activities you have them circle different qualities they want to bring to their life.

There are a few assessment tools you can use that have patients rate how important life domains are and how they rate themselves in terms of how consistently they are living in the life domain and that tool helps you develop discrepancy between stated values and behaviors.

One important thing about value-based work is not something you do for a couple of sessions and moved to other things. It is a topic that is helpful to introduce at the beginning of treatment and a topic you want to weave throughout treatment. It can be particularly, helpful when you see your patient start to struggle with motivation or ambivalence of after they made progress to revisit and go back to.

DBT has a set of strategies within it that are focused on enhancing motivation for treatment and recovery called commitment strategies. For those familiar with motivational interviewing these strategies dovetail nicely with that. Pros and cons of the strategy that can help patients to examine the benefits and downsides of one or more courses of action. I you strategy the patient expressing ambivalence it about treatment and recovery and one important thing you keep in

mind is you have to be willing to accept your patient may choose the status quo and continue to engage in behaviors or not seek treatment and the strategy to be most effective you have to be open to the possibility.

It is important if using this technique that you're not coming in with an agenda and generally helping the patient tease out pros and cons from their perspective. Playing devil's advocate involves taking up the side of change in the hopes the patient will take up the side of change. One important caveat to strategy is if your patient start to agree with you, is important back down to a different strategy and try to reinforce the commitment to the side of change.

Foot in the door and during the phase techniques are well-known sales tactics in the context of behavioral health. Foot in the door makes an easy request followed by Carter technique where during the face is making the request larger when she will your patient would go to in the back down.

You might be asking a patient ambivalent about getting treatment at a residential level of care and discharging his medical device to commit it to two weeks in treatment but negotiate down a shorter timeframe with a plan to revalue at that time with her treatment is the right thing for them.

Connecting present commitments to prior commitments is if you're working with the patient on outpatient basis and they previously committed seeking high-level treatment of care they continue to lose weight. It would have reminded them of the commitment and holding them to it. Having freedom to choose in the absence of alternatives is one of my favorite strategies.

Honoring the almost all circumstances our patients have write to choose whether they pursue treatment and in all cases that the right to choose whether or not they want to pursue recovery.

Simultaneously our patients are faced with circumstances that feel they have any alternatives and for many of our patients boundaries may been set by loved ones or other individuals in their life that limit their choices. A parents and they cannot go back to college until they get treatment or partner saying they need to end relationship and list the patient gets out.

If I was using this strategy I might say to an adolescent patient is it is completely your choice whether or not you continue to restrict and I know your mom mentioned you cannot go back to school into you complete treatment.

Another strategy that can assist with helping with commitment and many of our patients and with eating disorders can get stuck in black and white and all or nothing thinking. Is a provider we can get stuck in that as well. The idea behind shaping involves being willing to accept smaller commitments and associated actions with the goal working on establishing larger commitment and actions of the course of time. If I'm working with the ambivalent patient struggling with substance use disorder, I'm not choosing to ask them to attend a meeting right off the bat. I can stop asking them to go to one meeting and reflect on their experience with the goal of get in the blink more to the community over the course of time.

Cheerleading and other commitment studies that involve providing individualized encouragement in this strategy aligns well with motivational interview principle organizing patient strength and self-sufficiency.

Agreement on homework is involving a green on a type of activity for patient to complete in between sessions. For patient feeling really ambivalent about treatment and recovery, some of the values we talked about earlier it can be a good option for homework assignments instead of something that is aggressively targeting eating disorder behavior or substance abuse disorder at that time.

In my extensive work with patients diagnosed with eating disorders and substance use disorders I have found even if not willing to work on decreasing the behaviors, they are willing to track those behaviors. They usually have other things they are interested in targeting in the context of treatment. This is where DBT diary cards can be helpful both as a method of ongoing assessment and subtle form of intervention.

Diary cards are tool patients choose to self-monitor behaviors, emotions, thoughts, urges, events and skills they're using to manage different things. There are dozens of variations on diary cards or tools that serve a comparable function. Self-monitoring forms are a recovery record falls in the same category. I like to highlight that function is more important than a specific form. There are a number reasons why diary cards are useful tool in treatment. The process of having patients check things like behaviors, emotions and urges these two positive change. A patient has not bought into targeting and it is still possible that this intervention alone can lead to change even if they say they're not willing to make change.

There is evidence of monitoring alone is a predictor of change when making change when it comes to eating disorder behaviors. Diary cards can help you to effectively and quickly set a session agenda with a patient. Patients who present with co-morbid disorders often complicated clinically. Diary cards give you a nice glance that can help you sort through what things both you and your patient think would be most important to get to in the context of treatment.

There helpful in terms of developing hypotheses about what might be going on and increasing insight and as a tool to kick off chain analysis which is another DBT strategy we will discuss later in the talk today. You want patients completing diary cards on a daily basis which helps get you more accurate information the memory alone might provide.

If you remember Alice from earlier, we fast forward in time. Alice went through inpatient and residential treatment. Now she is down to partial hospitalization level of care. Here is the diary

cards she completed last week. If this is difficult for you to see on the screen, it is one of the three handouts you can download and in the sidebar to get a bigger picture if you think it would be helpful.

I want to orient you to the diary card to give you a sense to what you're looking at. This can be a lot of information to take in if you have never seen one before. At the top of the diary card is her name and the date she started completing the diary card and noted she completed her diary card on a daily basis. On the left side of things of the different behaviors that Alice has agreed to track in the context of treatment.

You see eating disorder behaviors restricting and compulsive exercise. She agreed to track the intensity of her eating disorder thinking. She has agreed to track substance use and whether or not she's taking her medications as prescribed or engaging in some sort of self-care daily. Immediately to the right are her global ratings of the course of a day in terms of emotions she is experiencing. On a scale from 0-5.

You see assessment of how she feels she did in terms of skill use that did and the key for that column is below. On the left-hand corner is brief summary of important summaries that happen throughout the week that she thought were notable. I want to give everybody a minute or two to look this over. Start to think through both what you want to focus on in session if your patient came in with this diary card and any hypothesis you have about what might be driving the behaviors you are seeing.

I will pause at 30 seconds and let everyone take it in and then talk about how I might use this as a tool my session with Alice. What whatever target first are the uses of instances you see on Saturday in the second column from the left-hand side. And some hypotheses I might have about what led to that restriction would be eating of intensity eating disorder thinking emotions like shame at play in difficulties with motivation around both skill use and recovery.

It is a hypothesis I might have but I want to get more detail in session with Alice. If a time to focus on the second target in this session, the next things that might look at her either instance of compulsive exercise you see on Saturday or instance of marijuana use. This is how you use this diary card to think through what might be important things to get to in a session with Alice.

One strategy the majority of DBT's therapists use in assessing get further insight beyond what you can get from the diary card is the chain analysis. Their moment to moment reviews of the emotions, behaviors, bodily sensations, thoughts and environmental events leading up to and follow a target behavior as well as review factors that might have made a patient more vulnerable to the target behavior in the first place.

Some examples of behaviors I might choose to chain when working with a patient might be bingeing, purging, restricting, engaging in compulsive exercise but the options are limitless in terms of different things you might chain with the patient. Once you've done a chain analysis, the next step is due solution and analysis. This is going moment by moment on the chain and trying to identify different DBT's skills you think could address key controlling variables related to the target behavior and coming up with a plan to implement one or two things you identify.

With thing the process of doing chain analysis is creating a movie script. My goal is get such a detailed understanding of what happened for that patient both internally and externally that if I gave in after movie script that is based on the chain analysis, they could act out what happened with a good degree of accuracy. In order to do this, it is really important to avoid leading questions and simply ask questions like what happened next? What thought did you have? What emotion did you experience? You trying to get the patient to tell the story.

After you've done chain analysis, you probably noticed different patterns in terms of emotion and behaviors and bodily sensations and thoughts that come up for your patient. These can be

compiled into a behavior analysis which can be useful in terms of informing treatment planning and figuring out what's most important to work on with your patient in the context of treatment.

Let's look at a chain analysis and solution analysis together. This is where the other two handouts are for you. You have a copy and if it does not show up on your screen, feel free to use that. There is a key for the chain analysis and solution analysis and this is a lot of information to take home. I want you to have something to take home and process on your own time.

Let's walk through it a little bit together. On the left is chain analysis component. On the right is the solution analysis. In this case, we're looking at a specific instance of restriction that Alice had at work. Up at the top is vulnerability factors. Things she identified that she felt made her more vulnerable to engaging in restriction.

She highlighted she did not get enough sleep and experiencing a lot of anxiety about a plan to eat pizza over the weekend. Then you see prompting events. This is what the patient identified as the thing that kicked off the chain for her. The spot she knows the chain went into motion. In this instance, she did not have her usual pair of work pants available and tried on a pair of pants she should not want and while. She found out they did not fit and experienced intense shame and embarrassment.

Then you see below that the different lengths in the chain that go from the prompting event to the behavior itself. What she knows is that breakfast was slow that day. She worries about how she's going to pay her bills and has a lot of thinking how she feels she is getting fat and disgusting and the spotty sensation of feeling her stomach hanging over her waistband.

As she goes through service, she goes to the table to drop off drinks and ends up bumping into a table and one of the drinks spills on the floor. Everybody at the table she was going to serve

looked irritated and she hear someone laughing at a different table. Or start her heart start to race in her cheeks turns red and she notices she starts to feel anxious and feels shame. But she goes to get a replacement drink and she perceives her thighs to be lumpy and gross. Her manager stops or and ask if she can pick up additional tables and she says okay.

I cannot take a morning break if I pick up the tables the need the money and I don't need calories for lunch. This is excited about the prospect put but she agrees and drinks diet coke instead of eating lunch. Below that are different consequences she identified. These are immediate and delayed. Immediately she notices she feels more in control and has the thought if I skipped lunch, may as well skip afternoon snack. But she notices later in the day that she starts to feel she is never going to recover and worry about her treatment team is going to think.

This gives you a detailed picture for Alice of what happened that led her restriction of consequences of that. On the right is the solution analysis. This would take a considerable amount of time to go through so what I like to highlight is the specific skill link to specific spots in the chain. If you look at your key for the chain analysis and solution analysis later, it outlines what the DBT skills are. The main taken point is you want to be linking specific behaviors to specific links on the chain.

Regardless of your orientation, you can incorporate other skills. If you note CBT instead of DBT or you can have A P skills instead of DBT skills. The skills do not have been necessary to be drawn from DBT.

You might have noticed in terms of solutions for the chain we reviewed is they were focused in identifying skills that can be used at different points in the chain. There are other CBT change procedures within DBT that can use to target address behaviors. First is behavioral skills training. In the event a patient did not know skills that are helpful in terms of targeting behaviors or if they knew skills but having difficulty to implement them, behavioral skills training could be

an appropriate intervention. For example, if we take a look back at the chain analysis to the pace reason was when the skills identified that could be helpful. If my patient was not familiar with the skill I could spend time in session providing them education and practicing it together with that patient.

Exposure-based procedures are another critical part of eating disorders work. When working with patients diagnosed with the eating disorder of the many different contexts they have difficulties being exposed to without engaging in eating disorder behaviors and response. Restricting or purging. Some examples could be being faced with fear foods, eating certain type of restaurants, shopping for groceries, trying on clothes and others. Plate with patients diagnosed with eating disorders, is important to identify all the different context they are struggling in and helping them progress through exposure to the situation where there also refraining from engaging in eating disorder behaviors.

For patients who appear to be maintained in part by faulty belief or functions, cognitive modification procedures can be important. They often times struggle with inaccurate beliefs about food and weight and shape and size an important part of treatment involves exploring and challenging those beliefs.

Contingency management involves explaining how behavioral principles might be functioning to maintain ineffective behaviors or punish effective behaviors. One example of contingency management working with adolescents involves elation patient communicating to the parents only eat if the parent purchases diet products and parents agreed to do sue out of fear the child will eat nothing at all.

Contingency management works by helping the parent who continue to purchase nondiet foods for the child figure not contingency to help the child meet their nutritional needs. Limiting certain activity the patient is not able it with a eat or allow an additional activities.

One to assist a patient in achieving absence from eating disorder behaviors and substance use, working on relapse prevention is key. A good spot to start is providing education that relapse is often time is part of the recovery process and the goal when I relapse occurs is returned to adaptive behaviors as soon as possible.

There are a number different topics that fall under relapse prevention umbrella. Cultivating and sustaining motivation for recovery. Reviewing the pros and cons of eating disorders and substance abuse and help with the patient connect with their values and life worth living. Maintaining positive changes involves identifying changes the patient has made in the context of the treatment process and coming out with a plan for maintaining the changes outside of the structure that treatment provides.

Creating structures is another component for eating disorders and substance use disorder in this involves creating both day-to-day structure during downtime as well as thinking through short and long-term goals the patient may want to work on.

Addressing current and potential challenges recognizes for our patients they might be absent from behaviors at the time they're working on relapse prevention planning but still struggling with things like body image distress or co-morbid mental health symptoms. The idea is to help our patient plan in advance how they deal with some of those challenges.

Identified warning signs involves helping patients identify behaviors and symptoms that suggest there on a path to relapse like canceling appointments with providers, avoiding eating with other people, not attending a meeting and weighing themselves regulate and so forth and coming up with a conference of list of those things.

Disordered thinking involves examining thoughts that come up for patients like skipping new change or skipping a meal is no big deal or smoking a little bit of weed is not an issue for me. And exploring if there is alternative perspective on the thoughts to consider.

Having a strong social support network is critical both in terms of eating disorders and substance use disorder recovery. Another element of relapse prevention planning is ensuring patients both have appropriate multidisciplinary team is from the ongoing treatment as well as making sure they have other supports they've identified and connected with outside of treatment.

We know lapses and relapses are a big part of the recovery process. The last step in relapse prevention planning is outlining the steps in the event of a relapse and patients write a letter to themselves in the future when they may have struggled or had a lapse.

There are important things to highlight when talk about relapse prevention. You want to capture all of these different topics in a written relapse prevention plan that you treat is a living document put as the patient is learning more about themselves in the context of recovery, they are updating this document as part of that process and highlighting different things they need to attend to or things that have been helpful.

It can be help for the patient not only have a copy of a relapse prevention plan for themselves but share a copy of it with their treatment team and their support outside of treatment. I hope today's presentation has inspired you to want to learn more about eating disorders. Here are a few different resources that a been helpful for me along the way.

[Reading slide]

These are wonderful organizations that can give you more information about eating disorders. For each of the sites listed here, that have things like education materials, brochures, blog articles, ways to search for providers who specialize in eating disorder carriers and information about additional training. Please peek at these websites. Their awesome and full information that can be simple -- super helpful.

We covered a large volume of information today. I want to leave you with three summary points that hit on key things I hope you take from today's presentation. Eating disorders and substance use disorder commonly co-occur in patients are at increased medical and psychiatric risk. It is important you do a thorough outside disciplinary assessment with these patients.

Multidisciplinary treatment at the right level care for an appropriate duration of time is important for both eating disorders and substance use disorders. And regardless of your erotic orientation there's a lot of strategies you can draw from DBT that you can use to target both eating disorders behaviors and substance use disorder concurrently.

This will be the last of our polling questions for today. The importance of thinking of how you translate what you have learned about in a webinar or live talk into practice. We know the literature on training suggest that training alone does not lead to significant behavior change. In order to use training to impact your day-to-day practice, you have to make a conscious and ongoing effort to do that.

In the spirit of this I wanted to give you a moment today to consider what might do differently in your work as a result of today's webinar.

>> MODERATOR: Thank you, Alyssa. This poll is launching on your screen. As a result of today's webinar, I will. You can continue sending in questions we have a lot and thank you for sending those in. Send them into the questions box and will have a live Q&A in a few moments.

We will make sure to ask your questions in the order in which we have received them.

For those curious about getting your continuing education hours for your CE certificate from this event, stay tuned to the end of the webinar for a brief demo from our sponsor RecoveryRecord. We will give you detailed instructions on how to get the CEs for your NAADAC webinars. We are coming to the end of this poll. We will close the poll and I will turn it back over to Alyssa.

>> ALYSSA KALATA: This is wonderful. I am happy to see some things I see here. When I do training I like to try to give people concrete and practical treatment strategies they can use. I'm glad to see that was the top one. I am excited to see folks want to make changes to their current screening and assessment process. Knowing eating disorders and substance use disorder will occur so frequently and for professionals is critical to screen for this and is awesome to see it as another high response in this poll.

I have a couple of pages of references there are none I want to highlight but this exists. If you want me to send you resources, let me know. I'm happy to share references for eating disorders. I will turn it over.

>> MODERATOR: Thank you so much, Alyssa. Thank you for your valuable expertise on this complicated topic. Now to continue the clinical professional business development for the addiction profession. NAADAC is fortunate to welcome sponsors like RecoveryRecord and Jenna is cofounder of RecoveryRecord. I will turn this over to you. The floor is yours.

>> Fantastic and thank you so much, Samson and Alyssa. That was a powerful presentation. I am Jenna and cofounder of RecoveryRecord my background is clinical psychology, behavior change and I was an instructor at Stanford University and healthcare innovation.

This is my passion is allowing patients to use best practice tools to achieve behavior change and better results. RecoveryRecord platform has been used by 1 million people with eating disorders and we have addiction record RecoveryPath but I share with you today is a quick demo of their RecoveryRecord product and touch on how this can support the practical strategies that Alyssa outlined in her presentation.

The tool has been evaluated in five clinical trials and my information will be made available if you want access to that research. In the spirit of keeping things practical I will dive in.

Here is the patient and clinician and the patient opened up their app and see the provider set a breathing exercise for them to do. There feeling triggered right now. They are documenting the events and knowing what are the triggers that are present in the life right now. The list of triggers is probably different for your clients. And this person was the virtual happy hour.

For eating disorders, we could do a whole presentation on this but is particularly, pertinent at the moment. The information this patient is looking is allowing them to do in the moment processing but they surface two different skills to try to apply right in the moment. The app has around 200 of these skills preloaded into it and it covers DBT and CBT but you can choose an approach that aligns with their set of skills.

We have rules-based engine that surfaces the skills and knowledge or patient to evaluate whether they think that would be valuable for them and the climate are not. You will see in your clinical tool what they are self-monitoring as well as what skills they are planning to find help for are

not. They have affirmation and a puppy high five. It takes some the pain out of the homework of therapy. And in addition to the DBT diary card, meal monitoring is really best practice of eating disorder treatment.

Every meal requires processing. This is classic CBT and monitoring this calorie is like who I was with? Hunger and fullness is a big part of treatment as well as any symptoms. This person had a banana for lunch and a strong urge to binge. Any specific questions pertaining to substance use can be included in this also.

They were assigned some smart goals to work on this week for today. They've been prompted to indicate whether they achieve those goals are not. Those goals are relevant for the eating disorders and addiction and you can set goals for them for they set goals for themselves. We try to keep it in specific measurable achievable smart on that.

And thoughts are urges coming up around the time of the specific meal. And I love the thought in the suggested coping strategy and I will show you the thought diary. I noticed in the poll a lot of you are cognitive behavioral in orientation. This is classic relevant eating disorder record and identifying type of thoughts they may have and actions they are going to take as a next step.

You have the skills that are then relevant to that thought diary. We don't have a lot of time so I will jump over to the practitioner app. As a practitioner, this is like your live feed of your patient's progress. It shows which patients have disorder behaviors or not. What is important is when thinking about technologies, you're not expected to be on this 24/7. You consider office hours in the app and we have patient agreement which is shared and you can contract with your patient that the goal is create accountability but will not be looking at them at realtime.

And you can outline the language you use but you will check these briefly before the session or in session with them. I see the trigger log that patient logged in the moment can provide feedback. That is context based feedback. Other types of interactions you can do is send affirmation image and the end to do a break in the hall of shame is empathy. You can connect with empathy or powerful image.

The patient can link with multiple members -- you can link with any member of the care teams who have the same up-to-date information. That was my rapid fire demo. You can contact me and I be happy to answer any questions you have.

>> MODERATOR: Thank you, Jenna. We have awesome questions coming in for RecoveryRecord and for you, Alyssa. Jenna, thank you for the time and effort you spent on the demo. So much in RecoveryRecord. You will notice additional information in a special link from our sponsor in your chat box and receive automated email from go to webinar that says thank you for attending or sorry you missed.

This email is not an indication of your attendance. Over the last few weeks, videoconferencing systems have experienced numerous errors as result of bandwidth overload and one is that you may receive an email that says sorry you missed. No worries. We monitor attendance using a different system and that email will give you additional information from RecoveryRecord with additional link.

Let's shift to our Q&A. Alyssa's contact information is on the screen. Alyssa we will start with a question for you and have a question Jennifer you right after. Alyssa, the first question is from Jennifer from Florida.

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

>> ALYSSA KALATA: One of the things is when we talk about eating disorders it was recently that opioid use disorders overtook anorexia is the most lethal mental illness. One of the things is we are talking about a disorder that has severe and significant ramifications. It is important from a liability standpoint that we catch this early and being aggressive and addressing it in the practices we work in.

That is one piece. Often times people do not recognize how significant and risky eating disorders can be. Other things I might consider the NEDA website has a lot of great resources that you can reference and bring to your organization as part of that discussion. The main thing is talking about a very severe psychiatric illness that has significant ramifications.

That for me justifies increased focus on targeting that in your practices. I hope that's what your hoping for if not, email me or call me. I will chat further.

>> MODERATOR: Thank you, Alyssa. Jennifer, thank you for the question. The next question is for Jenna, RecoveryRecord from Vicki. Vicki is sending us love the question answers box we love that during the COVID-19 pandemic. This is the best webinar she is taken in years. She asks Jenna, can this app be used for people just with substance use issues or do you have complementary technology similar to this app for people with just substance use disorders?

>> ALYSSA KALATA: Samson, I can comment on that. We use RecoveryRecord in our organization and I love it. For both eating disorders and substance use disorders. I find it to be helpful.

>> I had an audio dropout. My apologies.

>> MODERATOR: Alyssa spoke from experience. Please fill in. If the app can be used with substance use disorder issues or people just dealing with that?

>> Yes. We have a separate app called RecoveryPath. It is free to patients and you find that to be extremely robust and evidence-based. If you have clients that just have substance use disorders with no co-occurring eating disorders that is app I would use. Does a lot of activities that Alyssa mentioned around motivation enhancement and identifying your values and articulating them with respect to recovery and your goals.

A lot of amazing features but to those kinds I would use RecoveryPath but if our client has co-occurring I would use RecoveryRecord make sure is tailored for addressing both of those conditions.

>> MODERATOR: Thank you for the answer and the love in the Q&A box, Vicki. Next question is from Emily. Alyssa, the patient is pregnant and has substance use disorder does it change the recommended level of care? And could eating disorders present differently in pregnant patients?

>> ALYSSA KALATA: That's a really good question. I don't have the ASAM criteria with me now but that is what I reference in terms of the piece around pregnancy and influencing level of care for substance use disorders. I have not worked with a lot of pregnant patients diagnosed with an eating disorder. I don't know if I can comment extensively on that piece.

I have colleagues who've done work so what I would do if it's okay is get in touch with them and include that in the subsequent comment think I will fill out after this book if that is okay, I do not

want to speak out of turn if I do not a lot of expertise on the specific piece. Let me get information back to you.

>> MODERATOR: Great, Alyssa. Anything that maybe requires the presenter pointing you in the right direction or to a link or resource or information like the level of care is great. You can add that in the Q&A document. The next question is for Jenna. This question comes from Donna. I am a counselor at a high school. Is this an app I can recommend to students or it doesn't need to be used alongside with a clinician?

>> Great question. We just wrapped up a 3000 person clinical trial devaluing the app in the self-help capacity. I am pleased to say there is 60% users achieved clinical significant reduction in their eating disorders as result of using the app. Even without other supports.

Eating disorders are serious and require clinical treatment but we found 30% of the users in our platform have never disclosed their eating disorder to anyone before. Now works in civilizing technology and care model where the first step is installing an app. There may be students at your school who have eating disorders and not ready to talk about or tell someone but if they see there is a resource available, we know a lot of people go to the app first put.

You can be confident it is evidence-based. We have probably over 30 student counseling centers around the country using RecoveryRecord extensively with that population. That is the short answer. I'm happy to provide more information if it is helpful.

>> MODERATOR: Jenna, there is a complement to a question along these same lines. We have had a few people ask the same questions about is the app shareable? Is the meal monitoring section you showed on the app, is it shareable with someone's accountability partners, counselors, recovery coaches or is it primarily self-management tool? Is that HIPAA compliant?

>> I think eating disorders and substance use disorder operate in a system of relationships and we think recovery the very same way. We have applications for practitioners and peers and loved ones and is up to the individual and recovery to who they shared their records with an who they stop sharing the records well. It's important they have empowerment and own that process. The provider can install the clinician application and link with their patients. That is an important first step for creating accountability and there might be things are willing to share with you that the not willing to share with a loved one.

[Audio interference]

The pairing is important for accountability and there's a big jump in compliance and engagement when someone links with someone and it does not matter who that someone is as long as is a trusted relationship.

With a clinician, the clinician sees everything but if they link you with a loved one response or the client can choose what aspects of it is shared. That is something to be aware of. As a provider you have full insight into what is happening. Samson what was the last question?

>> MODERATOR: It being HIPAA compliant.

>> We work with health systems around the country and in Europe and compliant with HIPAA and the HITECH Act and we gone through technology assessments so you can have peace of mind. I have to share privacy information in more detail, but, yes.

>> MODERATOR: Thank you, Jenna. I'm switching back to the RecoveryRecord record. Her information is on the slide to reach her. It is on the slide deck if you want to print out the slide deck, it's a print to PDF and you go to this slide and see her email.

Alyssa, we have a few more questions. Some are very similar. Vicki asked where does one find a list of skillfully behaviors you mentioned earlier strategies to use for social analysis?

>> ALYSSA KALATA: The best reference would be marshal and hand skills training manual second edition. That is a great summary of all the different DBT skills. If you email me of a cheat sheet that has one sentence summary of the skills and anyone else can email me and I will share it. Your marshal and hand skills training manual is your best bet. Those who work with adolescents there's a version that Alec Miller and Joe [indiscernible] put together and you can find those through any major book seller.

>> MODERATOR: One more, Alyssa. Many patients are struggling with eating disorders and another addiction that is sort of hidden. The eating disorder itself. Do you think it's better to get clean and sober and abstinent at the same time?

>> ALYSSA KALATA: Absolutely. A lot of times when you are targeting co-occurring disorders like symptoms swapping and one disorder improves you see worsening in the upper disorders. I think is important are targeting both concurrently and if not you see a flip-flop between symptoms from either disorder. It is really important you're taking this holistic approach and targeting all the different things going on for your patient simultaneously versus trying to do in a sequential fashion.

>> MODERATOR: Thank you so much, Alyssa. Your questions are so important to us. Please continue to send in your questions and you have one final chance to ask questions in the survey.

At the end of the webinar, a survey will pop up and being your thank you email from go to webinar. In that survey is an opportunity to ask any final questions for the presenters or for us.

You can give us feedback to help us continue to craft and shape you're learning experience. Now you are wondering about your is CE quiz for the webinar and how to access the recording after the live event. Every NAADAC webinar has its own webpage that houses everything you need to know about that particular webinar.

Immediately following the live event, you will find online CEs quiz link on the website you use to register for this webinar. Everything you need to know about this webinar will be permanently hosted at the website listed on the page. The yellow arrow on the screen says coming soon, that will be an active link within about 10 minutes or so after the webinar and go straight to that page and click that active link to get your CE quiz and receive your continuing education hours.

Here is the schedule for upcoming webinars. Tune in if you can. There are interesting topics with great presenters. The newest national emergency response webinar is on April 29th on psychological first aid during COVID-19. It is presented by Dr. Frederick Dombrowski and be provided in collaboration with the American Mental Health Counselors Association.

The next session of our free peer recovery supports or is April 24th, 2020 on supervision and management. You will see the list of the six webinars in the free series and if you are a peer recovery support specialist work with peer recovery work specialist or in an integrated care setting with the specialist, the series is for you. It is free. Go to the website listed on the slide to register for both upcoming webinar for the ones you missed.

Currently, NAADAC is offering two specialty online training series. Visit the website listed on the slide for more information on this exclusive content. This series is different. Each course cost \$25 to register and most of us know that even the most experienced clinical supervisors in our field admit that clinical supervision in the addiction profession is more complex than general supervision.

There is a wide array of variables to consider in this series provides up-to-date research is a consummate to our newest workbook which is not available in our NAADAC bookstore. This training series and the work is led by Dr. Thomas Dunham and continue to work that Mr. Powell did.

Some of the most respected are also are most vulnerable. As a nation tries to stand down during a national crisis, those with trauma related symptoms in the history of substance use disorder are right now reexperiencing some of the worst fears and trying to manage triggers an ever-changing environment.

This series if presented by Duane France licensed counselor and addiction treatment specialist and retired military combat vet. You can visit the website listed on the slide. AS a NAADAC member this is a quick review of the benefits of becoming a member with us. If you join NAADAC, all of the free educational webinars CEs are freeware nonmembers there is a small processing fee. You will receive reportedly advances were each article is available for CEs and NAADAC offers in person seminars throughout the US and internationally. There are many more benefits.

You can email the website listed on the slide and there many ways to connect with us. As a reminder, a short survey will pop up on your screen at the end. Please take time to give us feedback to share note you have with the presenter or for a sponsor and tell us how we can

improve. Your feedback is super important to us as we continue to work to improve your learning experience.

Thank you for joining us today and, Alyssa, thank you for your incredible expertise on such a challenging topic and RecoveryRecord, Jenna, thank you for your sponsorship. I encourage you to take time to browse our website and learn how NAADAC helps others. You can stay connected with us on LinkedIn, Facebook and Twitter. Have a great day everyone.

[End]