

TITLE: Treating Eating Disorders: Importance of an Interdisciplinary Approach Across the Spectrum of Care
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Host: Hello, everyone, and welcome to today's webinar, Treating Eating Disorders: The Importance of an Interdisciplinary Approach Across the Spectrum of Care. This webinar is paid for by McLean Hospital, a top-ranked freestanding psychiatric hospital, a leader in psychiatric care, research, and education, and the largest psychiatric teaching hospital of Harvard Medical School.

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Next, today's program does not offer CE. However, we will email everyone watching live today a Certificate of Attendance. Certificates will only be issued to those who watch for a minimum of 45 minute. A recording of the presentation will be emailed to everyone within the next two weeks. That email will also include a copy of today's presentation slides.

During our time together, you will be on mute. If you would like to communicate with us, you can use the Q&A box located on your webinar screen. If you have a question for our presenters, please type it in using that Q&A box, and we will address it during the Q&A portion towards the end of the hour. A link to the presentation slides will be posted in the chat box, and if you miss them, we will email them to you along with the recording within the next two weeks. With that, I would like to introduce today's presenters.

First, we have Dr. David Alperovitz. He earned his doctorate in clinical psychology from the Massachusetts School of Professional Psychology and is an assistant professor of psychology in the Department of Psychiatry at Harvard Medical School. He has over 25 years of experience working at McLean Hospital, primarily with individuals with OCD, eating disorders, trauma histories, and dissociative symptoms. He has maintained a private practice treating adolescents and adults for close to 20 years. He joined the staff at McLean's OCD Institute as a behavioral therapist in 2018 and is currently the program director of the Klarman Eating Disorders Center at McLean Hospital.

We also have Dr. Holly Peek. Dr. Peek received her medical degree and a dual master of public health degree from Tulane University. She is board-certified in both adult and child psychiatry by the American Board of Psychiatry and Neurology. She also has a private practice in which she specializes in child, adolescent, and adult psychotherapy and medication evaluation and management. She is an instructor in psychiatry at Harvard Medical School and serves as the assistant medical director for the Klarman Eating Disorders Center at McLean. Welcome to you both.

David Alperovitz: Thank you.

Holly Peek: Thank you. Great. I think you've handed over the power of the slides to me, so I'm waiting for it to kick in. What we're going to start with is a basic introduction about the different eating disorders and the DSM-5 criteria for the most common eating disorders that we see. There we go. All right.

We'll start with anorexia nervosa. DSM-5 criteria of anorexia nervosa is a restriction of food intake relative to what somebody's energy requirements might be to maintain homeostasis in their body, leading to a significantly low body weight. The DSM defines low body weight using BMI. They rank it mild, moderate, severe, extreme based on BMI. Anywhere from BMI of 17 to 18 might be a mild anorexia, all the way down to extreme, which might be a BMI of 14 or 15.

Psychologically, there is an intense fear of gaining weight or becoming fat and persistent behaviors that interfere with the weight gain. That might not only be restriction of food intake, but it could also be excessive exercise. It could even be purging. It could be fasting. Any sort of behaviors interfering with weight gain.

Also psychologically, there is a body image disturbance. What these patients see in the mirror may not be what or what objectively medically that we see. There is a lot of influence of body weight and shape on their self-evaluation and their identity. There can be this lack of recognition of the seriousness of the disease. Like I said, you might see an individual that looks incredibly emaciated, and they may see themselves as overweight and still needing to lose weight.

Slide delay. Again, going back to the BMI leads to severity, according to the DSM, and then we also have the subtypes of anorexia, both the restricting type and the binge-purge type. The binge-purge type of anorexia, it still meets criteria for anorexia in terms of the low body weight, primarily food restriction, but there may be occasional bingeing and purging episodes as part of their anorexia.

In the next slide, there we go, is avoidant/restrictive food intake disorder, or ARFID. Now, medically, these patients are also underweight, and this is also a restrictive type eating disorder, but the psychological underpinnings of it and how it presents is very different than anorexia. The criteria for ARFID is a failure to meet appropriate nutritional needs associated with significant weight loss, some sort of nutritional deficiency, and maybe even a dependence on oral nutritional supplements or NG tube feeds.

The psychological underpinning of ARFID is very different in that the weight loss in the restrictive of food intake, there's no body image component or no desire to control weight, shape, or size. It can be a variety of other things, like a lack of interest in food, avoidance of food based on sensory characteristics. If you think of somebody on the autism spectrum disorder that has sensory sensitivities, that would be an example of someone who might be at risk for ARFID. If you think of somebody with a metaphobia, fear of throwing up, they may avoid eating because they're worried that they're going to choke or throw up. That might be a typical presentation we see of ARFID. Medically, it could look very similar to anorexia in terms of the malnourishment and the need to refeed piece, but our approach to treatment will look very different.

Next slide is bulimia nervosa. DSM-5 criteria is recurrent episodes of binge eating followed by some sort of compensatory behavior. Now, that's often bingeing and purging, self-induced vomiting, but it doesn't necessarily have to be. It can be bingeing and a misuse of laxatives. It can be bingeing and restricting. It can be bingeing and excessive exercise. Just think of it as the cycle of bingeing and some sort of compensatory behavior. Often purging, but it doesn't have to be.

There is a body image component of bulimia. These patients are often trying to lose weight and controlling their shape and size. Medically, they're often of normal weight, maybe even overweight, depending on how much bingeing is part of the picture. They don't typically have the low-weight component that we see in anorexia. The severity is based on the number of compensatory behaviors we see per week.

Then finally, we have binge eating disorder, which is just recurrent episodes of binge eating. Now, the DSM doesn't give a caloric value necessarily of what a binge might be, but you can think of it on something on the order of like hundreds, if not thousands, of calories at a time. The DSM does define bingeing as eating rapidly, eating until uncomfortably full, eating large amounts when you're not hungry. People may be eating alone because they're embarrassed. There's a lot of guilt and shame and disgust involved with it, and it can impact a lot of distress when the binge eating is present and after the binge eating.

The difference between binge eating disorder and bulimia is that with binge eating, there's no regular use of compensatory behaviors. Now, these patients may have, restrict at times, or they might diet at times if they're trying to lose weight or they're having health problems, but the primary thing that we're seeing in their pathology is the binge eating, no regular compensatory behaviors.

Then finally, we have OSFED, which stands for other specified feeding or eating disorders. Here, these five bullet points are different diagnoses that fall under the category of OSFED. Really, what I want to highlight is atypical anorexia, which ironically is more typical than anorexia nervosa and much more common than anorexia nervosa, yet it can fly under the radar often. It's really important that we're familiar with the diagnosis of atypical anorexia. OSFED is actually the most common eating disorder diagnosis because you can see a lot of things fall under that category.

Like I said, atypical anorexia is more common than anorexia nervosa. Basically, it is meeting all the criteria for anorexia except for the low-weight component. They may restrict their food intake relative to their needs. They may be engaging in other behaviors that interfere with weight gain. There could be a body image component of really trying to control the weight and size. On paper and objectively, their BMI might look normal. What's important to know is that these patients can be just as malnourished and psychologically and medically impaired as patients with anorexia nervosa.

For example, let's say someone is 190 pounds, which is overweight for their body type. The doctor says, "Hey, you need to lose weight." They say, "Okay." Then they lose 30 pounds in three months without getting bariatric surgery or any other interventions. On paper, weighing 160 pounds, maybe that's a perfect weight for their body type. The problem is they lost 30 pounds in three months and likely using pretty

unhealthy means to do so. It's that rate of weight loss that can actually be pretty dangerous. They can still be at risk for signs and symptoms of malnourishment as well as refeeding syndrome. It's really important to know that this is pretty common and these patients fly under the radar often.

Finally, when we're talking about diagnostics, it's really important to recognize this issue of eating disorders in people of color, something else that often flies under the radar. Stereotypically, eating disorders can often be thought of as a White female's disease, and it can be further from the truth. Really, there are actually similar rates of eating disorders among White, Hispanic, Black, and Asian people in the US, but people of color are much less likely to receive help for their issues because they are underdiagnosed and not recognized.

This study demonstrated this nicely. There was a case study that was presented to three different groups of clinicians. In the first group, the case study, it was a White woman. In the second group, the case study, it was a Hispanic woman. In the third group, the case study was a Black woman. Same details of the case. As you can see in that first group when it was a White woman, 44% of the clinicians said, "Hey, this eating behavior is problematic. They're at risk for an eating disorder." When it was a Black woman, only 17% of the clinicians identified this as being problematic eating behavior.

It really demonstrates how our biases play a role in diagnosis and even funneling people into treatment, which is even more of a problem because that can lead to worse outcomes, worse health outcomes. Something also to be very mindful of as we're thinking of diagnosis. All right, hand it over to David.

David: Okay, thank you, Holly. I'll wait for the slides to come over to me. I think I'll be able to drive them shortly. I'll say one thing about the OSFED that Holly was just mentioning. I think in the DSM-5-TR is where OSFED really came into being and it replaced what was previously known as eating disorders not otherwise specified. I think it was a really good advance because I think the not otherwise specified category really led people to minimize the seriousness and significance and prevalence of people that might not fall neatly into the constructed boxes that were already existing.

People that do struggle from one of the OSFED diagnoses can be quite serious illnesses. I think that's given good credence with the new DSM. It's really important not to just see them as something less significant or less prevalent as Holly mentioned. Actually, atypical anorexia is more prevalent. I'm going to transition into determining level of care. Hopefully, I can drive here.

There we go. Okay, slight delay. I'll talk about this from least intensive, from outpatient all the way through inpatient, and go through sort of a continuum. What I'll say at the outset is throughout these different sort of continuums of care, one thing remains consistent and constant. That's the importance of both working as an interdisciplinary team. We'll talk more about that in a little bit, but also the communication between the levels of care, primarily with the outpatient team and the team at a higher level of care.

Starting with intensive outpatient, and this is a funny term, most of you are probably familiar with this, but intensive outpatient sounds like it's a really intensive treatment, but it's actually less intense than what we're going to talk about in a moment, partial hospital, which doesn't sound so intense. It sounds like it's partial of something.

The language is a little misleading, but intensive outpatient is essentially for people that are medically stable, they're not at a significantly low body weight. They're also primarily psychiatrically stable. They don't need to be taken away from their lives to enter treatment. Their symptoms are under some control, but they may need some more support in order to gain more control over their symptoms.

These programs, usually are group programs with some individual meetings, family meetings, and some supervised meals. They can be three to four groups a day from anywhere from three to four days a week. While people are in IOP programs, they're often still seeing their outpatient providers, dieticians, therapists, psychiatrists as well.

Outpatient is actually even a little bit more removed on the continuum. It's really living your life, going to work, school, doing whatever you may do, volunteering, and seeing a treatment team. This is sort of where we'll first begin to talk about the importance of a multidisciplinary treatment team. I've been working with Eating Source for 15 years. Sometimes people will refer to me as an expert and I'll sort of look at them like they have two heads. I think there's this misnomer that in order to work with eating disorders, you need to be this expert in eating disorders.

It's very intimidating to a lot of people because I think it scares a lot of people away from working with people that struggle with weight, shape, size, body. It's really not true. You work within a team. I do not need to be an expert in all the medical issues, all the nutritional issues, all the medicines. That's really working in a team. I have to have a working knowledge and be familiar with some of the underpinnings and ideology of eating disorders and the treatments, but I don't have to hold everything. This is a very, very painful disorder. It takes a lot of courage for people to fight. It really is, there is a real strength in numbers in working together as a team.

Currently, what we think of as sort of an ideal team, and this doesn't always happen, but there's an individual primary therapist, often a family therapist who is a separate person ideally from the individual therapist, a dietician who will really be sort of running meal planning and nutritional needs, psychiatrist doing medications, and a primary care doctor who may be meeting regularly with them, collecting labs, making sure they're physically okay, vital signs, things like that as needed. Then sometimes there are adjunctive treatments that may fit in. If someone has a coexisting disorder like OCD, they may see an adjunctive therapist and do some ERP, or if it may be around substance abuse, adjunctive therapy can also be very helpful.

Partial hospitalization is a step up in level of care. Now, this is five to seven days a week, more robust days, nine to three. Patient is still medically stable, and their body weight is still sort of not too compromised. They're meeting their basic nutritional needs, but it's an effort. The eating really impairs their ability to function and attend to other meaningful activities in their life. They actually have to take time during the week to get into treatment, right? This might disrupt things like work, school, family relationships.

They're engaged in their eating disorder behaviors, and I'll use that term generally because people are coming in with various different experiences to an extent that it's interfering with their lives. They actually need to devote a thoughtful and serious period of time to look at that. That's what partial hospitalization is. They're still medically stable.

Now, when we get to residential, they really are being removed from their lives and they're not living at home. They have to come into a facility at 7 days a week, 24 hours a day. Ideally, people are medically stable. There are some programs that will have NG tubes that are considered residential programs, but most of them do not do that. People are not in real need of IV fluids for all practical purposes, their vital signs, EKGs are stable. They have fair motivation, and it's an interesting word. I think there's always a great deal of ambivalence in facing eating disorders. I think the vast majority of people all want to get better and feel better, but some of the work that it is involving to get better, there's a good degree of ambivalence about that. Motivation can really vary, even by day.

When people are in a residential program, they really need that 24/7 supervision. They really do need a profound support from others to refrain from using behaviors and to change their own behaviors more towards recovery. Usually, residential is something that's been tried after other levels have failed. Again, that's in an effort to primarily keep people as connected to their lives as is possible.

Finally, inpatient, which can take a couple of different forms, either, sort of psychiatric inpatient or medical inpatient. Here, the patient is not medically stable and may not be psychiatrically stable. This could be represented by vital signs, an abnormal EKG, lab results, and significant psychological distress, and a real inability to refrain from eating disorder behaviors. They need more supervision, more support, both during and after meals and around the clock. There may also be concurrent suicidality, which may also dictate inpatient hospitalization as well.

Okay, I'm going to transition into talking around the types of therapy associated with eating disorders. This is an interesting topic because I'm going to just sort of say there needs to be more research, both into the treatments of eating disorders, the etiology, the prevalence. If you look at eating disorders compared to schizophrenia, there was a recent study that for every \$76 that's spent researching eating disorders, \$86 is spent researching schizophrenia. A huge difference.

With that caveat in mind, there is not great evidence for all of the therapies that we know to be helpful for eating disorders. We need to do a better job. We need to research them more. All the therapies I'm going to talk about have some research that supports them. Some of them are evidence-based. Some clearly anecdotally we know work and have some research evidence to support it, but we need more evidence. I always put a plug in and get on my high horse about trying to fund more research around all aspects of eating disorders.

I'll talk through some of these generally because this may be a review for a lot of people. Acceptance and commitment therapy is one that I'm quite fond of, ACT. It's really focused on changing our actions, our behaviors, rather than our thoughts and our feelings. We don't have control over what we think and feel. Those things come

into us. What we do with them, our behaviors, is where we have opportunity to change.

The change that ACT really promotes is in keeping with our core values, things that are of meaning and deep, significant meaning to us. With eating disorders, where there's often typically an anxiety base and fear may be driving behaviors, this is very different. It's letting the values and meaningful activity drive the behaviors. It provides a very good underlying rationale for why people would do difficult work because they want to get to the good stuff that they find meaningful.

It really, really works on helping people to bear difficult emotions, and that that's part of life, and pain and anxiety are a normal part of life. We don't pathologize thoughts and feelings. They are what they are, but our ability to bear them and make choices in keeping with our values is really what the therapy is about. When people do that, they often start to feel better.

Cognitive behavioral therapy is a broad umbrella. I won't go into depth, but in essence, it's postulating that the psychological problems that underpin a eating disorder, in part, are based on faulty or distorted ways of thinking, and psychological problems are based on learned and repetitive patterns of unhelpful behavior that can become a way of life and so familiar that they just become ingrained. That the people who are suffering in these situations can really be relieved of their symptoms and lead much more effective lives and learn different ways of coping with them through various strategies using cognitive behavioral techniques to challenge and look at what they're thinking, feeling, and then ultimately doing.

I won't go too into depth about CBT-E. It's essentially a cognitive behavioral therapy that has a lot of the same principles of CBT, but it's primarily focused on eating disorders. It's generally time-limited. Most often, it's done on an outpatient basis, but it does have good efficacy, both with anorexia and bulimia in particular. It's a little bit more narrow in the focus towards eating disorders.

DBT therapy is also a very, very useful therapy for many, many different psychiatric disorders, but it's essentially a behavioral treatment, and there's good empirical evidence for binge eating and bulimia as well as anorexia. It's a way of allowing people through basically four different modalities, interpersonal skills, distress tolerance skills, emotion regulations, all with a sort of central component of mindfulness. It's a skill-based therapy in really helping people begin to change their behaviors. It's really looking at shifting maladaptive behaviors to more adaptive behaviors. There's some parallels there, as you can hear me saying about ACT. I will always add in the value-based component of some of the changing behaviors that people are striving for.

Family-based treatment or FBT, commonly known as the Maudsley Method or Maudsley Approach. It's a very effective treatment, primarily for adolescents and younger folks. This is a home-based treatment, and it's not really focused on the root causes or underpinnings of the eating disorders, but it's a very behavioral process really focused on refeeding and restoring weight.

To that end, all the family members are an essential part of the treatment team, which essentially is focused on reestablishing regular and healthy eating, restoring

weight, and really interrupting any compensatory behaviors that might be present. Ultimately the goal, again, is to return to eating back to the control of the adolescence and focusing on the remaining issues.

Interpersonal psychotherapy, again, another evidence-based treatment both for bulimia and binge eating. This is really looking at interpersonal struggles at the root of the problem. They really are looking to resolve those interpersonal struggles, and they tend to fall in four areas. Interpersonal role disputes, transitions in life, interpersonal deficits, as well as grief. Then the final stage is really around maintenance of recovery and relapse prevention.

Finally, psychodynamic therapy, I think also really has a place with eating disorders, although I feel and worry a little bit that it's losing its hold and favor, but I think fundamentally really is useful, particularly in formulating some of the underpinnings of an eating disorder. This really does differ where the root causes of the behavior are important, and understanding them are quite critical in terms of moving forward in a different way.

If you were to not address some of the underlying root causes of the behaviors, progress wouldn't be possible. Symptoms and disrespect are viewed as expressions of their underlying needs and issues and thought to be resolved through working through. Now, I'm going to turn back over to Holly, but I'll keep driving. We've touched a little bit on the interdisciplinary team, but I'll turn it back over to Holly.

Holly: Yes, so David, I found myself thinking as you were going over these different modalities of therapy, there's probably a lot of people on this webinar who specialize in each of these modalities who may or may not treat eating disorders. I think one of our take-home messages here is that you don't have to be a "eating disorder specialist" in order to treat what, in many cases, are these complicated cases.

Patients with eating disorders can be multifaceted and have different areas of struggle. It's important to be able to work within a team and everyone holding a different piece. With everyone holding a different piece, let's say the therapist holding the therapy piece, whether it be ACT or CBT or DBT, while the dietician takes care of the nutritional piece, the psychiatrist takes care of the medication piece, you have a medical management, all of these different pieces come together to form a comprehensive treatment team and each holding a different piece.

It can sometimes feel like it's too much to hold alone. Who knows all the nutritional, the medical, the therapy, and the psychiatric piece for any disorder? Nobody, but I think in working with eating disorders, the importance is a desire to work within a team to treat what might be these complex cases and to have a way to communicate with one another that is secure and also easy to communicate to because I know sometimes it can be really hard to call a number of providers.

We can talk about some strategies for communication too that can streamline how to work on a team. Really, this slide demonstrates again what we would call like maybe an ideal treatment team. I realize not in all cases, maybe not all of these pieces are covered, but ideally, you do have this individual therapist, a family therapist, particularly for kids, adolescents, and young adults where families really can play a role.

An eating disorder-specialized dietician. I'd say not all dietitians are created equally in terms of their specialization. Maybe having a more specialized dietitian who knows how to treat eating disorders can be important. A psychiatrist, a medical management provider who's ordering the labs and the EKGs and monitoring the medical piece. All those folks can talk together in order to each hold their piece of the treatment puzzle. You can go to the next slide.

Like I said, these patients can be challenging for anyone to treat alone, but as a member of a team, oftentimes, there's not as much of difference between treating an eating disorder patient and non-eating disorder patient, other than knowing some of the nuances of what people are doing among the team and having a basic understanding of their roles. It does require this multidisciplinary involvement in order to hold all these pieces. I sometimes think of eating disorders as a psychological issue that can have severe medical consequences. You have to have an understanding of what can happen in each person holding that piece of care and to communicate.

I often, when I work in outpatients, with outpatients as well as in residential, always communicating via secure email, and there are other secure methods that people can communicate as Microsoft Teams as an example or a secure email that doesn't take that much time or energy. I'd say the most communication happens when something significant happens in the-- and we have a case upcoming that can demonstrate it, but something significant happens like transition in level of care, or if someone has a concern about something, I'd say that's mostly when the communication occurs, but it can actually work quite seamlessly as a member of a team.

David: I'll jump in, Holly, because I really want to underscore, I think the broad majority of the audience are psychologists and probably tending to find themselves in the individual therapist role. I was at a conference with a multidisciplinary eating disorders association in the spring, and they were talking about how there really aren't enough individual therapist providers to cover the vast needs of eating disorder patients.

I think in part, that's because people may be a little timid to enter in, feeling like they need to be the supposed expert, but one of the discussions that followed was, well, what does it take to work with eating disorders? Essentially, all of the basic sort of core principles of good psychotherapy apply, building or a curiosity, being kind and curious, and at best, to be able to gain a perspective, not an exact perspective, but a good understanding of what it's like to walk in someone's shoes.

That's what I tell people to look for if they're interviewing potential therapists. That doesn't describe sort of someone who should be an expert, that describes a good therapist, and someone who's willing to, because eating disorders appear and present in so many different ways, you really have to understand them on an individual level. Again, the aspects and importance of working in a team really dovetail nicely with that need not to be an expert in some ways.

Holly: Next slide. Okay, so we'll do a brief case presentation about what it might look like to be a member of a team and working with a specific case. In this example, we have a 17-year-old female with a history of anorexia. She's currently at her healthy

weight at 130 pounds, has high urges to restrict, and struggling with her body image, but she's seeing her outpatient team, maintaining weight, and functioning well in her life and able to manage having these urges and being in her life.

What the outpatient interdisciplinary team looks like at this level would be seeing her individual therapy once a week, dietician once a week, psychiatrist once a month, family therapist once a week. She's at the point right now, she's been pretty medically stable, just seeing the PCP every few months for labs and vital signs. The team is just giving periodic email updates to each other to update on their respective progress and their treatments.

Next slide. In this case, as what can happen when there are relapsing and illnesses involved, let's say, two weeks later, this individual was pretty stable in her life, but two weeks later, the dietician actually notes when getting a weight in her office that the patient lost 8 pounds in the last two weeks. The dietician alerts the other team members via secure email like, "Hey, something's going on, there's a pretty significant weight loss." The PCP sees this and makes an appointment to see the patient for labs and vitals, notes that labs in the EKG are stable, we're having some mild orthostasis, but we're doing okay right now, we're not looking at medical hospitalization.

The therapist hearing from the dietician that there's this weight loss is curious with the patient, "What's going on? What's been going on for the last couple of weeks that may have led to this relapse in behavior?" The therapist learns that there's been this big recent disappointment with a college rejection leading to the increased food restriction and worsening and depression and anxiety symptoms as well.

They continue to work on alternative coping strategies together about how to manage this depression and anxiety. The team together has decided like, "Look, things aren't looking too great right now, but we're all doing our part, let's give this patient one more week to stabilize her weight, or we may need to look at a higher level of care." They left it at that.

One week later, the patient went to the PCP appointment for another weight and vitals and actually saw that the weight did not stabilize and the weight has dropped another 4 pounds. The heart rate has actually dropped to 45, and she's dizzy when she's standing and having some orthostatic vital signs. The family therapist chimes in and says, "Hey, the parents are actually noticing that they're hearing some noises in her room at night and she's been secretly exercising in the middle of the night for what may be hours. The parents have seen food in the trash, so she's not completing her meal plan and she's really not eating unless directly supervised by the parents."

The patient is reporting to both the therapist and the psychiatrist, like increasing hopelessness, really starting to have passive suicidal thoughts, but willing to work with the team and maintain their safety. Given all these components, the medical piece, the nutritional piece not being met, and the work with the therapist and psychiatrist who are a little bit more worried about safety, the team decides together, "Hey, it may be appropriate to step up to a residential level of care right now for many reasons we talked about before when we were talking levels of care."

Then one week later, the patient is admitted to the residential facility and works with a residential team. Now, a residential team can often mirror an outpatient team, and here at Klarman, for example, everyone has an individual therapist, a dietician, a psychiatrist, a family therapist, working in their role as an interdisciplinary team and communicating with their outpatient counterparts so that they have this collateral information and are aligned on goals and what we need to see to step back down to outpatient level of care.

The patient is at the residential level of care for four weeks, she's successfully weight restored, we've seen an improvement in her depression and anxiety, able to demonstrate more independence in eating when she's going on passes in the community. The high urges to restrict her are still there, but she's able to use alternative skills to not engage in the behavior.

Then at that point, she steps down to the partial hospitalization and then finally back to IOP and outpatient and then resumes care with the outpatient team. You can see the cycle of communication. All the different members of the team communicating and holding their pieces, moving up and down the levels of care as would be clinically indicated. It can seem like a lot and really stressful when these patients are struggling, but with each team member holding their part, it can feel more manageable.

David: I'll just add in a little bit there that throughout this continuum that Dr. Peek is discussing, there's a couple of things that I think remain consistent, and that each discipline is working hard within their areas of expertise, and again, if this is an audience primarily of psychologists that may be doing therapy, I'll just personally say that the most successful therapies that I've engaged in really have very little discussion around food, and often very little discussion around weight, shape, and size.

It has a role and a place, but really, some of the more profound struggles, the things behind dissatisfaction with body, the struggles to eat are really what we focus on, which may be more anxiety-based, more socially constructed, and again, with an aim on really trying to return to what the eating disorder has gotten in the way of, and again, the important things to them. What do they like in life that has been diminished or even taken away by their eating disorder, and how can we, one, resurrect that as an important area to target, and two, help them get back to it?

I think one of the things that people will often say is being in recovery and healthy is a prerequisite to getting back to those meaningful activities in life, and I couldn't disagree more. I think if someone's on an inpatient unit, they need to be medically stable in order to do some of these things. That much is true, but the two can occur concurrently, and that I think the best successful treatments are when people are engaged simultaneously in all the hard work in therapy, doing medications in groups, but also as much as they can be engaged in meaningful activity that is far removed and generally outside of treatment, whether it's connection with family, and I realize this may be interrupted by some of these levels of care. It's still important to really do that. Even in a residential setting, we're really promoting outings and passes and opportunities to engage in activities that are not food-related, some that are, but many that aren't as well. I think we're at the Q&A section.

Host: Yes, thank you both so much, and there have been some questions asking for resources, so if that was you, take a look at your screen, because the speakers so graciously put up some resources for everybody. That's great. We've had a lot of questions come in. First thing we'll start with is a lot of questions about treating ED when there are comorbidities. Generally, and one that was called out specifically is BPD.

David: It's a great question. First of all, people don't generally tend to fit diagnostically into constructed boxes, and often more so, they don't generally tend to fall into just one box, and with eating disorders, we see a lot of this. There are a lot of comorbidities. The most common that we see, certainly, there's a great percentage of folks who struggle with coexisting OCD, substance abuse, PTSD trauma, sometimes dissociative symptoms as well, and substance abuse.

Personality disorders as well, and again, I think going back 15, 20 years, I think the thinking was more along the lines of treating these in separate and doing one before the other, whichever one was most severe. To an extent, that still exists with an eating disorder. If there's real nutritional needs that need to be addressed, they often do need to be addressed first, and they will give people a platform, the strength, the nourishment to do the other work that is important, but ultimately, they can be done concurrently.

I think it's harder to do that in a general psychiatric program because they won't be set up ideally to focus as much on containment and support around eating disorder behaviors, but within an eating disorder program and within a good eating disorder program, there really is that potential to sort of major in the eating disorder, but also attend to other important issues that may be a part of what someone struggles with, whether it's BPD, whether it's OCD, whether it's something else, so I don't know how you feel about that.

Holly: Yes, I'll add that often treating the comorbid condition can help the eating disorder and vice versa. An eating disorder very rarely exists in a vacuum. Let's say you have a patient with bulimia and BPD. Maybe their individual therapist focuses in DBT and working on DBT skills, whether it involves food or emotion regulation in other areas of life, you can see improvements in both ways, and again, then you have, speaking of an interdisciplinary team, you have the dietician focusing on the food piece of things, and you're doing your good DBT work with the patient who has comorbid bulimia and BPD.

Host: Thank you. We've also gotten several questions about health at every size. If you could speak to that a little bit, and do you have any recommendations for going about that with a team?

Holly: I'm, for one, really happy that we're talking more now about health at every size, because I often think of there's health at every size, and there's also unhealth at every size, too, and BMI is often not the end all and be all, and even when we're thinking about what is a healthy weight range for this individual as we're refeeding them, we're actually not really thinking about BMI at all. We're looking at their developmental growth curves and growth trajectory, and really, that is more of a health at every size approach, so really as we're also doing body image work with

patients at any level of care, keeping that in mind as well. David, I don't know if you would have anything else to add to that.

David: A lot. I think what you said is really nice. I think the paradigm of health at every size really allows you to take the focus off of weight, and eating disorders exist in all different kinds of bodies. You can't tell just by looking, and by taking the sort of focus off the weight, rather than ideal body weight, we're talking about ideal health, and ideal health, that's what allows you to feel strong, and energetic, and lets you lead a good and meaningful life. I think that's a much more inclusive way of looking at, and thinking about, and ultimately treating eating disorders because of shapes and sizes.

Holly: Yes, and we even think about the most common eating disorders being OSFED, like atypical anorexia, is not low weight. It literally is every size, so I think I'm happy. I'd like to think, as a culture, that we're trying really hard even in the media to move in that direction, but something always to keep in mind.

Host: Thank you. Going back to comorbidities for a second, we've gotten a lot of questions about the links between OCD and ED. Are there any special considerations that you have to take? Is there a particular link between the two? Is it more common? That kind of thing.

David: Yes, so again, this is an area where I would love for there to be a little bit more research. I was at the IAED conference this past summer, and I think they were quoting a 20% comorbidity of people who have eating disorders have some coexisting OCD. I couldn't quite find where they got their statistics. They dovetail intuitively with what I think exists, maybe even a little bit higher, but the research I'd seen suggested 10% to 70% comorbidity, which is somewhat meaningless. We know it's significant. It's less significant the other way, that people with OCD are less likely to have eating disorders, but there is significant overlap. People with eating disorders do often have OCD, and we see it a lot.

I think in our residential program right now, we've got a good percentage of people, if not with a coexisting diagnosis, certainly with significant symptoms around compulsive issues. I think, again, when you're looking at that, you really want to understand where is the overlap because some of the obsessional and compulsive components of eating really are more related to the eating disorder than OCD per se, and you want to be able to separate those out.

The treatment is not all that different. I think there's also always this question, which comes first, the chicken or the egg? I think there probably is some importance in understanding that in terms of driving factors, in terms of what you're focusing on for treatment. Interventions at any stage, as Holly was mentioning, tend to help the other thing that people are struggling with. If you're in an eating disorder program and someone's coming in with significant OCD and you're treating the eating disorder primarily, but you're also doing a little bit of exposure work, I think you're going to see benefit across the board.

I think where it becomes problematic is if you ignore one or the other. Again, I think typically, eating disorder programs are set up to do both things simultaneously a lot better. For instance, I used to work at the OCD Institute, and they're not well set up

to sort of have a real robust support for eating disorders. They can collaborate with us at Klarman, but as an institution, they're really focused more on OCD.

Host: Great, thank you. Could you all speak a little bit to screening techniques and the best way to do that to find eating disorders?

Holly: Did you say training techniques?

Host: Screening techniques, but training techniques has also been a large question, so we'll throw that in there too.

Holly: You want to go, David?

David: There's different screening techniques. There's the ESP, which is really, a series of, I think, five questions, primarily for primary care doctors. These are not, in and of themselves, diagnostic tools. They're really sort of, if people answer in the positive to these questions, there's really evidence to support further questions around eating disorders that there may be a problem here, and those questions, could be, are you satisfied with your eating patterns? Do you ever eat in secret? Do you currently suffer with or live with people that have eating disorders? They're fairly direct questions, but they're not diagnostic.

Similarly, there's a measure called the SCOF, which I think is just four or five questions, and then a more robust measure that we'll use here is the EDEQ, which is an eating questionnaire, which is a self-report measure, and again, not in and of itself a diagnostic tool, but gives a lot of information in a relatively short amount of time, and delineates some areas where people might struggle, again, because eating disorders are fairly diverse in their presentation, so it's like a jumping off point for more questions, but if you're not someone who's versed in eating disorders, these are really good screening tools, and even for people in eating disorders to sort of narrow and pinpoint their questions or refer to someone else who may specialize more.

Holly: I'll say, when I do training for medical students and residents and talking about eating disorders, they're like, "Well, how do I ask about body image?" Well, ask them how their body image is. Oftentimes, patients, if you don't ask, they won't tell, because eating disorders thrive in isolation and secrecy, and for some reason, people do have a tendency to dance around eating disorder questions about food and body image and things like that, but just bringing into general practice when you're doing first meeting a patient and doing an initial screening, you always ask about mood, anxiety, OCD, trauma.

Throw some eating disorder questions in there, too. Ask about, have you ever restricted your food intake? How's your body image? Do you ever purge, laxatives, binging? If it's no to everything, you can move on, and it's actually pretty quick, but just being direct, compassionate, and non-judgmental in those questions and not dancing around them, I think, is a generally good approach.

David: Direct and compassionate is right on, because we're trying to gain more information and understanding what people are struggling with, but we're not trying

to undermine their defenses, and there is a lot of shame and secrecy around eating disorders, so it can be tricky to learn more in an interview process.

Host: I think we have a lot of time for probably two or three more. This is a little specific, but it's actually been asked several times. Could you speak to the presence of ED in elite athletes and folks who are rewarded for meeting a specific weight to succeed, and how you would treat that?

Holly: I'll dive right in, and David, please add. My first thought was, as we're thinking about an interdisciplinary approach, actually bringing a team coach in or a team trainer actually might be helpful to have a good understanding of, what are the actual expectations of the team? Where can there be some wiggle room in terms of trainings and weight requirements and how we talk about these things? When we've had athletes at Klarman, in our residential program, we have involved coaches, and the treatment is part of that too. Even to educate the coaches on what's helpful and what's not as well, because sometimes they don't know, and want to be as helpful as possible as well.

David: I think it's an area where there's a lot more attention, and this is a great thing. There's actually an annual conference now that usually takes place in Boston in the spring. Dawn Hines, I'll give a shout out to her. She has a sort of recovery and exercise and sport consortium and referral network. It's a non-profit. It's a wonderful resource for people, for elite athletes in particular. She's done some work with Olympians and college athletes, professional athletes. I think that's a great resource to utilize as well because there are some differences.

Host: Great. We've also had several questions. We have had so many questions. This is the first I've seen in quite some time. We've had a lot of questions about any tips if you are having trouble with getting a team together to help treat, whether that be lack of resources or just disjointed team members, or the patient themselves is refusing to see certain doctors.

David: Two different questions, it sounds like. The first one, just the sort of difficulty of getting a team together. I don't think there's been a tougher time to do that than right now. There's one so much need. I am finding it harder to find therapists to recommend, but all the disciplines I think are struggling in terms of providing care. It is inherently difficult.

I think, going through some of the local and national resources can be a good starting point. It does take work. I think often engaging the patient themselves in doing some of that is the most fruitful that they have stock in the game. Ultimately, the person they're working with is most important to them that they match and connect and have rapport. I think a shared responsibility that we're not sort of left doing all the work. We can be helpful and point in the right direction. We may have some connections that we can leverage and utilize, but it is difficult to do that. I'm forgetting what the second part of the question is now.

Holly: What if someone refuses to see a certain member of the team? I think that that's going to be a fairly individualized approach, and there's many different ways to approach that. One of them is, that points to some sort of lack of alliance with the

treatment team and as a whole, and thinking about how, as a team, we want to approach that.

I often insist, but my role as the psychiatrist is different than the role of the therapist. I insist that like, I'm not sure I can be a part of your team if, X, Y, and Z isn't met. Just having more of a conversation, it's not like I leave them immediately, but have a conversation about what position that's putting them in, what position that's putting me in and how can we find a way where you can get all the members of the treatment team together and those needs met for you. It can be a part of treatment to work through. I think it's fairly depends on the person and what they're running up against and why they're refusing to see that person too.

David: I really agree with that. I find myself doing exactly the same thing as the individual therapist. That gets back to the not wanting to work in isolation, and not expert in all these other modalities. If a key component is missing, it may not be safe to provide effective treatment. If someone is refusing treatment, I'm a big fan about talking about talking. When that fails, you talk more, but this is important subject matter because people really do need a team to be most supportive and helpful.

Host: Awesome. Unfortunately, we are just about at the hour mark. Thank you both so much for joining us, and thank you to all of the listeners today for your participation and for your fantastic questions. We'd also like to thank McLean Hospital for making today's webinar possible. We are going to send out a recording of today's presentation and also a copy of slides that will be emailed to everyone within the next two weeks. As soon as the webinar has ended, a short survey will appear on your screen. We ask that you please take that and give us your feedback so we can continue to improve our webinar programs. Yet again, thank you, everyone, for your attention, and we hope you have a wonderful rest of your Friday and a great weekend. Thank you.

[00:59:44] [END OF AUDIO]