Eating Disorders in Primary Care and Community-Based Clinics: Tools and Resources for the Clinician Webinar Transcript

November 3, 2022

la-shell_johnson@med.unc.edu: Good afternoon, everyone.

la-shell_johnson@med.unc.edu: Welcome to today's presentation, “Eating Disorders in Primary Care and Community-Based Clinics: Tools and Resources for the Clinician.”

la-shell_johnson@med.unc.edu: A few things to note, participants will be muted upon entry and videos turned off. For technical assistance, please use the question and answer feature located at the bottom of your screens. You will also receive an email approximately one month from today requesting feedback and impact on today's presentation. Slides from today’s presentation will be sent immediately after the webinar has ended. We will also allow ten minutes for questions and answers at the end of the presentation. I'll go ahead and introduce today's speaker. Dr. Christine Peat is the Director of the National Center of Excellence for Eating Disorders (NCEED) and an Associate Professor of Psychiatry at the University of North Carolina, at Chapel Hill, UNC.

la-shell_johnson@med.unc.edu: As the Director of NCEED, Dr. Peat is focused on broadly disseminating education and training on eating disorders to health care providers across a variety of disciplines. Her research centers on eating pathology across the spectrum, but with a distinct focus on binge-eating disorder.

la-shell_johnson@med.unc.edu: She is particularly interested in the intersection between obesity, bariatric surgery, and eating pathology and investigating physiological comorbidity associated with eating disorders. Dr. Peat is also a licensed psychologist in North Carolina, and as such, treats eating disorders across the spectrum. Given her background in behavioral medicine, she has also established clinical services in GI Surgery where she provides both psychotherapy and behavioral medicine interventions to this patient population.

la-shell_johnson@med.unc.edu: In addition to her clinical and research responsibility, Dr. Peat is also the Associate Director of Program Development in the Clinical Psychology Internship Program at UNC. I'll now turn things over to Dr. Christine Peat.

Christine Peat (she/her): Great. Thanks so much, La-Shell. I appreciate it. Uh and thanks to everybody who is able to join us this afternoon or this morning, depending on where you are in the country. Uh,

we're really pleased to have you here with us today as we spend a little time uh talking about eating disorders in primary care. Um, and we're really focused on making sure that you have tools and resources that are going to be applicable for those of you that are in clinical practice.

Christine Peat (she/her): Alright. So in terms of a little bit of a roadmap here for this afternoon. Uh, we have a couple of different goals. Um, I think first, that it's really helpful to kind of have a shared understanding of how eating disorders might present, particularly in primary care, as opposed to sort of other specialty settings.

Christine Peat (she/her): We'll also spend some time talking about evidence-based tools that you can use for detecting eating disorders in your practice, and then we'll spend some time discussing best practices for how you manage eating disorders in a primary care or community-based sort of setting.

Christine Peat (she/her): A little bit about our organization for those of you who might be new to us. The National Center of Excellence for Eating Disorders, which I direct, was established by SAMHSA back in 2018, and we're a technical assistant center that really provides education, training, technical assistance, and best practices those sorts of things when it comes to managing eating disorders, particularly focused on health care providers and clinicians. So there's a screenshot here of our website. I've also put our hyperlink there on the bottom right hand side of your screen, um, and you can see that we have a variety of different resources, some of which I'll highlight towards the end of our presentation. But um certainly wanted to encourage you all to explore our website if you haven't had a chance to look at those resources yet.

Christine Peat (she/her): Alright. So before diving into, I think some of the heart of our presentation for this afternoon. I wanted to do a little bit of a level set and have us spend some time talking about the social and economic cost of eating disorders here in the U.S. All of the data that we're going to talk about on this slide and the next are from a report that was published in 2020 from Deloitte Economics in collaboration with the Academy for Eating Disorders and STRIPED, both of which are really focused on eating disorders their treatment research, all of those sorts of things. So um, the Deloitte Economics report found that roughly, 28 million Americans will struggle with an eating disorder at some point in their lifetime.

Christine Peat (she/her): So, that's about nine percent of the U.S. population, which I think really stands in contrast to some of the old stereotypes that we have about eating disorders I think for a long time. And maybe even still uh to this day, there's still this idea that eating disorders are rare conditions that most people won't struggle with them. But what we're really seeing here in the Deloitte report is that a sizable chunk of the U.S. population will struggle with an eating disorder at some point in their life.

Christine Peat (she/her): Um, really troublingly we also know that these are life-threatening conditions such that um, about 10,000 people will die every year as a direct result of their eating disorder. The Deloitte report found that roughly one person dies every 52 minutes as a result of their eating disorder. So in the course of this presentation, that would be at least one person dying from an eating disorder. Importantly, we know that eating disorders can affect anyone. Again, there are these really predominant stereotypes about you eating disorders primarily affecting young, cisgender, White women.

Christine Peat (she/her): But in reality we know that eating disorders happen across all different kinds of dimensions, whether that's age, race, gender identity, or expression, sexual orientation. But one of the real challenging pieces is that if you don't fit that stereotype or that kind of dominant narrative for an eating disorder, you're less likely to receive treatment, you're less likely to even be detected with your eating disorder.

Christine Peat (she/her): The Deloitte report also outlined some of the costs specific to eating disorders, care and eating disorders as a whole here in the U.S., it's kind of a busy slide so I'm going to try and do my best to walk you through this. What you can see on the top left hand side is the yearly economic cost associated with eating disorders. So the Deloitte Economics report found that eating disorders cost the U.S. economy roughly 64 billion dollars in a single year. So we're talking about really staggering costs.

Christine Peat (she/her): A lot of them have to do with the direct care costs for eating disorder. So again, if you're focusing on the left hand side of your screen, you can see that there are some costs associated with things like visits, inpatient hospitalizations. What's represented here on these couple of slides are not exhaustive. There's a whole report that you can read where they broke down all the different costs. But these are just some of the highlights.

Christine Peat (she/her): Some of the other really high costs associated with eating disorders are not just associated with treatment, but also with economic losses which you can see on the right hand side of your screen. So the Deloitte report outlined some of the different um economic losses that occur, whether that's to individuals and families, or to employers, to society as a whole. And we're thinking about these kinds of losses. We're really thinking about things like folks needing to take time off of work because they themselves are in eating disorders treatment, or it might be parents or caregivers who are needing to take time off to care for a loved one or a child with an eating disorder. So all told, when you add up the costs associated with the direct treatment for eating disorders in addition to the other economic losses, that's where that 64 billion dollars that comes in again for the annual cost of eating disorders.

Christine Peat (she/her): So when we're thinking a little bit about these conditions that we know are common and life threatening, I think it's also helpful for us to be using the same language when we're

talking about the diagnoses. So I wanted to do a little bit of an eating disorders refresher, so that we have a shared understanding of what conditions that we're really referring to when we talk about eating disorders.

Christine Peat (she/her): So I'm intentionally starting with a diagnosis called other specified feeding and eating disorder, or OSFED. And I'm starting with this intentionally because it is likely to be the most common diagnosis that you will see, especially in a primary care or community-based setting. We really think about this as kind of that spectrum of disordered eating, where folks might have a handful of symptoms from one eating disorder, a handful of symptoms from another, or maybe they kind of ping pong back and forth between diagnoses.

Christine Peat (she/her): These might be folks that don't nicely fit into some of the other diagnoses that we'll talk about, or they might just kind of dabble with certain behaviors. So again, if we're thinking about a primary care or community-based setting um yeah, that OSFED diagnosis is really what you're most likely to see.

Christine Peat (she/her): Another really common eating disorder is what's called binge-eating disorder. This is a term that I'm sure many of you are familiar with, but the defining feature of this particular diagnosis are these recurrent binge eating episodes. So, I think it's also worth us talking a little bit about what a binge eating episode actually is. And so when we're talking about binge eating, we're not necessarily just focusing on the amount or the volume of food that's being eaten. We're actually really focusing in on this sense of loss of control.

Christine Peat (she/her): The hallmark feature of a binge eating episode is a sense of being out of control. I cannot stop eating. Once I've started, even if I wanted to stop eating, I felt like I could. Kind of like a car rolling downhill without breaks. That kind of experience. And so, these individuals with binge eating disorder are having these recurrent eating episodes where they're feeling out of control. Oftentimes they're feeling guilty, ashamed, or disgusted with themselves afterwards. And so, these folks are really struggling with kind of a whole host of symptoms, in addition to their binge eating. Anorexia nervosa, is another diagnosis that I'm sure most of you are familiar with. But, the defining feature of anorexia nervosa is not so much somebody's weight status or whether or not they're underweight. The defining feature of anorexia nervosa is an intense fear of weight gain, or sort of this idea of um engaging in activities that prevent any kind of weight gain. So folks will talk about being afraid of becoming fat or fear of putting on any weight whatsoever.

Christine Peat (she/her): And so, it's this feature that really drives folks to restrict how much they're eating. They might skip multiple meals in a day. Uh they might eat a really limited variety of foods, such that in some individuals can actually become underweight or become um at a at a low body weight that might require hospitalization. But many individuals will experience precipitous weight loss, even if

they're not necessarily underweight. And so we think a little bit about a diagnosis called atypical anorexia nervosa, we're really thinking about anorexia nervosa in a higher weight body.

Christine Peat (she/her): So these might be individuals who have that same intense fear of weight gain. They're skipping multiple meals, maybe they're only eating five hundred calories a day, but the amount of weight that they've lost still puts them kind of in that normal range for BMI. And I highlight this diagnosis in particular because it's something that I think is much more likely to be seen in a primary care setting than those folks who are frankly underweight, or to be seen in a primary care setting than those folks who are frankly underweight, or to be seen in a primary care setting than those folks who are frankly underweight, or to be seen in a primary care setting than those folks who are frankly underweight, or to be seen in a primary care setting than those folks who are frankly underweight, or to be seen in a primary care setting is really easy to slip through the cracks.

Christine Peat (she/her): Because these folks aren't going to have any obvious signs in terms of being underweight. For example, the QR code that you're going to see in the bottom right hand side of your screen is actually a link to a New York Times article that actually highlighted atypical anorexia nervosa in the community. They spoke with some individuals who are in recovery from this diagnosis, clinicians and researchers. So it's also gaining a lot of attention in the traditional media sources as well.

Christine Peat (she/her): Uh, with respect to some of the other eating disorder diagnosis, bulimia nervosa is another diagnosis that I'm sure most of you have heard of. The defining feature again are those same sorts of binge eating episodes like we talked about in binge-eating disorder, but these end up being paired with what we call an inappropriate compensatory behavior. So that might be things like self-induced vomiting, over exercising, abuse of laxatives or diuretics. So with bulimia nervosa, individuals are having a binge eating episode, and then pairing it with one of these sorts of behaviors in an attempt to try and make up for that binge, or get rid of the calories that they've eaten during a binge eating episode.

Christine Peat (she/her): Another diagnosis that you may not necessarily be familiar with is called avoidant/restrictive food intake disorder, or ARFID. And the defining feature here, is a failure to meet appropriate nutritional needs.

Christine Peat (she/her): So for those of you that we're thinking a little bit about anorexia nervosa. And you're thinking, how is this different from that diagnosis? It sounds really similar. Recall that the defining feature of anorexia nervosa is that fear of weight gain or fear of gaining any kind of fat. The folks that have ARFID, don't have that same sort of cognitive presentation. These are folks that are just simply failing to put enough caloric energy into their body throughout the day. And again, this isn't a one-time thing where I sort of forgot to eat breakfast. I got busy over lunch.

Christine Peat (she/her): It's a pervasive pattern that can actually lead to malnutrition and significant weight loss. Now folks might fail to meet their appropriate nutritional needs for a number of different reasons. Some of the sort of subtypes that have been proposed have been things like just a lack of interest in food or in eating. There are some folks who struggle with the sensory characteristics associated with food. Things like the texture, the color, and the smell, such that they can become malnourished, because they're really just not able to feed themselves appropriately.

Christine Peat (she/her): Other individuals will talk about having had aversive experiences when it comes to their eating, so they may have had a choking episode or a really bad bout of GI upset after eating, and now they almost become sort of fearful of eating, because they've associated being with one of those sort of unwanted outcomes. So again, ARFID is a diagnosis that I think takes some careful monitoring for. But, these are folks that will often be malnourished, because they're only eating a handful of foods that feel safe or comfortable for them.

Christine Peat (she/her): When it comes to warning signs for eating disorders, I won't take the time to read all of these here, because you'll have access to these slides immediately after today's presentation. Um, but when you think about warning signs, they can really vary from, you know, very frank, physical, obvious signs like being underweight, for example. Um, but they can also be things that sort of fly more under the radar. So you know, these might be folks that are hiding food or eating in secret. They might be folks that are often talking about their weight and their shape in a way that's really negative or derogatory towards themselves. So, when we're thinking about warning signs, I think it's wise to kind of cast a wide net, and be thinking globally about how your patients or the folks that you work with might be talking about their relationship with food as a whole, or their relationship with their body as a whole.

Christine Peat (she/her): When it comes to common symptoms, and the medical complications associated with eating disorders, we know that really there isn't any single body system that is spared from an eating disorder depending on the diagnosis. Um, what's here is certainly not an exhaustive list of different symptoms or medical complications, but I just wanted to highlight some of the ones that are very common. Um, I would say across the board, irrespective of the diagnosis. Most of our patients are talking about just this general sense of fatigue and malaise, just generally not feeling well.

Christine Peat (she/her): Many folks will have difficulty with temperature regulation. There can be all kinds of cardiovascular, metabolic, or endocrine abnormalities associated with eating disorders, especially if folks are over exercising, or if they're engaging in things like self-induced vomiting or abuse of laxatives for example.

Christine Peat (she/her): Um, I would say that gastrointestinal complaints are probably the most common uh sort of physical comorbidity that we see with folks with eating disorders. Um, they'll present with all kinds of symptoms. It sounds kind of like functional GI symptoms like being constipated or bloated, or feeling uncomfortably full, even after eating what might be considered a small amount of food. Um, and again, that's not to say that you can't have a GI disorder and an eating disorder, but sometimes eating disorder. Symptoms are actually what's driving some of the GI presentation.

Christine Peat (she/her): I also want to highlight that most folks with eating disorders will have some sort of psychiatric comorbidity. Um, some of the numbers that you can see here are probably the highest for anxiety and depression. I'm really hard pressed to think of a single patient I've worked with over the course of my career who hasn't had anxiety or depression at the same time. Um, but there's also a high overlap with substance use disorders. Many folks will be um ah engaging in really problematic relationships with alcohol or other kinds of substances in addition to having an eating disorder diagnosis and knowing that there are physical complications associated with substance use disorders and with eating disorders, it makes it a particularly dangerous combination.

Christine Peat (she/her): One of the other things I also wanted to highlight during today's presentation is this idea that eating disorders are conditions that don't simply affect your relationship with food and your body. They can really have a global impact on your daily functioning, in your daily life. So, I pulled some data from a study that was done through the World Health Organization that actually looked across 14 different countries with different income stratifications. I specifically zeroed in on folks with binge eating disorder. So again, these data here really focus on one particular diagnosis, but I just kind of use it as a case illustration.

Christine Peat (she/her): So these individuals with binge-eating disorder also completed what's called the Sheehan Disability scale, which assesses illness severity in each of four domains. And what you can see here on this slide are on the left hand side the four different domains where folks might be experiencing impairment because of their illness. So in this case we're talking about having impairment in these domains associated with binge-eating disorder. And what you can see is that around half of the participants were reporting some degree of impairment in any of these four different areas, and 13% of them are reporting severe impairment because of their binge-eating disorder.

Christine Peat (she/her): The most notable was in social life. So folks with binge-eating disorder in this survey were around 38% of them, were saying that they were having some degree of impairment in their social life. And around 8% were talking about having really severe impairment in their social life. I highlighted these data in particular, because we know that eating disorders are conditions that thrive in secrecy. Folks are really motivated to conceal their behaviors or conceal the fact that they're struggling in some way, and in many ways it just makes the eating disorder worse.

Christine Peat (she/her): But it also cuts you off from the people who might be able to help you the most, and provide you with that crucial support as you're trying to work through towards recovery from an eating disorder. So, I think that these data were really illustrative of this idea that folks with eating disorders struggle not just with their relationship with food and body. But, in all of these different life domains such that they can really have global impairment in their daily life.

Christine Peat (she/her): Again, when we think a little bit about eating disorders, you know we've talked about these as being, you know, somewhat common conditions that are serious, and life threatening that are costly to the U.S. economy. We've talked about the diagnosis, we've talked about sort of global functional impairment. I think its important then, when we're thinking about these diagnoses, that we have, these kinds of images in mind when we think about who might be affected with an eating disorder. Because, again, I think that stereotype is still one that is really predominant, not only in the traditional media sources, but also in social media and movies, and all these other kinds of outlets. So for those of you that are working in direct clinical care, and even those of you that are not, I think it's important that we have these kinds of images in mind. We're thinking about who might be affected by an eating disorder, so that we can really kind of cast a wide net when it comes to screening for these conditions.

Christine Peat (she/her): I also want it to take some time to kind of bust some of those old stereotypes or old myths about eating disorders. Again, because you'll have access to these slides. I'm not going to take the time to read one of these to you while we're here together, but I wanted to highlight a few things. So first, the 9 Truths About Eating Disorders was actually a document that was developed by the Academy for Eating Disorders that really focused on sort, of course-correcting, right, instead of just predominantly putting out those same myths and then trying to challenge them. We wanted to lead with the truth, so that people have the right information about these conditions.

Christine Peat (she/her): So the first one, I think, is particularly important, and the truth number one states that many people with eating disorders look healthy, yet may be extremely ill. And I think this really fights that myth, that you can tell who has an eating disorder just by looking at them, right, because in reality the vast majority of people with eating disorders are not going to have obvious signs or symptoms. These are going to be things that are going to easily slip under the radar and kind of through the cracks.

Christine Peat (she/her): Um, with truth number three. We also know that eating disorders are a health crisis that can disrupt personal and family functioning. I use the term health crisis um intentionally here, because one of the things that sometimes can happen is that because there's so much misinformation about eating disorders, there can be this impression that they aren't that serious, that this is the sort of thing; it's just like a diet gone wrong. Or maybe it's just something that's a phase, and maybe this person will grow out of it.

Christine Peat (she/her): But we know that eating disorders need to be treated as soon as they're identified, to give folks the greatest chance of recovering. And if not, it's a situation where folks go on to struggle for multiple years and have all kinds of very serious medical complications. So again, we don't think this to necessarily frighten individuals. I think the idea is, though we want people to take this seriously in the same way that you would, if you were diagnosed with diabetes or with some form of cancer.

Christine Peat (she/her): Again, we've talked a little bit about Truth five when it comes to eating disorders, not discriminating, no matter, sort of what dimension that we're talking about. And importantly, we know that eating disorders are biologically based disorders that some people are just genetically predisposed to um. I think it stands to reason that all of us are exposed to sort of this toxic environment when it comes to food, and dieting, and body image, and all these sorts of things, but not all of us go on to develop eating disorders.

Christine Peat (she/her): So we know, and especially with some emerging research that there are certain genetics at play, and it's that combination of genes and environment that can trigger the development of an eating disorder in genetically vulnerable people.

Christine Peat (she/her): And then Truth nine, I think, is probably the most important one that we could focus on. And it's really that full recovery from an eating disorder is possible. Um, I think sometimes, when you think about the seriousness of these conditions, or the fact that they can be as life threatening as they are. It can sometimes give the false impression that folks can't recover from these conditions. But the reality is that we know that full recovery is possible, especially if folks are detected really early on in their disease progression, and they're given the evidence-based intervention that they really need.

Christine Peat (she/her): When it comes to thinking a little bit about again some of these marginalized populations with eating disorders, I wanted to illustrate a study that was actually conducted several years ago with the National Eating Disorders Association. And in this study they presented a case vignette of somebody with an eating disorder. I can't remember the exact symptoms that were described, but it may have been something like binge eating episodes, self-induced vomiting, you know, caloric restriction. All of these sorts of fairly obvious hall markers of an eating disorder.

Christine Peat (she/her): And when the individual um in that vignette was identified as a White woman, 44% of the clinicians identified that the eating behavior was problematic. When the identity of that person was changed to a Hispanic woman, only 41% of those clinicians identified that the behaviors were problematic. And when you changed the identity of the person into a Black woman, same exact behaviors, only 17% of the clinicians in this study found that the behaviors were problematic.

Christine Peat (she/her): And I don't highlight these data to malign clinicians, or say that folks are failing, because, you know, they're intentionally wanting to do bad outcomes for their patients. It's really more to kind of highlight that we have a real blind spot when it comes to identifying eating pathology among diverse folks. Again, that sort of predominant stereotype that's really in the back of our minds and kind of went out here.

Christine Peat (she/her): Importantly, we also know that there are some forms of eating pathology that are actually more common among racial and ethnic minorities. So, there was a study that was done a few years ago in a community-based sample. So this isn't a clinical sample or treatment sample uh, and they found that binge eating was actually more prevalent among Latina and African American women than it was among their White counterparts. So there is a growing body of evidence to suggest that there are certain forms of eating pathology, binge eating, maybe being one of them that can actually be more common among our patients who are of a racial, or ethnic minority.

Christine Peat (she/her): We also know that when it comes to eating disorders, men are actually more in the minority than women, which I know of sort of the reverse for a lot of other health conditions that we think about. But it's important to recognize that OSFED, for example, or these sorts of sub-threshold eating disorders are nearly as common among males as they are among females. So, when you're thinking about who you're screening, or who you might think of for as having a differential diagnosis of an eating disorder. It's important that we're thinking about our male patients, our female patients, and with all kinds of gender diverse expressions.

Christine Peat (she/her): For those of you that may be working with transgender communities, there is some research looking at eating pathology in this particular community. One study found that roughly, 7% of transgender teens or young adults are struggling with eating disorders, and many of these folks are engaging in eating disorder behaviors in an effort to suppress the secondary sexual characteristics. So, these are folks that are already having gender dysphoria, feeling very upset about sort of the lack of congruence between their body and their gender identity. And so they may be trying to delay puberty or trying to delay any kind of weight gain in an attempt to try and have their body match their gender expression. I think it's important, though, to note that it's not just a body image component. There are many individuals who identify as trans who will continue to struggle with an eating disorder even after receiving gender affirming care. But, I wanted to highlight this particular community, because we know that there tends to be an increased risk for eating disorders in the trans-community than there is, let's say, you know the cisgender community.

Christine Peat (she/her): So collectively, then we think a little bit about eating disorders, again, we know that these are common conditions and their life threatening. In fact, they have the second highest

mortality rate of any psychiatric illness. And unfortunately, many of the folks that have eating disorders will die by suicide.

Christine Peat (she/her): One of the other really challenging pieces about the treatment landscape is that only maybe at best, 57% of those with an eating disorder, will ever receive the treatment that they need. There are lots of different reasons for this, and we do a whole other presentation about sort of the shortage of mental health care providers let alone eating disorder specialists. Um, but it's a really um challenging landscape for folks to kind of get the care that they need, even if they have been detected with an eating disorder.

Christine Peat (she/her): I'm sure many of you have experienced it's not as simple as just saying, you know, go down the street to the next local clinic, and you can get treatment there. It can be really tough to find the treatment that's necessary.

Christine Peat (she/her): Some of the different barriers to detection have to do with those stereotypes about eating disorders. That again. I know we've spent some time kind of going over at the beginning part of this presentation. But, one of the other real barriers when it comes to detecting eating disorders, especially in a primary care setting, is that many folks will kind of downplay their mental health symptoms, and instead kind of focus more on their physical symptoms. So, with something like depression or anxiety, folks may be much more willing to talk about things like insomnia, maybe having an upset stomach, headache, muscle tension, those kinds of physical symptoms versus being willing to talk about feeling hopeless, or feeling worthless, or just being in despair.

Christine Peat (she/her): Those kind of things are harder to talk about in general, and so the same is true for eating disorders where you may have folks that will just say, you know, it's just sort of a little bit of a change in my weight, no big deal, but they won't, maybe be as forthcoming about saying that they feel out of control what they're eating or um that they are afraid of gaining weight, for example.

Christine Peat (she/her): And again, that reluctance to disclose symptoms is one of those things that's kind of part and parcel to an eating disorder in some way sort of like substance use disorders where folks are motivated to conceal some of these symptoms. Um, because in many ways they may be serving a purpose for that person at a certain point in their life.

Christine Peat (she/her): I think one of the other real challenges when it comes to detection, is that even if you, as a health care provider have identified that something is off, something is not quite right with this person's relationship with food or with their body. I'm concerned about my patient. It's very common for folks with eating disorders to lack insight and awareness into their own behaviors, or into their own eating disorder. Um. One of the things that we commonly hear from people that are

struggling with an eating disorder are things like only people who need hospitalization have an eating disorder.

Christine Peat (she/her): I don't need to be in the hospital. I'm fine um, or I don't have an eating disorder. This is what everyone thinks about or eats or worries about, it's something that's really common, right? This is in an actual disorder. We often hear things like everybody is on a diet all the time; why is what I'm doing any different from that? So again, I think it can be really challenging when you, as a mission, have identified that there's a concern. But the patient that you're working with has this lack of insight and awareness.

Christine Peat (she/her): I wanted to highlight some of this information to make sure that you knew that when this happens it's a common part of the illness for people to sort of deny it seriousness, even if folks are having very frank physical symptoms like having fainting spells, for example. We have folks that this happened actually just earlier this week, where we had folks that we're experiencing syncope episodes, and were still insistent that it couldn't be related to their lack of intake, it couldn't be related to an eating disorder. There must be some sort of other physical explanation for what's going on here. So again, I think this lack of insight and awareness is really common. It's something for you all to be aware of as clinicians.

Christine Peat (she/her): We do know, however, in terms of good news, that early detection can play a crucial role in getting set folks set up for an overall better prognosis and a better chance of recovery. It's really rare that patients would just wake up one morning and say, you know, "Oh, I have an eating disorder. I'm going to go to UNC Center and get treatment." It's much more likely that they're going to be interacting with you all as their primary care clinicians or their community-based clinicians. And it's in that relationship where we see a lot of potential to have some of this early detection work get done.

Christine Peat (she/her): So for a lot of folks you may have an existing relationship with these patients. Maybe you're seeing them once a year, maybe it's every few months to take care of chronic conditions. And in those situations you already have a relationship with these patients that might make them more open to talking about some of these concerns than somebody who is going to be a brand new provider to them, and in that way you can help kick start treatment. Get them start getting, get them starting to think about these symptoms, and whether or not they warrant treatment. It doesn't mean that they have to sort of accept and go ahead and do that referral during that particular visit. But, maybe it gets them thinking about it. Maybe it gets them considering something that they hadn't necessarily been thinking about from before.

Christine Peat (she/her): So when it comes to screening for eating disorders, we wanted to give you some practical tools about, you know what's out there that is appropriate for scope, um in a, in a

primary care setting. So we'll talk a little bit about these three different screeners. The SCOFF, the Eating Disorder Screener for Primary Care, and the Binge-Eating Disorder-7.

Christine Peat (she/her): The SCOFF is represented here on this screen. The five questions of the SCOFF are fairly sort of face-value questions with respect to eating disorder symptoms. So, you can see that the first one has to do with self-induce vomiting. The second one has to do with those binge eating episodes, feeling out of control, and you eat, and you can see the rest of the questions that are listed there. The SCOFF has been extensively studied, and has actually been determined to be appropriate for use in a primary care setting and a positive screen would be if a patient said yes to two or more of these questions, and they've done all kinds of studies looking at different thresholds, but two seems to be kind of what is a good balance between sensitivity and specificity.

Christine Peat (she/her): Similarly, the Eating Disorder Screen for Primary Care is another five-item measure that is designed to kind of be a little bit more broad in nature when it comes to eating disorder symptoms. So you can see here that there's a little bit of a shift in the focus. So if you look at the first question, it says something like, “Are you satisfied with your eating patterns, or do you ever eat in secret?” So there may be less specific to uh eating disorder, behaviors or thoughts but maybe more kind of globally reflecting somebody's relationship with food or their relationship with their body. Similar to the SCOFF, the Eating Disorder Screen for Primary Care would be considered a positive screen. If a patient says yes to two or more of these questions, and what you can see on this slide are some asterisks, next to the first question and the third question, and these are to flag.

Christine Peat (she/her): And what you can see on this slide are some asterisks, next to the first question and the third question, Um, and these are to flag. That these were found in a research study to be the most sensitive at picking up an eating disorder in a primary care setting. So if you're thinking about, you know which of these five questions are going to kind of give you the most bang for your buck. It's really those first, I'm sorry, the first question and the third one. Are you satisfied with your eating patterns, and does your weight affect the way you feel about yourself?

Christine Peat (she/her): Those were found to be the most sensitive at picking up eating disorders in a primary care setting.

Christine Peat (she/her): The Binge-Eating Disorder-7, I'm not going to go through and read all these questions for you. But, suffice it to say that this is a measure that is designed to detect whether or not folks are experiencing recurrent binge eating episodes like we talked about at the beginning of the presentation. And kind of ruling out other things that might qualify for a diagnosis of bulimia nervosa, for example. Again, this is a self-report questionnaire. Fairly easy to administer, and as might be of use if you're particularly worried about binge-eating disorder in your patient population.

Christine Peat (she/her): One of the things, however, that the National Center of Excellence for Eating Disorders has done is actually develop kind of a one-stop shop or a complete protocol for screening, for eating disorders, particularly in a primary care setting. Many of you here may be familiar with the model of Screening, Brief Intervention and Referral to Treatment that was developed for substance use disorders in primary care. We've taken that same evidence-based framework, the SBIRT framework and simply swapped out the content so that it's now relevant for eating disorders.

Christine Peat (she/her): So SBIRT for eating disorders gives you access to an evidence-based screener which in this case is SCOFF. It gives you brief intervention in the form of scripted prompts, so you can talk with your patient about your concerns, and it gives you sort of a one stop shop for referring patients to treatment, irrespective of where you may be in the country. I provided the hyperlink there at the bottom of the screen. This is up and running, it is available publicly for use. So please feel free to use this tool if you find that it would be helpful in your scope of practice.

Christine Peat (she/her): Some important things that I think would be good for you to know about how we developed this. First and foremost we developed SBIRT for eating disorders with our colleagues who work in primary care. I'm a clinical psychologist by training. I specialize in eating disorders, and so my scope of practice, and what I understand is going to be really different from somebody who's a clinician working in primary care. So we thought it was important to work with our primary care colleagues so that we could be developing a tool that would be relevant for use in that setting.

Christine Peat (she/her): One of the things that we often heard from our primary care colleagues is that they felt very comfortable doing screening. Screening to something that gets done on a regular basis for all kinds of conditions throughout primary care. But the clinicians told us, “Listen. I'm okay with screening, but if somebody screens positive, I need to be able to demonstrate that I'm able to do something about that positive screen. And maybe that's part of what's made me reluctant to screen for eating disorders in the past.” So with that being said, we developed that referral to treatment component, it's a step-by-step guide that is designed for you to give to patients, or you can actually walk through this process yourself if you have a behavioral health provider in your clinic. This is something that a provider could do very easily. But, it basically gives you access to a searchable database of eating disorder treatment providers and programs that you can zero in on, based on your geographical location, based on insurance, all of those sorts of things.

Christine Peat (she/her): The other thing that our primary care colleagues told us was that, even if they could screen and refer, they're not quite sure how to talk about it. What do I say to a patient who's struggling? What's the language I should be using, so that I'm not triggering them or making this worse somehow? And so that brief intervention component really takes the form of those scripted prompts. We have given you some language to kick start a conversation. Of course you don't have to read them verbatim, but it gives you a sense of, maybe, how to guide that conversation, so that you and that patient can have an open conversation about what's going on with their eating disorder symptoms. So

again, SBIRT for eating disorders is really designed to kind of leverage an existing evidence based framework, but to apply it to eating disorders and to give clinicians really everything they need within a couple of clicks.

Christine Peat (she/her): So again, when it comes to detecting eating disorder, there are lots of different things to consider. We've talked about some of these already. But if you have patients who are having frank discussions with you about being unhappy with their weight or shape, those would certainly be folks you might want to consider screening for a meeting disorder. You might have folks in your practice to say all of a sudden they're going, vegan, or they're going, they're going to do Keto, or maybe intermittent fasting. That doesn't necessarily mean they have a meeting disorder, but it may be a reason to sort of lean in and show some degree of curiosity, and just make that they're not, in fact, engaging in eating disorder behaviors.

Christine Peat (she/her): Of course, any changes in weight, whether those are changes in weight up or down, irrespective of someone's starting weight, those would be things to be paying attention to, and of course, in as much as many of you are already taking care of patients with anxiety and depression or GI complaints. Those might be folks that are worth screening for eating pathology. Given the overlap that we know that these diagnoses have with eating disorders.

Christine Peat (she/her): Of course, if you were to ask any of us who work uh in a specialty setting, who should be screened, we would say, everyone uh but we're certainly biased. So, understanding that screening everyone may not necessarily be feasible, we thought it was worth highlighting some high risk groups to consider when it comes to screening for eating disorders. Um! So we certainly know that adolescents are at a time in their life where they're at an increased risk for eating disorders. Um, this is for lots of different reasons, and again, we could probably have a whole other conversation about adolescents and eating disorders, but given that, we know that they/we have a much higher prevalence of these conditions, and an onset of eating disorders around this age, it's worth thinking about routinely screening your adolescent patients

Christine Peat (she/her): Also, any patients who may be in those key transition periods, so folks that are graduating from high school or college, maybe getting their first job, getting married, their first kid, or moving to a different city. These key transition periods can often be really positive, really happy things for folks, but they can also be really stressful. Uh, and we know that stress just makes the ground really fertile for eating disorder development. So maybe we're thinking about screening some of your folks who, you know, are approaching some of these key transition periods. Again, any patients with medical morbidity, some of which we've already talked about. But folks, for example, PCOS, diabetes, both type one and two. We know that these are common conditions that can be associated with eating pathology

Christine Peat (she/her): Athletes of course, I think there's been a focus on athletes and eating disorders for a number of years, but I think it's important that we're thinking about screening athletes in general,

and not just those who maybe engage in aesthetic sports or sports that require a certain weight component, but really thinking about all athletes, knowing that their relationship with their body is often a real focus in their day to day life. Of course, any patients with a family history of eating disorders, knowing what we do about the genetics associated with these conditions.

Christine Peat (she/her): Any patients who are seeking help for weight loss. Many individuals, actually we over the year's they've done some studies looking at folks that have developed eating disorders, and they found that a consistent risk factor for the development of these conditions, is a history of being overweight, or history of obesity, or history of dieting. That doesn't mean that every patient who diets will have an eating disorder, but many individuals will find that that diet quickly spirals into something that looks much more like an eating disorder.

Christine Peat (she/her): And then there's also a growing body of evidence indicating that veterans and actually even service connected folks, um are at higher risk for engagement and eating disorder behaviors. There's lots of different reasons for this. Some of it has to do with sort of big changes from being active duty to being veteran, with respect to physical activity components the way that you might eat when you're active duty versus being a veteran. But suffice it to say, it would be worth thinking about screening those groups if you happen to work with veterans in your in your clinic.

Christine Peat (she/her): So what do you do now? If you've screened somebody, or you have um detected an eating disorder in a patient. Again, we've talked about some of the screeners already. What do I do next? What do I do if I'm concerned about somebody? I think one of the most powerful things that we see happen in a specialty clinic is when our primary care colleagues can express that medical concern when it comes to some of what they're seeing, with eating disorder symptoms. Oftentimes, if they are hearing from their doctor that you know this amount of weight loss is actually really dangerous, and could be really scary in terms of your physical health, or using laxatives in this way can actually be really bad for your health and here's all the reasons why.

Christine Peat (she/her): Many times patients are much more willing to kind of tune into that information. If it's coming from a trusted medical provider, and for many of you that have been working with patients in primary care for a number of years you've seen that happen. You've seen that happen in a relationship that you have with patients, and so we know that the same is true when it comes to eating disorders. You all have this really unique opportunity to help increase a patient's awareness of and motivation for their eating disorder and their treatment.

Christine Peat (she/her): Also, when it comes to the role of the PCP. We know that there is a real need for ongoing management of these patients. Um, not that you yourself have to provide the treatment, but especially if a patient is receiving outpatient care for their eating disorder, their physical health has to continue to be monitored to make sure that whatever eating disorder behaviors they're still engaging

in aren't going to land them in the hospital, for example. So that kind of regular communication, regular management, is an important role of somebody in a primary care or community-based clinic and consistent messaging is really key. Making sure that all members of the team have the same stance when it comes to the eating disorder treatment, because otherwise it just leaves room for the eating disorder to thrive.

Christine Peat (she/her): When it comes to referring to specialty care, I provided uh again the link to the SBIRT for eating disorders protocol to kind of give you everything you might need. But when you're doing so, I think it's important for you to be prepared for some degree of ambivalence, or maybe even some reluctance to accept that referral. Um in this regard. There's a lot of parallels with substance use disorders where folks may recognize that there's a problem. They see that what maybe they're doing is bad for their health, or it's affecting them emotionally, or from a mental health perspective. But they still may not be ready to make some of those changes.

Christine Peat (she/her): So I think it's really important that if you are making these recommendations, and you're making these referrals that you continue to follow up on it to make sure that folks have actually established care with an eating disorder provider or are getting established with an eating disorder program, for example. Because they may need some of the extra accountability and nudging to really kind of move forward with those steps. And as we talked a little bit about already. Just be prepared that access to eating disorders care is really challenging. This was true before the pandemic, but has certainly gotten worse after the pandemic. I don't mean to just sort of give you all bad news, but I think it's more to kind of set your expectation that it may take a couple of tries to get somebody referred , and to where they can actually get into a treatment program.

Christine Peat (she/her): There are some other challenges when it comes to making specialty referral, some of it has to do again with that ambivalence, or maybe resistance, to receiving that sort of care. Sometimes it may mean actually needing to coordinate some out of state care for some folks. If what is in your state isn't going to serve the needs that they have as I mentioned before, bed availability um has been really challenging after the pandemic, and there can be a long wait list um, and then sort of navigating that insurance piece is always challenging when it comes to mental health benefits given that they are treated differently from the rest of the medical insurance.

Christine Peat (she/her): I wanted to also outline a little bit about what treatment might look like again, recognizing that most of you are not going to be engaged in this sort of specialty care, but I think it can sometimes be helpful to sort of have in mind what treatment might look like if you're going to make referrals for some of your folks. Um. So when it comes to eating disorders care, there's all different kinds of levels. And this really kind of mirrors, a lot of other mental health conditions. But there's everything from inpatient which is typically hospital-base for folks that are really medically acute all the way down through outpatient care where someone you might be working with their therapist and their dietitian on maybe a once, maybe twice a week, kind of basis.

Christine Peat (she/her): And then everywhere in between, you know, there's kind of that intensive, outpatient couple of times a week treatment. Partial hospitalization is more like day treatment; Monday through Friday. Residential, um a little bit like inpatient, in that it's 24/7 care but they're usually less medically acute. Um. So again depending on the symptoms severity, the chronicity of the symptoms. Um, that's really kind of what determines, what level of care is appropriate.

Christine Peat (she/her): And typically it's going to be an eating disorder specialist who is doing the assessment of these patients who will make the determination about what level of care is appropriate.

Christine Peat (she/her): So what does treatment actually look like um, irrespective of which level of care we're really talking about psychological interventions for eating disorders? Um, there are really only a couple of medications that are indicated for eating disorders, and we'll talk a little bit about those here in a moment. But, um largely. When we think about eating disorder treatment, we're talking about talk therapy, psychotherapy. Um. One of the more common modalities is cognitive behavioral therapy, which I'm sure many of you are familiar with.

Christine Peat (she/her): There's a specific sort of trans-diagnostic-kind of CBT, called CBTE or enhanced CBT that has been adapted to specifically focus on eating disorders. For children and adolescents who may be struggling with eating disorders, there's something called family based therapy or FBT, where parents and guardians are actually the ones who are primarily delivering the treatment. They're the ones who are refeeding their kids, setting contingencies around meals, monitoring weight, monitoring um progress throughout therapy. But they're doing all of that under the expert guidance of somebody who specializes in family based therapy.

Christine Peat (she/her): As I mentioned, there are a couple of medications that have been indicated for the treatment of eating disorders. Lisdexamfetamine is on label, FDA approved as a monotherapy for binge-eating disorder and fluoxetine is also on label for bulimia nervosa. Again, these are medications that can be really useful for folks, especially knowing that fluoxetine, for example, may also address some of the ongoing anxiety or depression for folks that are struggling with an eating disorder. So again, I think it's important to think about the full armamentarium of options that we have for folks when they're looking to try and recover from an eating disorder.

Christine Peat (she/her): In the wake of the pandemic, we have also seen a real increase in access to virtual care, which I'm sure many of you have done since the pandemic. And that has also been true here with eating disorders. In fact, there are now several eating disorder groups that are providing eating disorder treatment entirely virtually so I've hyperlinked to a couple of those organizations that are doing that. Equip Health, Arise, and Within Health are all providing multidisciplinary care for patients

with eating disorders. I know that Equip is up and running, in all fifty states. I'm not a hundred percent sure about the others, because they're newer on the scene. But I would encourage you to check out their websites and find out if they're operating in some of the states where you all are.

Christine Peat (she/her): But when we think about eating disorder, treatment, we really are thinking about treatment as kind of a four legged stool. Whether this is inpatient, whether it's virtual, whether it's outpatient, we're really thinking of all of these different disciplines being involved. So, there has to be medical nutrition therapy. There has to be psychotherapy. There has to in some situations be psychotropic medications to manage other psychiatric conditions. But then always primary care is involved in some way so needing to monitor again the physical health of individuals who are struggling with these conditions. Given that we know that there's kind of this global effect on health.

Christine Peat (she/her): So when you are working with a special team, as I mentioned, I think it's really important to have good and consistent communication. It's really tough if somebody with an eating disorder is hearing from their team, no, you're not allowed to exercise, you're still losing weight, you're not eating enough. And then one member of the team says, 'Oh, sure, go ahead and exercise no big deal' right when there's that kind of splitting. It leaves too much room for the eating disorder to really flourish. So it's important that you're in regular communication with the other members of the team to make sure that we're all kind of giving the same message about the eating disorder and any expectations that there might be around treatment. I also think it's important too, when you're working with a specialty team to understand the difference between referring to a specialty team for an evaluation versus referring for ongoing treatment.

Christine Peat (she/her): Just given sort of the long wait list and everything that's going on with eating disorders care. There are many teams that are well equipped to rule in or rule out an eating disorder diagnosis, or to do a full, comprehensive assessment and say, 'yes, this patient has binge-eating disorder, and we think that a partial hospitalization is indicated.' That is one specific service, but actually picking those patients up for ongoing treatment is a separate service line, and it can be a long wait for folks to get into those sorts of services. So it would not be uncommon for you to make a referral to a specialty service, for that service to do the evaluation, and then your patient to be referred to another outside facility if that team can't actually pick the patient up in a timely fashion. Again, I'm sure some of this is stuff that many of you are familiar with. But I like to highlight this just so that you understand that there can be some uh additional wrinkles when it comes to making these referrals.

Christine Peat (she/her): for those of you that are interested in learning more, I wanted to highlight a few resources. Um, these are screenshots of our website, that gives you access to a resource library that you can filter based on the type of provider that you, are based on the diagnosis that you're interested in learning more about. Again, all of these are freely and publicly available.

Christine Peat (she/her): And then we also have um a training center that would give you access to free, online courses. We have a whole series dedicated to primary care. We have webinars that are focused on addressing eating disorders in um racially, and ethnically diverse populations. So, again, depending on your interest, I would encourage you to check out uh the courses that we have available on demand on NCEED, and then I've made a couple of QR Codes for some resources that I think will be relevant from today's discussion. Um. The first is to the SBIRT for eating disorders protocol, and then the second is to some of the treatment guidelines that we have for medical professionals who might be interacting with folks with eating disorders.

Christine Peat (she/her): With that I will put up my email address, and you are, of course, welcome to be in touch with me directly. If there's anything that you have questions about, or there's any ways in which NCEED could be of assistance to you or to your practice. And we also encourage you all to sign up for the NCEED newsletter should you be interested in learning more about what we're offering on a monthly basis in terms of programming, webinars, all those sorts of things.

Christine Peat (she/her): So with that, I will turn things over to the Q&A to see if folks have any question from today's presentation or anything. With respect to you know, patients, you may have encountered um again for those of you that are here with us this afternoon live, um you are welcome to put any questions that you might have into the Q&A feature that's located at the bottom of your screen, and I will do my best to try and answer as many of those as I can during um our time here together this afternoon.

Christine Peat (she/her): I'm just keeping an eye on the chat and on the Q&A here. Of course, I'm sure many of you have other things that you need to get to for today. You may have another patient that you need to see. Please feel free to just go ahead and shoot me an email, if there are other questions that we don't have time to get to here today. I do see one question here from [intentionally omitted], have you ever used the EAT-26 questionnaire? Thoughts? Yeah, Deb, that's a great question. The EAT-26 is a very common self-report measure um for those of you who may not be familiar with it. Um! It is a twenty-six item measure that is designed to assess for all different kinds of eating disorder thoughts, and it is a well-validated measure, and has been used in all kinds of research studies.

Christine Peat (she/her): Part of the reason that I didn't highlight it here is that it's not necessarily feasible all the time in a primary care setting. When we think about those kinds of screening tools we're really thinking about those brief instruments that can be administered very quickly, maybe as a patient is being roomed, those sorts of things. The EAT-26 is a great measure, just not something that always kind of rises to the top in terms of feasibility and primary care.

Christine Peat (she/her): Emily has a question about a recommendation for ADHD meds for eating disorders, is this still recommended? It's a great question, Emily. The medication that I mentioned with respect to binge-eating disorder, Lisdexamfetamine is Vyvanse, and Vyvanse is on-label, FDA approved

for the treatment of binge-eating disorder. Um, again, I think sometimes that there can be some challenges when actually prescribing this medication to patients. Given that some patients will actually have contraindications to stimulant medications, whether it's the history of substance use disorder, maybe it is a cardiovascular profile that sort of disqualifies them from stimulants.

Christine Peat (she/her): But, broadly speaking, um! It is something that is available as a treatment option for individuals with binge-eating disorder. The next question is about food or feeding for familiarizing providers.

Christine Peat (she/her): Suzanne, I am not quite sure that I can quite address your question. I wonder if you wouldn't mind to sort of um typing in a little bit of a clarification on food or feeding. Um, that you might have. I'm sorry for families. It sounds like any advice on food or feeding for families to provide. Yeah, that's a great question. Thank you for clarifying. Um. There's actually a great resource that I will make sure gets sent out through the email today with the slides that really focuses on parents and caregivers and families, and how they can navigate eating disorders. It's called FEAST.

Christine Peat (she/her): I can't. I can't remember the acronym off the top of my head. But they're an organization that's entirely dedicated to parents and caregivers, and they talk about food and nutrition and sort of getting information on how to talk to your kids about food as well. So I'll make sure that gets sent around um with today's email. Um. I see that there is also a question from Lisa. If someone has significant alcohol use disorder, should that be addressed first? Yeah, that's a great question. So should it be addressed first prior to in-patient eating disorder treatment.

Christine Peat (she/her): You know Lisa, I think that the field is kind of split when it comes to how do we attack some of these co morbid conditions because it can be really tough to know. Listen, is this something that um needs to get addressed before the eating disorder, or after. There are some facilities that are actually set up to do both where you can receive um substance, use disorder, treatment at the same time as your eating disorder. I will say that those are few and far between.

Christine Peat (she/her): I think the general rule of thumb has been that there isn't any reason that you can't treat both at the same time. There are, unless, of course, you know one of the conditions requires hospitalization at any given moment, of course; any physical or medical health crises should be addressed um immediately, but if somebody is sort of more stable, and can be seen on an outpatient basis. It's not uncommon for them to be working with a substance use team in addition to working with an eating disorders team, it can be a lot to coordinate for a patient, and we certainly can appreciate it.

Christine Peat (she/her): There's some additional burden there, but it is possible to treat both at the same time.

Christine Peat (she/her): Another question with respect to binge-eating disorder patients. Not real sure how to treat them in the short term. Is there a good startup type of treatment? Wonderful question, Steve, and thank you so much for asking this. And again I'll make sure that this gets sent out with uh the email today. But there is actually a self-help book for binge-eating disorder in particular. It's called *Overcoming Binge Eating*. It's written by Chris Fairburn, who actually developed CBTE, the trans-diagnostic treatment. Um, I'll make sure that link is sent out.

Christine Peat (she/her): But that book, *Overcoming Binge Eating* has actually been studied in multiple clinical trials as a standalone self-help treatment for binge-eating disorder. In fact, the NICE guidelines out of the UK and the Cochrane Review actually recommended self-help for binge eating disorder as a frontline treatment for that condition. Again, just because there seem to be such good traction with that particular approach, so we oftentimes will recommend that if we have folks on a wait list that they get started with that book while they're on the wait list to see if they can make it any traction and see some improvement in their symptoms. Great question.

Christine Peat (she/her): The next question indicates that um some um folks have been cheating over the years have attended a group, a peer meeting called TOPS. Yeah, I am familiar with TOPS. Um thoughts about um, this particular approach, you know. I think it's kind of hit or miss, Emily, it really kind of depends on the patient. I kind of similar question in other presentations about things like over eaters, anonymous, or some of those other kinds of group based approaches, and there are some folks who find that it's really helpful for them in terms of having some degree of accountability.

Christine Peat (she/her): Sometimes it may be a sense of getting some structure in their daily life, or in their weekly life. But then there are some folks who find it to be really iatrogenic. Some folks who find that it's far too weight focused, far too sort of. I've heard some folks sort of feel as though they were being shamed in some way, so in as much as it may be helpful for folks.

Christine Peat (she/her): One of the things I like to do is just kind of lay out all the options, you know. I'll let folks know there's a book that you can try, or there's individual therapy you can do. There are some of these twelve-step kinds of approaches. We know that it’s based on the evidence that the psychological approaches and the pharmacological approaches are the ones that have the most evidence behind them. So I will often encourage folks to start there, but ultimately it's patient choice, right. I'm not going to tell somebody what they need to do in terms of treatment.

Christine Peat (she/her): I will let them know what has the most evidence behind it, and what might actually be the most accessible to them. Um, but it can be helpful to kind of lay out all the options, and that way folks have a choice, and they can make an informed decision about what type of care might be right for them.

Christine Peat (she/her): And then Lauren is asking for me to repeat the book title. It is *Overcoming Binge Eating* by Chris Fairburn. Again, this will all get sent out via the email later today with the slides and everything else that we've talked about, and so I'll make sure that that's included as well. But it is *Overcoming Binge Eating* by Chris Fairburn, widely available on Amazon. I think it's in its second or third iteration at this point. But certainly feel free to look into that. If there's interest for you or for the patients that you work with.

Christine Peat (she/her): I don't see any other questions at this time, but I want to give it just another second, just in case. We're almost at the two o'clock hour. While I'm waiting for any other questions to come in. I just want to say thank you so much for joining us here this afternoon. We really appreciate your attention and your time. We know that all of you are very busy, and we appreciate you, being willing to learn a little bit more about heating disorders. Again, my contact information is here on this slide, please don't hesitate to reach out if you have questions about anything that was covered from today. But otherwise again, thank you for your time and attention, and we hope you have a great rest of your day. Take care.