Eating Disorders in Your Clinical Practice: What You Need to Know webinar transcript
January 2, 2023

la-shell_johnson@med.unc.edu: Good afternoon, everyone. Welcome to today's webinar titled, “Eating Disorders in Your Clinical Practice: What You Need to Know.”

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 chat feature located at the bottom of your box.

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la-shell_johnson@med.unc.edu: Lastly, we ask that you visit www.nceedus.org/training to view other training opportunities as a reminder. Slides will be available at the end of this presentation along with the evaluation that will be sent out via email.

la-shell_johnson@med.unc.edu: If there are any unanswered questions, those questions will be sent with responses one week from today.

la-shell_johnson@med.unc.edu: This training will also be available via our on demand training center at www.nceedus.org one week from today.

la-shell_johnson@med.unc.edu: I'll now introduce today's speaker.

la-shell_johnson@med.unc.edu: Today's speaker is Dr. Stephanie Zerwas, a clinical and developmental psychologist and adjunct associate professor in the Department of Psychiatry, School of Medicine at the University of North Carolina, at Chapel Hill. She is also the former clinical director of the UNC Center of Excellence for Eating Disorders.

la-shell_johnson@med.unc.edu: Dr. Zerwas is a nationally recognized researcher of the developmental psychopathology of eating disorders and disordered eating. Her research focuses on modeling the genetic risk for eating disorders, transgenerational effects of eating disorders, and the developmental trajectories associated with eating psychopathology.

la-shell_johnson@med.unc.edu: Dr. Zerwas is also a licensed clinical psychologist, and maintains an active private practice, Flourish Chapel Hill, where she works with teens and young adults with eating disorders and anxiety.

la-shell_johnson@med.unc.edu: I'll now turn things over to Dr. Stephanie Zerwas.

Stephanie Zerwas: Thank you so much for that introduction La-Shell, and thank you to everybody for being here today. I know that this time of year can be extremely busy with the run up to the start of the New Year, and I just appreciate everyone's willingness to learn more about eating disorders and your generosity with your time today. I'm really excited to talk a little bit about eating disorders in your clinical practice. I often find that my friends turn to me just feeling confused about how to support their patients, and how to really assess for eating disorders. So we'll talk about that today. I also want to, just, you know, talk a little bit more about NCEED, and make sure that everybody is aware of NCEED as a resource.

Stephanie Zerwas: And clearly you've joined us here. But it's worthwhile pointing out all the other trainings that are online here that you can access at any time, and it's just a wealth of really great information, both for you as practitioners, but also for family members and friends who want some evidence based eating disorder education.

Stephanie Zerwas: So as for NCEED our mission is to advance the education and training of health care providers, and promote public awareness of eating disorders and eating disorder treatment, and definitely our goal is to ensure that all individuals with eating disorders are identified. So often people with eating disorders are. It takes so many years for them to be identified in clinical care, treated and supported fully in their recovery.

Stephanie Zerwas: And here's just a picture of me but you can see me in the chatbox or the webinar as well.

Stephanie Zerwas: Let's just point out some of the free courses for CE credit that are available that are going to be complementary to what you learned here today. This includes things like, assessing growth in children and adolescents with eating disorders; the assessment and treatment of Latino males with eating disorders, and then also CBT-E, which is enhanced cognitive behavioral therapy for eating disorders. So lots of training and education resources. If you want to get a jump start on your CE or CME credits as well.

Stephanie Zerwas: Alright, so my goals today are to describe how eating disorder diagnoses might present already in your practice. That you might have a patient who you are curious about whether they might be struggling with an eating disorder, or whether you just, there's something nagging at you about their eating practices.

Stephanie Zerwas: We're gonna also talk about evidence-based tools for identifying and assessing eating disorders, and also a new tool that's being created by NCEED as a way that you could have it in your pocket to assess for eating disorders as well.

Stephanie Zerwas: We're going to discuss the best practices for non-specialist management of eating disorders and really discuss stepped-care strategies and really guidelines for when can I hold on to this patient and, when do I really need to step this patient up to more specialist care with somebody else?

Stephanie Zerwas: And then we'll talk a little bit about North Carolina treatment referrals, but just treatment referrals in general, and where to get more information about how to find somebody with specialist ability to support this patient.

Stephanie Zerwas: Alright. So to start a little bit. Why learn more about eating disorders?

Stephanie Zerwas: When I talk to clinicians, they sort of you know, ask me like I'm not really interested in becoming an even sort of specialist. Do I really need to know this information? And I think it's important to point out that eating disorders are definitely in this level of surge right now. Over the past 3 years, we have discovered that during the pandemic, and we're not totally sure, for all the reasons why, but there's been a just rapid increase in the number of patients with eating disorders who have come into the clinic and sought out care.

Stephanie Zerwas: And here are some of the popular press articles about it.

Stephanie Zerwas: There was a CDC study that showed that more teenage girls with eating disorders wound up in the ER during the pandemic. That's especially significant. Because if you're coming to the emergency room for care, or emergency department for care, you're eating disorder symptoms are particularly severe.

Stephanie Zerwas: We, in general, we saw that almost a threefold increase in the number of people seeking care in our clinical practice, and many other places around the country saw a similar pattern

Stephanie Zerwas: Overall, it seems like these factors, and these are just clinical impressions. But these factors might be contributing to this increase in eating disorder prevalence. And one is that the increased uncertainty over the pandemic led to greater focus on things that were certain for folks that they wanted to track numbers, calories, exercise tracking because people were really looking for some place that they could have greater certainty and greater control in their life.

Stephanie Zerwas: The other thing that we saw is that people are spending much more time at home, but also not necessarily engaging in more social eating. And we know that so social meals, eating together as a household can be really protective for the development of eating disorders.

Stephanie Zerwas: There is also real concern, you know. Do you remember people talking? I know our, all of our memories since we've been going through this collective experience have been kind of fuzzy about the last 3 years.

Stephanie Zerwas: But I think it's important for us to, to, to note that there was a lot of concern, a lot of discussion about pandemic related weight gain or pandemic related body changes. During this time people talked about the quarantine 15. And so this general focus on oh, I've got to come out of this, or I've got to utilize or leverage this pandemic as a way to like, really lose weight or be very body focused with. That was definitely a part of this.

Stephanie Zerwas: The other thing was hearing a lot from a lot of teenagers especially, is that they had way more time on social media, and that the algorithms really discovered that they liked eating-related content information about dieting and really having a lot of information just about how to lose weight quickly, shaming information about certain types of bodies, and that once the algorithms realized that they like that sort of content, that they would be fed that content quite a bit. And so it started to shift their idea about what was normal, or how people talked about body and exercise overall.

Stephanie Zerwas: So let's talk a little bit about some of the warning signs of eating disorders. And a lot of times these can fly under the radar for a really long period of time, and lead other people not to take note of them, because they're not always observable or measurable.

Stephanie Zerwas: One warning sign that we see, is folks who have a dramatic weight gain, or dramatic weight loss in a short period of time. Whenever you see sort of a rapidity in the weight gain, or weight loss, that is frequently a concern. When people talk about their food, their weight, their shape quite a bit and just really seem like they're stuck on talking about what they're gonna eat next, or whether or not they should eat. That is often a real, it gets it sort of raises that red flag for the people around them, and especially for you as a clinician. If it seems like there's a persistent decline or increase in food intake.

So not just this shift in weight, because sometimes people can shift their food and take quite a bit. But there's actually no change to their weight status at all.

Stephanie Zerwas: And it, you know, I'm sensitive to the fact that we are also in January, which is when we have all of these New Year's resolutions typically. And so, it's important to take note of ok, somebody might have a New Year's resolution about shifting their eating pattern. But if they're taking it to an extreme level, that's when we get really concerned.

Stephanie Zerwas: Excessive or compulsive exercise patterns are definitely a warning sign. We all know that exercise is wonderful, wonderful medicine. And that we, you know, as humans feel better when we're getting regular exercise.

Stephanie Zerwas: And yet, if somebody is exercising so much that it's interfering with their life, or it just seems like they're compelled to do it. Even when they are injured, or other people are concerned about them, and they're still going out to exercise. That is of particular concern.

Stephanie Zerwas: Of course, purging, restricting, binge eating, or compulsive eating would be a warning sign, as well as abuse of diet pills, laxatives, or emetics.

Stephanie Zerwas: And oftentimes, we need to ask people directly about the use of these. They don't always volunteer this information on their own.

Stephanie Zerwas: The other really hallmark sign, and, I think this one is kind of tough to talk about, is that frequently the person who is struggling with their eating also denies that this is a problem for them, or, despite other people's concerns that this is like kind of a hallmark warning sign that this might be an eating disorder. That somebody maybe doesn't have insight to what they're up against.

Stephanie Zerwas: Eating in secret, sort of sneaking away food, feeling like you have to eat away from everyone else, or hiding food from other people, or just feeling out of control with food all together was definitely a warning sign, as well as any sort of medical complications. And these usually happen much further down the line.

Stephanie Zerwas: Having dizziness with standing up, a fainting episodes, more hair loss, really brittle hair. Sometimes you might see increased sort of downy hair on people's arms as the body tries to protect itself, and warm. Osteoporosis, lots of diarrhea or digestion issues, constipation as well as dental

problems are all signs that there might be something going on here. Alright, so we're gonna talk a little bit about the DSM-V, and you know this might be all old news to you. And yet, I just want to make sure that we're all on the same page about what eating disorders are, and who meets DSM-V criteria for an eating disorder.

Stephanie Zerwas: So in anorexia nervosa, the defining feature is this intense fear of gaining weight and a restriction of energy intake leading to significantly low body weight. So it is that combination of fear of gaining weight as well as having a very low body weight.

Stephanie Zerwas: And it's important to note that there are 2 subtypes for anorexia. You know those, so there is both restricting subtype or binge purge subtype. And sometimes people are very confused about what that diagnosis might be. I have, I've definitely had people come in and say, I think I have bulimia nervosa when they also have very low body weight, and better meet the criteria for anorexia nervosa. So it's important to take note that that binge, bingeing, binge eating and purging combination doesn't always occur in bulimia nervosa, that it can also occur in anorexia nervosa as well. The other characteristic for the binge eating type profiles, and we'll talk about bulimia nervosa as well as binge eating disorder.

Stephanie Zerwas: In both of these cases you're having binge eating episodes. And binge eating episodes really refers to eating an unusually large amount of food in 2 hours while experiencing a sense of loss of control over how much is in. So that's really important. You're not just saying, oh, did you have, did you eat a large amount of food, but that the person themselves experienced a sense of loss of control. It's just food became irresistible. It was hard to stop once they got started, and they really didn't feel like they could totally stop themselves after they started eating.

Stephanie Zerwas: It's important to note that there are 2 different types of binge eating episodes though. So one is an objective binge eating episode, and in that case anyone would agree, and in general that this is a large amount of food.

Stephanie Zerwas: You might also hear from your patients that they're having more subjective binge eating episodes. This isn't what anyone could consider a large amount of food, but they look at it as being a large amount of food, and that is still binge eating.

Stephanie Zerwas: In binge eating disorder, you have to endorse 3 plus more eating symptoms, including eating more rapidly than usual. Eating until uncomfortably full, eating when not physically hungry, so not having any hunger cues and yet still eating, being more likely to eat alone due to embarrassment about how much is eaten, or feeling disgusted or depressed or really having really self-critical thoughts after a binge eating episode.

Stephanie Zerwas: So bulimia nervosa. So let's go on. So we started talking about binge eating and binge eating disorder. So binge eating involves binge eating episodes, but no compensatory behavior whatsoever.

Stephanie Zerwas: Bulimia nervosa is that combination in people who are not at a very low weight, like anorexia nervosa binge purge subtype. But they're at sort of what you might expect a reasonable weight for their height.

Stephanie Zerwas: And so, in bulimia nervosa you have both binge eating and compensatory behavior to prevent weight gain. And this compensatory behavior might take many different forms, so it's not just purging behavior, but it could be also the misuse of laxatives, diuretics, or other medications.

Stephanie Zerwas: The misuse of laxatives or diuretics really has a negligible influence or impact on the individual's weight status, and yet they might believe that it helps them prevent weight gain. You might also see that individuals with bulimia nervosa will engage in fasting, that they'll have what they consider “a bad day”. And then the next day they sort of recommit, and what might fast for an extended period of time to try to make up for their binge eating episode.

Stephanie Zerwas: Or frequently, I work frequently with college students, and I see this pattern quite a bit where somebody will have binge eating episodes, and then try to make up for it with excessive exercise the next day. They'll tack on additional time in the gym or additional miles, and try to make up for what they ate before. So all of those types of things are compensatory behaviors.

Stephanie Zerwas: In the DSM-V criteria say that both have to occur on average at least once a week for 3 months straight. So about 4 episodes every month for about 3 months in a row.

Stephanie Zerwas: People with bulimia nervosa that often say that they have, they evaluate their selves by their body shape and weight, that they feel really good if their body shape looks a certain way, or if that number on the scale is where they want it to be, or they can feel very, very bad about themselves if it's if it budges off that. And again bingeing and purging does not occur exclusively during episodes of anorexia.

Stephanie Zerwas: Okay. So for binge eating disorder, mild would be 1-3 binges per week; moderate is 4-7 binges per week; severe is 8 - 13, and extreme would be 14 plus binges a week.

Stephanie Zerwas: It's also important for us to talk a little bit about some of the newer categories that were in the DSM-V as well. And one newer category that we as eating a sort of specialists had seen for many, many years, but didn't really have a diagnosis to fit it into is avoided restrictive food intake disorder, or also called ARFID.

Stephanie Zerwas: And in ARFID, you might find that your patient or a client has a persistent failure to meet their appropriate nutritional or energy needs. And one of the things that we commonly see is that people might be very uninterested in food, or they might really focus very closely on to certain sensory characteristics. So they're only going to, perhaps eat things that are white foods, for example, or they only feel comfortable with 3 different types of foods. Ad they can't expand their food intake beyond those specific foods that they feel like are safe or clean.

Stephanie Zerwas: You might also see that a person with ARFID might avoid certain foods due to aversive experiences. Sometimes this goes beyond allergies. Of course you would want to avoid food due to allergies. But sometimes we'd see people with ARFID who have a choking experience, and then they sort of generalize. Oh, I can't eat any meat, because I had I experience choking when I was chewing on some steak or something like that.

Stephanie Zerwas: A common feature is significant weight loss with this as well as nutritional deficiencies, and sometimes people with ARFID end up depending on new nutritional supplements or other sorts of supplements.

Stephanie Zerwas: Is ARFID similar to orthorexia is in the chat, and frequently it can be very similar. It's orthorexia that focuses much more on the clean eating sort of thing, and it's important to note that orthorexia is actually not in the DSM-V. And so it, it's sort of better fit into this next disorder that I'll talk about a little bit here.

Stephanie Zerwas: The other new diagnosis in the DSM-V was OSFED, other specified feeding or eating disorder, and this includes atypical anorexia nervosa, bulimia nervosa that doesn't meet that time criterion or frequency criterion, that we talked about same for binge eating disorder as well as purging disorder. That's where people don't necessarily have binge eating episodes at all, and yet, or experience a sense of loss of control at all, but still they feel the urge to throw up after every meal, and so that, that's also within this OSFED category as well as night eating syndrome.

Stephanie Zerwas: In atypical anorexia nervosa, I think this is the one, this is the category that most people haven't heard about before, and sometimes have a real difficulty detecting. So, I would say in atypical anorexia nervosa, you might see a patient who is basically starving themselves, not eating enough to meet their energy needs. Let's say they're getting 700 calories a day and trying to be, “good

dieters," and yet it's absolutely not having any change on their weight status. Their weight status might be in the, you know, the normal BMI category, or the obese or overweight category. And yet, nutritionally and behaviorally, they look almost identical to a patient with anorexia nervosa.

Stephanie Zerwas: So I think it's important to note the anorexia nervosa doesn't always have a particular look or a particular size. People can look like people with anorexia nervosa, and yet their body has just stopped responding to their dieting behaviors.

Stephanie Zerwas: Alright. You will see this slide a lot in presentations from NCEED. And, I think it's because it's really important for us to sort of buss some of the myths about eating disorders, and frequently these are some of the things that I hear. And so, we're just going to have a quick refresher about the truth about eating disorders.

Stephanie Zerwas: Eating disorders not have one particular look. Many people can look very healthy, strong, vibrant, and yet be suffering from an eating disorder.

Stephanie Zerwas: Often we hear, oh, if you have a need for it, it must be your family's fault. Families are absolutely not to blame. There is no evidence that there is a particular eating disorder predisposition in a family.

Stephanie Zerwas: Sometimes people look at eating, the services being kind of a phase, and it's actually a health crisis that can disrupt functioning completely.

Stephanie Zerwas: They're not choices. It's not that somebody, and none of my patients have ever chosen to have an eating disorder. Oftentimes they sort of found themselves in behaviors that are really similar to you know things that other people do. Like in January, for example, and 2023 at the start of the year. And yet the eating behavior, or the restrictive behavior kind of takes off and sets them on this course.

Stephanie Zerwas: There's no one particular look. It can affect people of all ages, body sizes, genders, sexual orientations, race, and socioeconomic status.

Stephanie Zerwas: It's not just a white, skinny girl disease, for example. And these are very risky mental health conditions. And they hold they are among the highest risk for both death and suicide. So the mortality rate in folks with eating disorders is quite high.

Stephanie Zerwas: Genetic factors definitely increase the risk of who will develop an eating disorder, but genes alone, that won't ever predict who will develop an eating disorder. So sort of genes increase the risk, and yet they're not sufficient in order to lead to further eating disorders. And it's also important to note here that full recovery is absolutely possible. Oftentimes people sort of think of these, and I hear this from families quickly, that that that families are worried that, oh, if my child is developed and eating this sort of this is a chronic illness that they will struggle with for the rest of their life.

Stephanie Zerwas: And that is not the case with appropriate treatment. People can recover fully from these disorders and live without the eating disorder in their life.

Stephanie Zerwas: One important thing to note, though, is that providing expert eating disorder, treatment also really means that people have to wrestle with their own understanding of diet culture in our society.

Stephanie Zerwas: And so sometimes I hear the sort of assumption that working with somebody with eating disorders basically is helping them be better dieters, right? And it's really important to note that our goals in eating disorder treatment are never to help the client be a better or more successful dieter. Right? We really one of our primary goals, initially, is to normalize the eating pattern.

Stephanie Zerwas: It's not to make sure that they get the exact right trainer to do the perfect exercise, to quote unquote, “burn off calories”.

Stephanie Zerwas: And it's not to help. You know I well, meaning people will sometimes say, “Oh, she feels really insecure in her body, so and feels really bad about herself, you know.” Let let's help her get to the quote on quote perfect weight/shape/size, in order to be content. That is absolutely never our goal. It's really to have people accept and tolerate, hopefully to start, but also really accept and embrace themselves as they are.

Stephanie Zerwas: It's also not our goal to help people be the quote unquote, “best eater.” They don't have to be perfect eaters in order to defend their choices to family and peers, that, that alone would be a concern as well.

Stephanie Zerwas: So some of the principles we often say, and treatment, and you know, I think sometimes diet culture is so ingrained in all of us. These can be kind of challenging statements, I would say like if I say these statements on Twitter, for example, I am sure to get lots of blow back from people who will disagree with me quite vehemently. And I think if we all sort of struggle with these diet culture waters.

Stephanie Zerwas: Food does not have a moral value, right? There aren't good foods and bad foods, and that all bodies are good bodies, that someone's value and worth is not dependent on their body shape. Bodies come in all different shapes and sizes.

Stephanie Zerwas: There's frequently a focus on restrictive dieting, as being you know, morally better, or showing control and restrictive dieting can be dangerous and increase the risk of eating disorders.

Stephanie Zerwas: Oftentimes, when I hear about you know a child in my neighborhood, for example, who are a teenager talking about starting a diet, I get really worried. Given what I know about the risk factors for eating disorders.

Stephanie Zerwas: Exercise is not really used as a way to improve mood. or it's used as a way to improve mood. It's not used as a way to compensate for what was eaten before, and so we really focus in eating disorder treatment to find ways to focus on function, and what exercise does for you; how it makes you feel rather than the form of exercise or a compensatory behavior.

Stephanie Zerwas: The other thing we have to work on frequently is that appearance-based comments can be very harmful. So your clients and patients really don't need comments about “Oh, but you look beautiful, or you look great,” right.

Stephanie Zerwas: Even positive ones can leave people feeling stuck, and like they have to continue looking this way in order to get this response from other people.

Stephanie Zerwas: Patients often report that they really fear that they will gain weight and become fat. And in studies this fear of fat is often at the center of eating disorder symptom networks. If we look at the individual symptoms that lead to other symptoms, which lead to other symptoms.

Stephanie Zerwas: The thing that we hear over and over again is that people are really afraid of gaining weight and becoming fat. And it's really, not truly fear of fat in research we've seen, but it's the fear of what fat will bring. That because of our diet culture being at a higher weight brings negative evaluation. It can be bring mockery and criticism by others. So it's really important that as clinicians and as individuals, we come to terms with our own diet culture and try to shift the needle and how we talk about people all different weight, shapes, and sizes.

Stephanie Zerwas: And the other important thing to take note is that internalized weight stigma can make it much less likely that somebody is seeking out treatment, and that an eating disorder is detected or treated. Weight stigma, having internalized weight stigma can exacerbate or trigger eating disorders. So I think there's this sense sometimes like oh, I have to, you know get on this person to be really critical about their body, and that that shame will somehow motivate them into quote on quote “eating better.” That shame is good, and instead we see quite the opposite. The internalized weight stigma, or weight stigma from others only serves to increase binge eating or triggers eating disorders.

Stephanie Zerwas: Alright, so going back to why we we’re talking about this today, and how you, as a clinician working with an individual, and really having an ear out for what might be going on with your client.

Stephanie Zerwas: Early detection is incredibly important and just key overall, and I think, even though my you know my website, says I'm an eating disorder specialist, and that I work frequently in this area. I can't tell you how many people I've worked with who have come to me and said, listen I don't have an eating disorder like I saw that you do that work. But like that's not my issue, and then are really surprised and completely overwhelmed to discover that actually they meet criteria for an eating disorder.

Stephanie Zerwas: So it's important that you listen to people because not all of your patients are going to come to you, knowing that they're really struggling with an eating disorder already.

Stephanie Zerwas: And your relationship with your client is a really important platform for you to educate your, your, patient about the eating disorder and really provide psychoeducation new information as well as providing sort of a correction to the diet culture beliefs that they hear day to day.

Stephanie Zerwas: And we see over and over again the early diagnosis and treatment results in much better prognosis overall. On average, it seems like it takes people 3 to 4 years before they get their first diagnosis of their eating disorder. And if we can interrupt that and shut, you know, narrow that window a little bit, we'll see better prognosis for patients overall.

Stephanie Zerwas: The other thing that I see over and over again is a lack of insight, or the other word that we use in the field frequently is anosognosia. So anosognosia refers to the fact that the eating disorder itself, often anorexia itself, prevents the person who is suffering from seeing the seriousness of the disorder. It leads to comorbid brain changes that makes it, them unable to understand what's going on with their body, or to see the seriousness of it.

Stephanie Zerwas: So one of the things that I'll hear from people. When we talk about an anorexia nervosa diagnosis is oh, but I'm not in the hospital, right? So I'm, I'm out walking around only people who need hospitalization have an eating disorder. Or, I can't have an eating disorder, this is how everyone talks. I hear everyone think like this, eat like this. This is what everybody worries about all the time.

Stephanie Zerwas: Or this belief that everyone is in on a diet all the time.

Stephanie Zerwas: And listen, the fact that I'm having a no period, or I'm having fainting spells, it really can't be that dangerous.

Stephanie Zerwas: Sometimes we will ask people to go to their medical providers and get labs in order to look at electrolyte imbalances, etc.

Stephanie Zerwas: And it, those can be helpful sometimes to provide evidence that this this eating, is sort of really impacting you physically. But sometimes those lab values look completely fine, and that can lead people to sort of a false sense of security. It can't be dangerous, my blood labs look okay.

Stephanie Zerwas: Alright. So I'm, I'm putting these up, and these slides will be available to you later. So some of these resources. If you see PMC ID's here that's the PubMed Central. All of these individual papers are available to you, and you can download them. The Binge-Eating Disorder-7 screening tool. There's also the Eating Disorders Inventory screening tool, and that's that PMC number is there, as well as well as the National Eating Disorders Association has an assessment tool online that sometimes people like doing and of working through with their client in session. And now we're also using the SCOFF in the National Center of Excellence for Eating Disorders.

Stephanie Zerwas: So I'm going to talk to you a little bit about the SBIRT for eating disorder tool that's now out.

Stephanie Zerwas: So the SBIRT tool is very easy to use. It's actually an app that you can use, and it helps you quickly screen patients for eating disorders. There's no need to like log in or download software. It's just like one click away and it contains 5 concise questions. And these are based on the SCOFF, which is an internationally used detection and screening tool for a patient. And the really nice thing about the SBIRT is it doesn't only just go through the screening questions, it also provides advice for you about how to talk with your client about your concerns, about their answers.

Stephanie Zerwas: So it gives you a sense of oh, we have to talk more about this, but it also provides training for you about how to guide them to the next step, to get appropriate care.

Stephanie Zerwas: So it's free, which is great, and you'll find it at eatingdisorderscreener.org.

Stephanie Zerwas: So it, this SBIRT, the screening brief intervention and referral to treatment tool was just released this fall, and we're really hopeful that this is going to be an excellent tool to use in the future. Okay.

Stephanie Zerwas: So I'm going to for the sake of time. I'm going to go over that.

Stephanie Zerwas: The other thing that you might be interested in is the Eating Disorder Assessment for DSM-V as well as the Eating Disorders Examination (EDE) for child and adult, and as well as the Eating, Disorder Examination Questionnaire (EDE Questionnaire). Those are much longer batteries, and I think with you wouldn't necessarily start with those.

Stephanie Zerwas: But the Eating Disorder Examination Questionnaire is something that your client can complete on their own in addition to the work that they're doing with you in session?

Stephanie Zerwas: Alright. So when to refer out, when do you need a higher level of care? Are they always necessary? And are there pros and cons of these different higher levels of care?

Stephanie Zerwas: We're let's just sort of like talk about the eating the sort of treatment landscape a little bit, because, you know, being in the field as long as I have, this is all very transparent to me. And yet, when I talk to providers, I hear. Wait. What, what is really available? How do you know? And where do you start? So the lowest level of care is outpatient level of care. Somebody might come in one to 2, or one to 3 times a week. They might have a series of providers.

Stephanie Zerwas: The next step is intensive outpatient, then partial hospitalization that includes day treatment all day long. Residential treatment is the next level of care. It's all day sorry, but with less medical acuity, and then inpatient level of care is hospital-based and for folks who are highly medically acute at the time.

Stephanie Zerwas: So we'll start with inpatient level of care.

Stephanie Zerwas: The criteria for inpatient level of care can sometimes vary by institution. And so it's important to note that one hospital might accept somebody inpatient and another one might not. It requires sometimes communication with the referral coordinator.

Stephanie Zerwas: But it is a both an eating disorder unit and a psychiatric unit with medical consultation. So if you have a patient who's highly medically compromised by their eating disorder inpatient is the right level of care.

Stephanie Zerwas: and there are different practice guidelines from the Society for Adolescent Health and Medicine, as well as the American Psychiatric Association that guide who goes into inpatient care. It is the most restrictive form of care, though, and it's really reserved for people who are medically unstable. So that could include being less than 85% of their expected body weight or having an acute weight decline, even if they're not less than 85%. So, having a sudden weight change at a higher weight status might lead to that. One criterion that's really helpful to know about inpatient level of care is that if you are working with somebody who needs an NG tube placement because they're having trouble eating on their own, typically, that can only occur in inpatient level of care.

Stephanie Zerwas: There's continuous supervision, meal support, supervision in bathroom and showers as well. In residential level of care, it's less medically unstable but there's still that same level of supervision as well. And the motivation might be a little bit better

Stephanie Zerwas: In partial hospitalization, you have to have much more cooperative and some motivation for recovery. Sometimes that day can look like 9 to 5 throughout the day, and includes group and individual therapy, as well as Dietitian support and medical management – sort of one stop shopping.

Stephanie Zerwas: And then the next lowest level of care is intensive, outpatient, level of care, and that's maybe like 3 to 5 days, but maybe 3 hours, 4 hours a day.

Stephanie Zerwas: This is much more minimal structure, and that somebody is self-sufficient and able to eat with just a little bit of external structure, and friends and family provide much more support in this level of care as well. In outpatient level of care, you might have 1-4 appointments each week, and when we think about what all goes into treating and eating disorder in outpatient level of care.

Stephanie Zerwas: Frequently you need a whole treatment team, so that might be an individual therapist, a family therapist, a dietitian as well as medical monitoring, to ensure continued medical stability during treatment.

Stephanie Zerwas: This this is much less restrictive care, but it puts much more burden on the individual who's recovering, or the family to provide that sort of structure around eating, as well as being there for emotion regulation, and support.

Stephanie Zerwas: And so friends and family really step up to provide continuous support in outpatient level of care.

Stephanie Zerwas: One, there are a couple challenges to referring people to higher level of care. Sometimes parents really struggle and experience some resistance to referring their child to a higher level of care, and it's understandable. You know it requires separation if a teenager is struggling with an eating disorder. It requires separation of that teen from the family environment. So oftentimes we try to start with family based therapy and see if we can have some success with family based therapy before we would ever refer somebody to residential.

Stephanie Zerwas: It can really be disruptive to an individual's life, and you know, oftentimes my patients are very committed students as well, and the idea of interrupting their whole life and leaving to go into residential level of care can be very challenging. The other thing, and we think about the eating disorder landscape, frequently people need to go out of state for their care, so it's not like they can have frequent visitation from their family members while they are in residential level of care, and that can be a sort of a huge hurdle to overcome being that alone and far away from home.

Stephanie Zerwas: Over the pandemic, we definitely saw that there were extremely long waiting lists, you know sometimes 6 to 8 weeks, and the bed availability was pretty low, and insurance coverage varies. So it's worth talking to people about whether their insurance covers residential level of care for example. The other challenges sometimes depending on the residential treatment center, they might not utilize evidence-based practice. So it's always really important to educate yourself and find out more information. Find out about the reputation of a residential or partial or intense outpatient program that you're referring to.

Stephanie Zerwas: Alright. So in these next 10 min I'm going to talk a little bit about some of the outpatient treatment options that you might want to investigate or educate yourself into these. This is not meant to be, you know, definitive. We can't really go through each of these trainings in depth.

Stephanie Zerwas: And yet it might point to some additional ways that you would like to learn more about outpatient treatment if you were interested in working with folks with eating disorders, or be able to refer to some patient to appropriate outpatient care for their eating disorder.

Stephanie Zerwas: So one of the most effective form of treatment for adolescents is family-based treatment for eating disorders. And so we'll talk about that a little bit in the principles of it, as well as CBT-E has also been shown in randomized control trials to be an effective form of treatment as well. And that's that that includes enhanced cognitive behavioral therapy.

Stephanie Zerwas: It's a transdiagnostic treatment, which means that you don't need to tailor the treatment based on the eating disorder presentation by diagnosis; you, it can be used in anorexia, bulimia, and binge eating disorder as well.

Stephanie Zerwas: We know that families historically have frequently been blamed for their child's eating disorder. Sometimes people talked about enmeshed mothers, or having a parentectomy.

Stephanie Zerwas: Modern approaches to eating disorders really demonstrate that parents can be the absolute best ally and the best sources of support for recovery, and for somebody who is struggling with an eating disorder, and that families are doing the best that they can and might also need additional coaching in how to support their child throughout their recovery.

Stephanie Zerwas: There are a couple of principles of family based therapy. One is externalizing the eating disorder from the child. We often discuss that it's like the eating sort of sort of into the child's life, and can they can be pulled apart again. So there are times when the evening disorder talks, and then there are times with the person who is trying to recover from the eating disorder. You also hear that sort of motivation and urge to recover. And listening to those 2 things can be really important.

Stephanie Zerwas: The therapist really tries to empower the family to take over what they know about feeding their child, and they act mostly not, as you know, a director of the treatment, but as a coach for the family. You really try to empower the parents to already do what they know which is, provide nutrition and care for their child with an eating disorder, the family is the expert on their child. They've known them much longer than you have, as the therapist.

Stephanie Zerwas: FBT is not appropriate in some circumstances though. If a parent is also struggling with an eating disorder, or there's abuse in the home, then obviously this this is not the right treatment path to go down. And sometimes families would really like to provide this type of care, but there insurmountable barriers to implementation just financially or in terms of the amount of energy that it would take in order to implement this care. And sometimes this is not an appropriate level of care when a patient is really medically unstable, and we really need the supervision of residential care and inpatient care.

Stephanie Zerwas: So parents lead the team; they take over a leadership position, and we try to empower parents to support their child.

Stephanie Zerwas: I'm gonna talk about CBT-E a little bit, because we're running low in time.

Stephanie Zerwas: CBT-E is theory driven and an evidence-based approach. It's suitable for both adolescent and adult patients and it's really designed for complex patients, as they call it, in the literature. It's not that patients only need to have, you know, just a pure eating this, or oftentimes our patients come in with anxiety and depressive disorders as well.

Stephanie Zerwas: And it's even though it's transdiagnostic in its scope, you also tailor it to the specific eating problem that the patient is struggling with.

Stephanie Zerwas: So, you might look at over and measure sort of over-evaluation of shape and weight, and whether that leads to strict dieting, and then you might, tailor based on whether that leads to then binge eating subsequent to that strict dieting or low weight subsequent to that strict dieting, so that it sort of splits off, based on the patient's own symptoms. In the stages of a treatment, you sort of have the first initial stages that involve starting well and then taking stock of how this is working in that patient's life and what the function of the eating disorder is. And then you would divide your care and sort of personalize based on whether it's body image focused, dietary and restraint focus, or events, moods and binge eating focus. And then, really, tailor the intervention based on those. Then you go to looking at setbacks and mindset and ending well.

Stephanie Zerwas: Well alright, both of these treatments technically in manualized form can be done in 20 sessions. Sometimes, you know, depending on your patients, they might take more or less time.

Stephanie Zerwas: And they both involve collaborative work with psychotherapy, nutrition, and medical monitoring, all working together to support the patient.

Stephanie Zerwas: Alright. So there, it's also important to note that there are also self-help approaches as well, and those include books or mobile apps, and that if you wanted to consider this a stepped approach. You might start with self-help first, see if it supports the patient, and then step up to maybe more specific eating disorder outpatient treatment all the way up that ladder of care. But the idea is not to sort of overstep and overshoot what the patient really needs.

Stephanie Zerwas: Just a couple of other notes about pharmacological interventions that are frequently used. One is Vyvanse, which is the first and only medication that's FDA approved for the treatment of a binge eating disorder and other medications are typically used off label, and yet can also be very helpful. Those include Fluoxetine, citalopram, bupropion. There're specific books that are really helpful, especially for binge eating disorder, Overcoming Binge Eating is a great book as well as Crave: Why You Binge Eat and How to Stop from our own Dr. Cynthia Bulik at UNC Chapel Hill.

Stephanie Zerwas: The other of course there's an app for that right? There's an app for everything these days. Our patients really like both of these apps, one is, *Take Control*. It involves helping people monitor their binge eating episodes as well as *Recovery Record,* which is an eating disorder specific way to increase self-monitoring over time.

Stephanie Zerwas: And it's important also that we recognize that virtual treatment has exploded over the past 3 years, and the pandemic really increased access to virtual care. And now, with PSYPACT there's increased access to virtual care that might be in even in a different state.

Stephanie Zerwas: So patients have much more opportunities to get in touch with an eating disorder treatment specialists than maybe ever before.

Stephanie Zerwas: And so there are several eating disorder groups that now provide eating disorder treatment entirely, virtually, and these are provided in sort of like comprehensive, outpatient package. So Equip Health is, one provides Family Based Treatment for eating disorders. Arise and Within Health are a bit more broad as well.

Stephanie Zerwas: Oh, name the apps. So there's *Take Control* and *Recovery Record*, are both apps, and actually Recovery Record has done great work in publishing some of their findings as well, and looking at the participants who have used the recovery record in order to recover through self-help.

Stephanie Zerwas: If you are starting to engage with a specialty team, who is interested in supporting your patient. It's really important to communicate, communicate, communicate. And it oftentimes in eating disorder care, we have to do much more communication than any other sort of form of treatment. So it's really important to look at the potential for ongoing therapy with local providers as well as communicating if you're concerned, and you're noticing something in your client.

Stephanie Zerwas: Alright. So here's some additional resources. We talked about how NCEED has ongoing CE's that are free at no cost, which is a tremendous resource.

Stephanie Zerwas: And thank you so much for your attention today. I'm so sorry about the technical details on my part, and sort of set us back a little bit for questions. But I really appreciate your focus, your attention, your interest in this work.

Stephanie Zerwas: And I also thank you on behalf of all the patients out there in the world who are struggling right now and looking for someone who has this information. You guys are tremendous in joining us today, and I really appreciate just your willingness to support your patients.

la-shell_johnson@med.unc.edu: Thank you so much, Dr. Zerwas, for this amazing presentation. As a reminder, we know that we didn't have a question and answer segment today. If we have questions, please place them in the Q&A. I'll give you 1 min to type those in. We will get those responses to you within the next week and a half.

la-shell_johnson@med.unc.edu: Slides will also be emailed after the presentation, and you also receive an evaluation for you to complete on today's presentation. This webinar has been recorded, and will also be available on demand via the NCEED Training Center on January 17th.

la-shell_johnson@med.unc.edu: Once again, if you have any questions, I'll give you one more minute to type those questions into the Q&A chat box. You will have those responses emailed to you. Thank you so much for joining today. And thank you once again, Dr. Zerwas.

Stephanie Zerwas: Thank you so much. I really appreciate it. Have a wonderful day everybody!