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Some Highlights from the 2020 iaedp Virtual Meeting

An international meeting as close as your computer keyboard.

After the 2020 iaedp conference planned for Orlando, FL, was cancelled due to the COVID-19 virus, the iaedp Foundation quickly went into action and turned the meeting into a virtual conference. Using virtual reality, members and other registrants were are able to take study sessions, visit the virtual exhibition hall, participate in Spanish sessions, complete classes for CME credits, and also to hear outstanding presentations by keynote speakers.

Here are three presentations by keynote speakers at the 2020 iaedp virtual meeting. Topics ranged from the power of laughter and hope, and uses of new technology to improving care for eating disorders patients. Here are a few highlights:

Humor Really Is the Best Medicine

Author, columnist, and educator Gina Barreca, PhD, told her audience that humor can be a powerful therapeutic tool. Detailing her own childhood in a large Italian family that had two sets of rules, one for men and another for women, Dr. Barreca described how the use of humor helped her establish her independence and enabled her to break out of restrictive patterns for women. According to Dr. Barreca, the traditions she grew up with dictated that women weren't supposed to take up much spaceâ€"this went not only for female bodies but other areas as well. Beginning in childhood, females were taught to not be too loud, not to want too much, and their assigned role was primarily to take care of everyone else. Taking care of everyone else all the time leaves little space for psychological real estate for ourselves, she said.

Dr. Barreca told the audience that humor enabled her to break out of the mold of her upbringing of Barbie dolls and her family's expectations of her. As females, "our first mistake was learning to be "good girls," she said, adding that as good girls, women are taught never to trust themselves or their own reactions. She also noted that ideals of beauty are always in flux. Beauty is a sort of compact between the beautiful being and the perceiver of that beauty, and the reflective surface can shift, shake, or reshape itself. She added that women's worth historically and culturally has been based on beauty and youth rather than accomplishments or talents. Why, she wondered, have women been made anxious about aging and experience while men, at least historically, have been rewarded for precisely those same attributes?

Humor and the way that it is therapeutic allow us to tell our stories and to give some space around it, she noted. One of its benefits is helping the individual learn to answer back and to defend oneself. She offered the example of Liz Carpenter, former Press Secretary to Lady Bird Johnson and assistant to Vice-president Lyndon B. Johnson. Carpenter wrote a very popular book and at one of her book signings historian Arthur Schlesinger, Jr. said he had heard that her book was selling well, and asked, who had written it for her. Without a pause, Carpenter answered, “Glad you liked it, Arthur; who read it to you?”

If we don’t know what we want or desire, it is hard to figure out what we need, she said. The struggle with identity is wrapped up in body image, she added. Women have “selves” that include the mother-nurturer, the girlfriend, the pal, supporter, encourager, and the delight of other people, she added. Dr. Barreca shared that she learned that anxiety was the motivating factor for most of what she did in her earlier life, even though she did not want to acknowledge it at first.

She told the audience about the power of writing or telling your own story so you can make sense of the world. This happens because you are putting yourself into the story, and with your own point of view you can control the story, she said. She added that by writing your own story things don’t just happen; you become not the victim or the object, but instead you become the subject of your own story. You become the narrator. She said that we are not just talking about what is happening or what has happened; instead, one gets to tell the truth. One possesses his or her life in a meaningful wayâ€”a story of what made you what you are.

Dr. Barreca said that laughter really is the best medicine because it detoxifies. “It is something that allows us to wash away the things stuck into us, and cleans out and rewrites some version of what has happened to us,” she said. A person can rewrite some version of what has happened, making things better. You can reset things in a different framework, she noted, and this can be done with love. It keeps baggage moving and one can learn to repack things. By writing things down, one can make herself or himself laugh. The truth is funny, she said, and it cleans things out and enables an individual to re-write some version of what has happened, and can make things better. Using the truth can reset things in a different framework. Humor is an act of welcoming, and laughter can make a community of people come together, said Dr. Barreca. It provides a moment of deep intimacy. Even if everyone doesn’t get it, it is a start, she said. If you have to rewrite, it makes you affirm and enjoy what you were.

[**Gina Barreca, PhD**, is the author of 10 books, including the bestselling book *They Used to Call Me Snow White, But I Drifted: Women's Strategic Use of Humor, Babes in Boyland, Perfect Husbands (and Other Fairy Tales), and It's Not That I'm Bitter,* and has edited 18 others. Dr. Barreca is a syndicated weekly columnist for *The Hartford Courant* and is Board of Trustees Distinguished Professor at The University of Connecticut. Her blog at *Psychology Today* has over 6.5 million visitors.]

Cultivating Hope Through Strength-Based Practices

Daniel Tomasulo, PhD, MFA, MAPP, told the audience that hope is the greatest advancement in positive psychology since the science of psychology was discovered. He added that most of the science and practice of psychology has been about reducing depression and anxiety. In contrast, positive psychology provides a way to enhance the positive, not only reduce the negative. It is a way to understand that your signature strengths are the way forward, and a means to have a positive perspective that tips the scale in factor of greater wellbeing.

Dr. Tomasulo described a new theory of well-being termed PERMA (Positive Emotions, Engagement, Positive Relationships, Meaning, Accomplishment)(Seligman, ME*. Handbook of Positive Psychology*. 2002. 2:3-12). The PERMA approach is a way of thinking about the five pillars of psychology and sustainable well-being, he explained. He noted that a change in one habit usually has a ripple effect on another. Positive emotions are like nutrients, feedback into thoughts and behaviors. Where does hope fit in? He noted that most of us are looking for problems all the time. Once we find them, a downward spiral starts, which makes it more and more difficult to pull out of anxiety and depression.

The answer to such a downward spiral is through positive interventions, he said. A group he termed “high hope people” use positive interventions to get past such downward emotions. In the past most psychology has been focused on the negative parts of depression or anxiety. Dr. Tomasula said what is needed is different tools and science to approach well-being, quoting pioneering psychologist William James, who wrote, “My experience is what I agree to attend to.” The true nature of hope is that you can decide what you focus on and spend time on, said Dr. Tomasulo. He asked, “What do your clients need to know? What are they going to focus on and attend to?” We have an extraordinary power and ability that we don’t recognize, he said, and added that negative emotions limit us, and physiology shows this. For example, when there are negative emotions, the digestive system reacts and peripheral vision narrows. With positive emotions, however, one tends to broaden and to build greater creativity and more dynamic resources.

Dr. Tomasulo provided a number of statistics about depression and anxiety prior to the onset of COVID-19. For example, 80% of those with depression relapse; 40% of Americans report being lonely; 10 times more people are depressed today versus during 1945; in the last 3 decades, 15- to 26-year-olds report twice as much anxiety, depression, and behavioral problems as their predecessors. Suicide is the leading cause of death in this age group, and between 2009 and 2018 the U.S. had more school shootings than 27 other countries combined.

Such data point to a sharp rise in society’s symptoms in a relatively short time, he said, which shows that the root cause of most depression isn’t a chemical imbalance, and human genes are not the cause. Rather, people are losing hopeâ€”and doing so faster than at any time in history.

Hope is not the same as faith, Dr. Tomasulo said. He gave an example of this from professional baseball pitcher James Augustus “Catfish” Hunter. When Hunter described all the ways he prepared for pitching a game, including striving to increase his strength and grip, for example, he said at some point he just had to let go of the ball and throw it, and didn’t have any control over it any more.

Calibration and correction through micro-goals

Giving patients a micro-goal is an important and powerful way to shift goals, he said. The current pandemic has challenged whatever goals existed before the virus attacked. For patients, the challenge is to form micro-goals, such as walking the dog, preparing dinner, making phone calls, or answering three e-mails, for example. Dr. Tomasulo added that these small goals allow one to see progress and the larger goal comes into sight again. Having a group of micro-goals, and agreeing not to plan further than 4 hours at a time can be very useful for helping patients engage.

It is a myth that one either has hope or not, he said. It can start with small acts of kindness, or as comedian Marty Feldman has said, the fastest way out of depression is to do something kind for someone else. Dr. Tomasulo said that while this seems like an incredibly simple and small step, it can take a person out of his or her own head and into a more positive direction. Using himself as an example, Dr. Tomasulo also recommended performing a gratitude review by stopping and thinking about three good things he is grateful for. This could be a beautiful day, seeing a friend after a longtime absence, a check in the mail, or seeing a grandson. These small good things are to be celebrated. He urged all to celebrate the positive. We all have a choice, he said, and can change our personal biographies by making such choices.

[**Daniel Tomasulo PhD, MFA, MAPP**, is a core faculty member for the Spirituality Mind Body Institute (SMBI), Teachers College, Columbia University, and holds a PhD in psychology, MFA in writing, and Master of Applied Positive Psychology from the University of Pennsylvania. He writes the daily column, “Ask the Therapist,” for PsychCentral.com, and developed the Dare to be Happy experiential workshops for Kripalu Center for Yoga & Health. He was honored by Sharecare, a digital health company, as one of the top 10 online influencers on the issue of depression. He is the author of *American Snake Pit* and a newly released book, *Learned Hopefulness*. *The Power of Positivity to Overcome Depression.*]

How Technology Can Enhance Mental Health Care

Dr. Sabine Wilhelm, Chief of Psychology at Massachusetts General Hospital, Boston, outlined the ways in which modern technology is helping attack the current global mental health crisis. Internet-based treatments, smartphone applications, sensors, and virtual reality are all reaching out to help patients in the ever-growing mental health crisis, which has only been made worse by the COVID-19 pandemic, she said.

A global health care problem

Dr. Wilhelm noted that half of all mental disorders begin by the mid-teens, and three-fourths of all mental disorders start by the mid-20s. Suicide is now the among the 10 most common causes of death around the world and, in the U.S., suicide rates between the ages of 15 and 24 have increased to the highest point since 2000, she said. Mental illness is also extremely costly, she noted: for example, the global cost of mental health problems was $2.5 trillion in 2010 and is predicted to reach $6 trillion by 2030. Despite the costs, 60% of people around the world are still not receiving any mental health care. And, if they do seek care, they must overcome logistical barriers, such as lack of transportation, no access to childcare, the stigma of going to a health care office, and cost of care. She added that one 18-session course of treatment for BN can easily cost $5,000 in Boston, where she lives. And, even when cost is not a barrier, finding a provider can be another very real challenge in this time of provider shortages. In some parts of the world, she added, there may be fewer than 10 health care providers. And, in one study, only 39% of those with 12-month psychiatric diagnoses received at least "minimally adequate care." She added that if all licensed psychologists worked 50 hours per week, they could only address 12% of the need.

Technology as a solution Internet-based CBT

Dr. Wilhelm reminded the audience that internet-based CBT (I-CBT) treatments have been around for some time. With I-CBT a therapist can deliver self-help treatment online, and the patients can then work on exercises on their own time and on their own computers. She added that good global work on I-CBT has been done in the U.S. and Australia, and most of these programs do not require a licensed therapist. In fact, guided I-CBT is equivalent to in-person CBT, and an additional benefit is the need for many fewer therapist hours per intervention. One of Dr. Wilhelm's specialties is body dysmorphic disorder (BDD), where the usual CBT treatment involves about 22 sessions; online, with I-CBT, only about 3 hours of therapist time are needed.

Smartphone advantages

The arrival of the smartphone in 1992 foretold a true revolution in information-sharing, and today more than 81% of Americans have a smartphone. Dr. Wilhelm outlined the key barriers to treatment that are overcome by smartphones: long wait times, logistical barriers, shame and stigma, high cost of treatment, and variable quality of care. She noted that the smartphone apps have many advantages because they are already part of the fabric of everyday life. In addition, many apps are already available to help with healthcare needs. The smartphones provide increased access to care for those who may be ambivalent about therapy. The phones improve low motivation by providing self-monitoring and, importantly, can provide just-in-time interventions, she said.

A study by de Zwaan and colleagues in 2017 compared internet-based self-help versus individual face-to-face treatment for binge eating among a group of 178 BN patients (*JAMA Psychiatry.* 2017; 74:987). The results showed that face-to-face CBT led to quicker and greater reductions in eating disorder psychopathology, and that I-CBT self-help remained a viable, although slower-acting, low-threshold treatment alternative.

Dr. Wilhelm told the audience about a small joint study Massachusetts General Hospital conducted with Telephonica Alpha. The two groups developed an app for patients with binge eating disorder (BED). A chat function in the app allows asynchronous communication with coaches to help boost engagement, while weekly safety assessments trigger clinician follow-up when needed. The researchers reported a reduction in BED symptoms from the baseline through the 6-month follow-up period.

Some of the negative realities of the 6 apps reviewed include few evidence-based principles. She said that most of the apps currently available are not based on empirical principles and do not take advantage of the full range of smartphone capabilities. For example, some of the apps do not provide personalized reminders to log in; there are no ways to personalize goal-setting or tracking; there is no feedback on the patient's progress toward goals; there is no use of passive behavioral data; and there is no way to intervene during high-risk situations. Another drawback is the lack of research on smartphone-based treatment thus far. There is also no evidence that using any of these programs will help improve access to treatment or improve treatment outcome.

Dr. Wilhelm also described her own recent work in developing mental health apps. She located a team from California that was interested in making an F5 network for patients with body dysmorphic disorder (BDD). Patients with BDD are preoccupied with a perceived flaw in their appearance and spend several hours a day obsessed about what might be a small scar, a pimple, or mole. They continuously check their appearance and engage in hiding the flaw, fixing it with plastic surgery, and avoiding other people at all costs. The more severely affected become housebound.

Dr. Wilhelm and colleagues worked to develop an app firmly based in science, with treatment components found in traditional cognitive exercises, and CBT components. Behavioral exercises were designed to encourage patients to return to situations that they might ordinarily avoid, such as group gatherings. Weekly assessments were designed to prevent relapse. An online coach was also provided. At first, the coach was a clinical psychologist, but over time this has changed to bachelor's degree-level coaches.

Dr. Wilhelm said that smartphone use can increase access to care and address current concerns. For example, if a person is at risk for a binge-eating episode, the phone signals this.

Dr. Wilhelm described the possibilities of using smartphones as exciting, although there is still much progress to be made, for example, in improving patient engagement. She mentioned that one post-traumatic stress disorder app was uploaded more than 100,000 times, yet people did not return to the site the next day, week, or even year later. While an app may be downloaded, it may not be as engaging as hoped. What to do? To increase patient compliance, increasing the therapist's time and patient's engagement doesn't have to involve the participation of a senior therapist but can just as well include a bachelor's level therapist or coach, as long as he or she is trained in motivating patients. Chatbots are one useful addition because they use natural language processing to mimic real text conversations. (A chatbot is a software application used to conduct an online chat conversation via text or text-to-speech, in lieu of providing direct contact with a live human.)

The benefits of virtual reality

Virtual reality assessment can also be very useful for patients with eating disorders, said Dr. Wilhelm. With virtual reality, the cameras on an iPhone or computer can "read" facial expressions or clues from body positions and can then use this data to infer what the patient may be feeling. This data can provide virtual learning. Last but not least, virtual reality can provide virtual learning on the website. With 7 Cups of Tea, a site listed as "the world's largest emotional support system," stakeholders can get together with active listening and can provide guidance to each other. More than 40 million conversations have occurred on this website.

To make such sites more engaging for patients, it is possible to add a virtual therapist from the very beginning, in addition to healthcare professionals, said Dr. Wilhelm. She noted that one study showed that 67% of health care apps were developed without the input of healthcare professionals. "We can do much better," she said. She suggested involving a range of stakeholders, or interested parties when a site is being developed, including clinicians, patients, third-party payors such as Blue Cross and Blue Shield, as well as engineers and designers.

Virtual reality treatment added to standard CBT can improve motivation for change, improve self-esteem, and improve body image disturbances, as well as reducing binge-eating and purging behaviors, she said. Virtual reality devices are much improved because they can be used for assessment and treatment. The technology is very powerful for exposure therapy and auditory as well as visual fun to participate in and can be therapist-led.Â Assessment can be improved because patients can help understand body distortions. For example, three-dimensional figures of the patient’s body can be presented in virtual reality, and patients can face and modify these figures. In addition, virtual reality (**https://apps.apple.com/us/app/7-cups-anxiety-stress-chat/id921814681**)Â allows the patient to see which foods and social situations trigger binge/purge cycles. Using virtual reality, patients can visit swimming pools and restaurants that offer high-calorie foods and can see which of these produce the highest levels of discomfort

Issues of privacy

In the midst of this, the developers of such apps also need to improve patient privacy to avoid selling medical data to third parties. This is an area that needs much improvement, she added. She noted that one analysis of 43 health apps showed a high risk of breaching privacy for 43% of users. One website works to help protect patient privacy. One Mindâ„¢ PsyberGuide (https://onemindpsyberguide.org) reviews apps in terms of their quality, providing a transparency rating, privacy policies, credibility rating, transparency guide, and professional reviews. PsyberGuide is now partnering with the Association for Depression and Anxiety (ADAA).

Dr. Wilhelm also outlined how sensors could be used in general. One drawback may be that clinicians may go for weeks without knowing exactly how a patient is doing. While some rating scales are available that indicate how a patient has been doing over the past month, they don’t indicate the patient’s condition during the past few hours. Once more, a smartphone can provide much background information, for example, about sleep. The phone is the last thing most of us use before going to bed, she noted, and the screen function on the phone can tell us about normal patterns of sleep, and perhaps hint that something else may be going on. You can engage your patient in real time or can even provide intervention right over the phone, she added.Â She also noted that the enthusiasm about sensor-based apps must be tempered. Different phones and different manufacturers may use the phone sensors differently, and even the ways in which a patient may carry his or her phone can have an effect.

Dr. Wilhelm said that we are currently finding ourselves in a major mental health crisis: most people are not getting good care or sometimes any care at all. Technology may help by providing or offering scalable opportunities that can maximize benefits for patients. As for assessment, sensor-based apps can be helpful, and with permission, social media can also provide information. This data can be combined with information from the patient’s electronic medical record, European Medicines Agency (EMA) data collection (**https://clinicaldata.ema.europa.eu/web/cdp/home**), MRI data, or genetic data. Thus, traditional information can be paired and assessed with machine-learning algorithms to provide patients with individualized and personalized treatment.

[**Sabine Wilhelm, PhD,** is currently a Professor at Harvard Medical School and Chief of Psychology at Massachusetts General Hospital, Boston. She is a leading researcher in obsessive-compulsive disorder (OCD) and body dysmorphic disorder, and principal investigator for NIH and privately funded studies investigating medication, cognitive behavioral therapy and digital services and other treatment of OCD and related disorders.]

To Visit the iaedp Virtual Symposium

Note: The 2020 iaedp conference is just a few keystrokes away (for conference registrants, see **https://gateway.on24.com/wcc/gateway/eliteIAEDP/2266259** and for more information, visit the association website, **www.iaedp.com**). This allows members and registrants to take their courses online, to hear and see the speakers and to attend the conference at their convenience.

Update: Eating Disorders PSA: A New Act to Help Prevent Disordered Eating in Schools

The Eating Disorders Prevention in Schools Act of 2020 (Eating Disorders PSA) was first introduced in the U.S. House of Representatives in early May. The act would encourage schools in the U.S. to include eating disorders prevention as part of their local school wellness policies. These policies are used to guide school districts to create school nutrition programs and physical activities to help prevent disordered eating and eating disorders, with a goal of improving the overall health of children. The bill would also ensure that mental health professionals are included in the development of local school wellness policies. The bill was introduced by Rep. Alma Adams (D-NC) and Rep. Vicky Hartzler (R-MO). Rep. Adams noted that once passed, the Act will provide students with education and will create screening opportunities for detecting eating disorders. She added, â€œAs students across the country face disruptions, stress, and anxiety due to COVID-19, all of which exacerbate mental illnesses like eating disorders, the need for this legislation grows increasingly clear.â€ The bill has been referred to the House Committee on Education and Labor.

From Across the Desk

The COVID crisis has pushed publications and organizations to turn to computer tools to bridge the challenges of office visits, seminars, meetings, and many services. This issue includes several examples, such as Dr.Sabine Wilhelmâ€™s exploration of helpful computer apps in the lead article and items from a virtual issue published online by the *International Journal of Eating Disorders.* As helpful as the online articles and virtual seminars may be, sadly there can be a downside, too. Some online articles offer content that may focus on potentially harmful topics, such as â€œHow to look your best on a webcam,â€ or at-home workout challenges, which inadvertently reinforce eating disorder cognitions and behaviors. Such sites can leap right into the homes of patients sequestered due to the coronavirus. As more than one eating disorder professional has noted, isolation only increases the risk for some ED patients.

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Addressing Stigma about Eating Disorders

Attention turns to needed changes in media coverage.

Australian eating disorders specialists recently have a new incentive to address stigma and shame among persons with eating disorders. In a program begun in November 2019, the government plans to invest $110 million to subsidize eating disorders treatment services (*J Eat Disord.* 2020; 8:11). The 4-year plan is aimed at improving recovery of the 16% of Australians estimated to have a *DSM-5* eating disorder, according to Rachel Baffsky of the University of New South Wales, Sydney, Australia. In a recent commentary, Dr. Baffsky proposes media regulations that could, in time, diminish stigma and enhance treatment-seeking.

The role of the media

Dr. Baffsky has singled out the popular media as creating stigma for people with eating disorders by reinforcing stereotypes that people with eating disorders are young and female, discounting the experiences of men and older adults. She noted that current articles in the popular press often focus on the social causes of eating disorders and ignore the biological causes. This reinforces the harmful stereotype that eating disorders are easy to recover from because they are a choice, which again creates stigma. Another element suggests that people with eating disorders feel undervalued by the public and as a result may conceal their eating disorder for fear of being stigmatized (*J Ment Health*. 2016;25:47).

A number of suggestions have been made to help improve media coverage of eating disorders, according to the author. One is that media could use more precise medical language to describe eating disorders, to reduce blame-based stigma. A number of studies showed that nursing students and undergraduate psychology students, for example, showed blame-based stigma when they were presented with social causes for eating disorders.

A mandatory code with 4 sections

The author recommends that Australia develop a mandatory Industry Code of Conduct that specifically helps guide media toward a more â€œmedicalizedâ€ approach to reporting stories about individuals with eating disorders. The Code of Conduct would include 4 sections. The first code would mandate a more demographically diverse representation of real individuals with eating disorders (*Patient Educ Couns.* 2007; 68:43). A second code would stress eating disorders articles that address biological etiologies for eating disorders. A third code would prohibit journalists from using derogatory language to label the symptoms of eating disorders. Finally, a fourth code would mandate realistic reporting of times for recovery for individual eating disorders.

The author does acknowledge some limitations of the Code of Conduct approach. One such limitation is that the Code has been criticized as being paternalistic, which is potentially problematic since persons with AN, for example, often perceive a need for control. Also, media emphasis on a biological etiology for eating disorders might encourage the general public to perceive that a person with an eating disorder is helpless to combat an eating disorder because of the disorderâ€™s biological and genetic origins. To counter this, a fourth code was strategically introduced to make certain that journalists accurately report that individuals with eating disorders â€œcan and do recover if they seek help.â€ (The Butterfly Foundation, 2019; **https://butterfly.org.au**).

When Family-Based Treatment Fails

Can therapist and family members successfully reboot treatment?

Family-based treatment (FBT) for adolescents with AN is well established, but does not always work. There may be a variety of explanations for this, including failure by the therapist. As a result the family and teen may not adhere to the original guidelines and may alter or modify the suggested treatment, or drop out of treatment altogether. What can be done?

Kellie R. Lavender of the New Zealand Eating Disorders Clinic, a private specialist outpatient clinic in Auckland, New Zealand, has shared her experiences with “rebooting” nine failed FBT cases between 2017 and 2019 (*Front Psychiatry*. 2020; 11:68). All nine families and their children agreed to try FBT a second time. One family dropped out; four families are still in treatment, and four other families have successfully completed treatment. After studying her results, Dr. Lavender emphasized five crucial areas essential to achieving successful FBT.

Getting it right from the beginning

All the families reported knowing what FBT entailed and had done extra reading, met with support groups, and participated in online forums. However, although all family members, including the patient’s siblings, had attended at least the first two sessions, further investigation showed that the family lacked the depth of understanding and knowledge of the core principles of FBT. When the sessions were redone a second time, each family commented that they had not really “gotten” the information the first time around about the nature of anorexia and how it affected their child. In the second treatment attempt, extra time was spent helping the parents understand the connection between what they knew about anorexia and how it affected their child. The second session, the meal session, was one that most families wanted to skip because they had experienced so much anxiety during the previous meal session. In response, the therapist slightly reduced the time for the meal session, but included it the second time.

Empowering the parents

Although all patients had achieved a weight gain of 2.3 kg or more during the first month of treatment, which was established as a key predictor of success, the need to “re-feed” their child sometimes became the parents’ sole goal. After this early success, most parents reported that they had felt “stuck”â€”three families reported that they were unable to transition to phase 2 of treatment. When they were seen for the second time, all parents told Dr. Lavender that they were exhausted, and felt hopeless and sometimes guilty about being a “failure” at parenting or being unable to feed their daughters.

Parental empowerment is more than being in charge of food, the author noted. Instead, it is a complex concept that involves parents becoming more confident when making decisions required for their child to recover from AN. One of the critical issues that required careful attention when starting FBT for the second time was determining whether the parents felt empowered. To do so requires actively identifying the family’s perspectives and strengths, reinforcing healthy decision-making, and setting clear expectations for treatment tasks and goals.

Attending to anorexic behaviors, not just weight regain

Sometimes the focus on weight restoration may eclipse taking care of anorexic behaviors and habits. The families also reported that despite their daughter’s weight gain, eating disorder cognitions and body image concerns had remained unchanged. The families as a whole seemed to be lacking the understanding needed to challenge and help change eating-disorder-related behaviors. Many of the teens admitted that they had hidden food and used water-loading and hidden weights or had secretly exercised during the first FBT treatment sessions.

In the second FBT sessions, the therapeutic discussion turned to food and eating behaviors and then to gradual transfer of responsibility from the parents to the teen. The first task for the families was to be aware of anorexic behaviors or to uncover behaviors they had overlooked the first time around. The parents also learned to solve problems and to stop unwanted behaviors in a systematic way. Often these anorexic behaviors had been missed and were habit-based, and the teens were initially anxious about having to “give them up.” However, as the behaviors lessened over time, the teens reported being less anxious and agitated. Dr. Lavender commented that in time the teens became very active participants in the sessions. During the first FBT sessions, the focus had been on increasing the amount of food they were supposed to consume. The parents hadn’t noticed that this was distressing to their child, which in turn led to a lack of faith and trust in the parents.

Where was the therapeutic alliance?

Nearly all parents were concerned about their perception of a lack of therapeutic alliance between the previous therapist and their child. In seven cases, families had transitioned to individual treatment when they thought FBT was failing.

Rebooting FBT after a teen patient has undergone individual treatment is always challenging, the author noted, because of the reluctance of the teens to renounce their perceived control and autonomy. For five of the families who restarted treatment, the young person (the teens were older than 17) was given more individual time at the beginning of sessions. At first, this was approximately 15 minutes of the 60- to 70-minute treatment sessions. However, the author noted that it was important to stress to parents and patients that this was not individual treatment, and the therapist made certain to continue to empower the parents, to avoid being drawn into divisive behaviors, and to continue to reiterate the need for parents to be part of the decision-making conversations.

Full completion of treatment

Finally, none of the families had experienced the third phase of FBT, and this was a new concept for them. Some felt that once their child's weight was recovered, and exercise and eating behavior achieved, further work wasn't needed. And, some studies have suggested that phase 3 may not be needed for some families (*Adolesc Psychiatry*. 2005; 44:632). It took persistence by the therapist to convince families not to skip phase 3. Dr. Lavender pointed out that phase 3 is meant to be brief and to ensure that the adolescent is on track developmentally. It also helps families to identify areas of need that may have left their child vulnerable the first time around. Phase 3 was not focused on the eating disorder per se but on other life issues and offered a means to model age-appropriate independence.

Dr. Lavender noted that the most critical point to consider is that it was possible to achieve full recovery by repeating FBT treatment, even after "failed" FBT. More broadly, this report underscores the value of careful and faithful administration of treatments such as FBT.

Dulaglutide Reduces Binge Eating in Patients with Type 2 Diabetes

A pilot study from Italy showed the drug was more effective than glicazide.

Binge eating disorder (BED), currently the most common eating disorder in the U.S., often co-occurs with type 2 diabetes (T2DM). In a pilot study, University of Udine, Italy, researchers found that a 12-week course of treatment with a medication used to manage T2DM, dulaglutide (TrulicityÂ®), led to greater reduction of BED behavior, body weight, and BMI in a study group than among patients treated with another sulfonylurea diabetes medication, glicazide (DiamicronÂ®) (*Diabetes & Metabolic Syndrome: Clinical Research & Reviews.* 2020; 14:289). [Note: Glicazide has not yet been approved by the FDA and thus is not currently available in the U.S.] Glucagon-like Peptide 1 (GLP1) receptors in the central nervous system are involved in appetite regulation, and treatment with GLP-1 receptor agonists like dulaglutide affects appetite and reward-related brain areas in humans.

In the 12-week study, Dr. Andrea Da Porto and her colleagues studied patients 65 years of age or younger who had HbA1c levels between 7.5% and 9%, who were taking a standard T2DM medication, metformin alone, and who had normal kidney function and who had been diagnosed with BED. Patients were randomly assigned to receive daily doses of dulaglutide, 1.5 mg, or glicazide, 60 mg, for 12 weeks. The researchers evaluated baseline and end of treatment BED scale scores, body weight, BMI, percentage fat mass, and HbA1c (to evaluate long-term blood sugar control).

After 12 weeks, patients taking dulaglutide showed much larger improvements across all measures (both ED-related and DM-related) than did those receiving glicazide. Because BED is common in those with T2DM, confirming these results in future studies could provide a useful approach to treatment when these conditions co-occur.

How Fitness Centers Deal with Suspected Eating Disorders

Most employees had experience with clients with EDs or

use of excess exercise.

A fitness center can be almost like a second home to many, but also can be problematic to some persons with undetected eating disorders. Some may over-exercise to compensate for binge-eating or to lose weight. Mixed in with these individuals are other fitness center clients who exercise excessively, but not to lose weight or change body image. Swiss sports and health experts wanted to know how commonly fitness center employees detected clients with suspicious exercise patterns and how they handled the situation.

In one of few studies of fitness center awareness of suspected eating disorders, Dr. Flora Colledge and her colleagues at the University of Basel, Switzerland, used an online questionnaire to contact 140 fitness centers in the German-speaking regions of Switzerland. The authors asked if any fitness center employees had noticed any suspicious behaviors that seemed related to eating disorders or excess exercise and, if so, what actions had been taken (*J Eat Disord*. 2020; 8:8).

Ninety-nine employees (60 men and 39 women) responded to the questionnaire. All reported having encountered at least one client who had an eating disorder or who was exercising excessively. Those who avoided confronting the customer explained that they did not know what to say, and a few felt it was not their responsibility. Most of the respondents reported they were able to differentiate between an eating disorder and excessive exercise. Age played a role, too, because older long-time employees were significantly more likely to act upon their suspicions. However, fewer than half had been given any guidelines on how to act when they suspected disordered exercise patterns, and most wanted more information about what to do with their suspicions and how to address eating disorders symptoms versus excessive exercise.

A unique chance to observe possible EDs

Employees of fitness centers are in a unique position to observe the signs of an eating disorder. The employees' reasons for suspecting an eating disorder or excessive exercise differed. For EDs, the clues included body shape and physical signs, while for excessive exercise, telltale signs were frequency and duration of training. Â According to the authors, this is particularly true for gym clients with AN, who may have physical signs, such as a layer of lanugo, or fine dark body hair, in addition to signs of semi-starvation. Similarly, those with BN may have Russell's sign of the hand, calluses on the knuckles or back of the hand, from induced vomiting. Other types of eating disorders, such as BED or orthorexia, offer few such clues and no clear-cut physical signs. Excessive exercise may be seen as healthy and even laudable, or might seem like a stage in the preparation of a high-level athlete.

Ways to approach gym clients

In a prior study of 143 Canadian fitness center employees, 62% reported having seen a client they thought suffered from AN; however only 25% had been trained on how to deal with this situation *(J Eat Disord. 2015; 3:40).* In the Swiss study, fitness employees all agreed they would like to have more detailed information about how to manage customers at risk, along with a detailed description of symptoms, management techniques, and a list of resources. They unanimously agreed that such information should be available in all Swiss fitness centers.

When a fitness employee suspected an individual had an eating disorder or was using excessive exercise, the first response was to show concern for the customer's health and to suggest they stop their session and consider taking a few days off from their fitness programs.

Whether it concerned a client suspected of excessive exercise or of a suspected eating disorder, the fitness professionals almost unanimously reported needing more information about bringing up the subject. There are a number of organizations and fitness centers that have collaborated on just such information. For example, Fitness Australia has collaborated with the Centre for Eating Disorders to issue guidelines on how to approach gym members with suspected disordered eating/or exercise (Marks and Harding, 2004), and the National Eating Disorders Association, or NEDA, has released a toolkit for those who work with school sports programs and fitness centers. The toolkit gives examples of steps to take and offers examples of conversations about EDs and excessive exercise (**https://www.nationaleatingdisorders.org/learn/help/coaches-trainers**). The authors also suggest that once an ED is suspected, guidelines and sample conversations can be practiced in advance before approaching clients.

Establishing Canadian Practice Guidelines for Children and Teens

The most highly recommended treatments were family-based

By any measure, it was a daunting project: establishing Canadian practice guidelines for treating children and adolescents with eating disorders. A panel headed by Dr. Jennifer Couturier at McMaster University, Hamilton, Canada, along with a panel of clinicians, researchers, parents, and those who had real-life experience with eating disorders recently took on the country-wide task.

The panel developed a list of suggestions, including strong recommendations for Family-Based Treatment (FBT), as well as care provided in the least-intensive environment (*J Eat Disord*. 2020; 8:4). Other types of treatment, including Multi-Family Therapy, Cognitive Behavioral Therapy, Adolescent-focused Psychotherapy, Adjunctive Yoga and use of atypical antipsychotics had weaker recommendations.

The investigators noted that despite the seriousness and prevalence of EDs and the need for earlier diagnosis, no Canadian practice guidelines existed to help clinicians make treatment decisions. When they evaluated clinical guidelines developed by the National Institute of Health and Care Excellence, the guidelines did not include any form of grading of the evidence. Guidelines from the Academy of Eating Disorders focused on medical management, not on psychotherapeutic/psychopharmacologic interventions.

Family-based treatment

Of all the treatments examined for AN, the group found that FBT had the most evidence to support its use in teens and children (see also “When Family-Based Treatment Fails,” elsewhere in this issue). As for bulimia nervosa, when FBT was compared to CBT, remission rates were significantly better in the FBT group (39% vs. 20%) (*Child Adolesc Psychiatry*. 2015; 54:886).

Recommendations

The group strongly recommended FBT for most children or adolescents with AN or BN, especially those who had been ill for fewer than three years. The group recognized that there are challenges when implementing FBT, including the need for specialized, well-trained staff members, access to care and costs of training, adding that Parent-Focused Family Therapy, where the patient is seen separately from the family, may be just as effective as traditional FBT, where the family is seen together. They concluded that Structural and Systemic Family Therapy might be helpful for children and adolescents with AN but evidence doesn’t show that it is superior to FBT, especially when costs are considered.

The group also listed some promising therapies that have some data but need more research before definitive recommendations can be made, including:

- FBT for children with atypical AN

- FBT for children with Avoidant/Restrictive Food Intake Disorder (ARFID)
- FBT for children across the gender spectrum, including those who are gender-variant or gender non-conforming
- Cognitive Remediation therapy, art therapy, and CBT for children and teens with AN
- Emotion-focused family therapy for BN and AN
- Other forms of family therapy, including Multi-family therapy, and CBT.

A few potential medications identified

According to the panel, use of olanzapine or aripiprazole might be reasonable options for certain populations of teens and children with AN, especially when monitored carefully. Some promising medications, which need further research, include selective serotonin reuptake inhibitors (such as fluoxetine for BN), risperidone and quetiapine for AN, atypical antipsychotics for use in ARFID, and mirtazapine for patients with AN. Some medications have no evidence of effectiveness or (in one instance) could be harmful, including selective norepinephrine reuptake inhibitors, mood stabilizers, and buproprion (elevated risk of seizures).

It is important to note that the review did identify the scant nature of the psychopharmacology literature in this area.

Parents and patient representatives weigh in

Parents and patient representatives pointed out the critical importance of peer support (parents and patients), especially during transition to different levels of care and during the transition from pediatric to adult systems of care. The panel also stressed the importance of a coordinated continuum of care from outpatient to residential care. This group noted a lack of services, especially the lack of residential care centers across Canada, and the great need for individuals with skill in working in intensive inpatient and residential services. This becomes especially essential for those patients who are medically stable and who also have psychiatric co-morbidities, who need longer-term treatment in a highly structured environment. For example, in Canada (as seems to be the case in many other places) there are no services for patients with substance abuse comorbidity.

The guidelines panel encountered several gaps that they feel need future study, including treatments for complex presentations of eating disorders and co-morbidities such as borderline personality disorder, obsessive-compulsive disorder, and substance use disorder. The panel also had difficulty recommending inpatient levels of care, noting that these services deserve further study and expansion throughout Canada. One important area for future study includes identifying and giving attention to transition-age youth (young adults 16 to 24 years of age), an important group with unique needs.

Anorexia Nervosa 30 Years after the Diagnosis

There were no deaths, but about 20% had a chronic ED.

Relatively few studies have reported on the long-term courses of EDs, and little is known about the long-term outcome of anorexia nervosa, according to Sandra Rydberg Dobrescu and her co-workers at the University of Gothenburg, Sweden (*Br J Psychiatry*. 2020. 216:97). The group has provided a tremendously valuable report of the 30-year outcome of people who had AN as adolescents.

The researchers started with a group of 4291 individuals born in 1970 who were eighth-graders in 1985 in Gothenburg, Sweden, when they were screened for AN. Gothenburg is the second-largest city in Sweden, with a population of 570,000 in the city proper and about 1 million in the metropolitan area. A final group of 24 individuals was pooled with 27 with AN who were identified through community screening who were born in 1969 or during 1971-1974. The 59 persons with AN and 51 school- and gender-matched controls were followed prospectively and examined at 16, 21, 24, and 44 years of age. Most participants (96%) agreed to participate at the 30-year follow-up.

At the 30-year follow-up point, there had been no deaths from AN. Of the participants, 19% had an eating disorder diagnosis (6% had AN, 2% had BED, and 11% had other specified eating or feeding disorders), 38 had other psychiatric disorders, and 64% were fully recovered from their eating disorder. Full recovery was designated as being free of all eating disorder criteria for 6 consecutive months.

During the 30 years, the participants had an eating disorder for an average of 10 years, and 23% had received no psychiatric treatment. Factors associated with a good outcome were predicted by later age at onset among individuals with adolescent-onset AN and premorbid perfectionism.

This important long-term study of the course of adolescent-onset AN showed a favorable outcome, with no mortality and full symptom recovery in most. One negative finding, however, was that 1 in 5 of the participants still had a chronic eating disorder after three decades.

What Keeps Young Adults with EDs from Seeking Help?

Professionals also need increased awareness of barriers to care.

Not all young adults seek help for an eating disorder, even when such help may be close at hand. Improving treatment uptake by diminishing barriers to care could have a major public health impact, according to a recent Australian study.

The study used an online survey among 291 young Australian adults 18 to 25 years of age, participants were surveyed about disordered eating, weight or shape concerns, barriers to help, attitudes, intentions, and behaviors (*Int J Eat Disord*. 2020; 3:894). Psychologist Kathina Ali and co-workers at Australian National University and Flinders University, both in Australia, and the University Hospital, Heidelberg, Germany, designed the study to evaluate help-seeking for a variety of eating, weight, or shape concerns among the young adults, who were then classified into four subgroups: AN, BN, BED, and other eating disorders.

Most just don’t feel they need help.

Only about one in three young adults had sought help, and most participants (73%) believed that they did not need help. The single most commonly cited barrier to seeking help was concern about disturbing others. Other reasons included a sense of self-sufficiency, fear of losing control, denial, and failure to understand the severity of their illness, along with stigma about their symptoms, and shame.

In an earlier report (*Int J Eat Disord.* 2017; 50:9), the same authors had systematically reviewed the literature and concluded that programs targeting prevention and early intervention for eating disorders should focus on reducing stigma and shame, educating individuals about the severity of eating disorders, and increasing knowledge around help-seeking pathways for eating disorders.

Better education is needed.

The authors reported that their findings in both studies underscore the need to better educate young adults about the severity and consequences of eating disorders and the importance of seeking help. They also pointed to the importance of increasing awareness of barriers to help-seeking among professionals who design public heath interventions as well as among clinicians. The authors also noted that barriers to seeking help may differ depending on the type of eating disorder symptoms.

The importance of lowering barriers to help cannot be overstated. Much effort is directed at improving treatments, and this should be the case. But a modeling study by Moessner and Bauer (*Int J Eat Disord*. 2017; 50:1378) has shown that, given the low number of persons who take advantage of ED treatments, increasing the rate of accessing treatment (in part by lowering barriers to doing so) would have a much larger impact than improving treatment efficacy.

QUESTIONS AND ANSWERS:

Seeking a Better Definition of 'Food Addiction'

Q. A colleague and I have an ongoing debate about food addiction. He claims that the true definition should be eating addiction, and that food addiction is not a true eating disorder but in reality is similar to substance abuse.Â Is he right? (*L.H., Merced, CA*)

A. That is an excellent but unsettled question. The concept of food addiction, or food-related behavior, was first described in 1956 by Randolph, and has received increasing attention, but its true definition is still controversial. "Food addiction" suggests that an individual may have addictive-like responses to food similar to those seen in classic substance abuse. This can be associated with obesity and disordered eating. As defined by the *DSM-5*, this may more appropriately be described as a substance-related disorder, more closely identified as an eating addiction. Others have proposed that food addiction is an addictive disorder rather than an eating disorder. Thus, BED is proposed to be a psycho-behavioral disorder while food addiction is a biologically based disorder (*Appetite*. 2009; 52:430).Methods of assessment, such as the Yale Food Addiction Scale now exist, but the appropriate classification schemes and treatments (and even whether any such addiction would be to food or eating) remain uncertain.

A recent paper by Carolin Hauck and colleagues, originally presented at the Nutrition Society Winter meeting and published in *Proceedings of the Nutrition Society* (2020; 79:103), argues that addictive-like eating may manifest through repeated consumption of highly palatable, highly processed complex foods, typically foods containing large amounts of energy, sugar and/or fat. Evidence thus far suggests this pattern of eating is similar to behavior seen in behavioral or substance dependence. The authors suggest that food addiction does not seem to fit in with established eating disorders. Instead, food addiction may represent a distinct pattern of disordered eating or may be a subtype of an already existing eating disorder, such as BED. Future studies are needed to clarify causes, point to treatment, and to describe the impact on individuals with these eating patterns.

— SC

In the Next Issue

More highlights of the iaedp virtual meeting, including keynote addresses by Dr. John Levitt on treating patients with complex eating disorders and trauma, and innovative treatment for eating disorders patients, using music, by Drs. Ralph Carson and Anne Heiderscheit.

PLUS

- Counteracting shame and stigma from social media
- COVID-19 and implications for patients with eating disorders
- A connection between prior overweight and restrictive eating disorders in teens and young adults
- Visual food stimuli and the brain

And much more...

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