TeleBehavioral Health 2026 Training Series

Behavioral Health Institute (BHI)
Harborview Medical Center
Web: bhinstitute.uw.edu
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Northwest Regional Telehealth Resource Center (NRTRC)
Web: nrtrc.org
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Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The BHI, a program of Harborview Medical Center and UW Medicine, advances innovation, research, and clinical practice to strengthen behavioral health systems and improve access to mental health and substance use care across Washington State.

BHI Pillars of Focus

- Clinical Services
- Research and Program Evaluation
- Training, Policy and Workforce Development
  - Digital and Telehealth Services & Training

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

- The NRTRC delivers telehealth technical assistance through consults, trainings, and resources to support telehealth program development and integration.

- NRTRC works to expand access to quality primary, specialty, and behavioral health care in rural and underserved communities, regardless of the zipcode you reside in.

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Speaker and Planner Disclosures

Speakers

> None of the series speakers have any relevant conflicts of interest to disclose.

Planners

The following series planners and team have no relevant conflicts of interest to disclose:

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> Topher Jerome
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Disclaimer

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Acknowledgements

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TeleBehavioral Health 2026

March 20, 2026

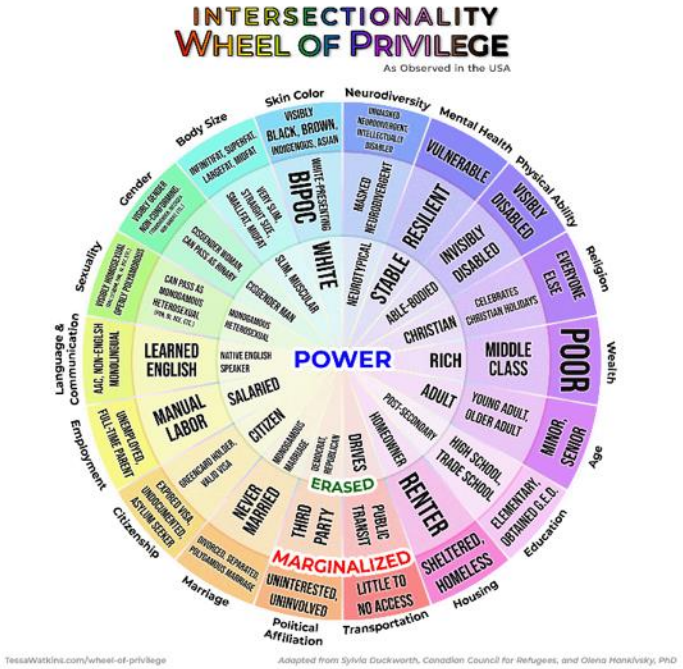
Virtual Care for Eating Disorders:

Screening, assessment, and brief interventions

Megan Riddle, MD, MS, PhD (She/Her)
Medical Director
Eating Recovery Center & Pathlight Mood and Anxiety Center

Privilege and Eating Disorder Treatment

- I'm speaking from a place of privilege
- It's important to consider ED treatment in the context of our own intersectional identities and those of our patients
- ED research and treatment has historically centered a white, able-bodied, neurotypical, female narrative
- It is important to ensure diverse voices are included at the table when we are having these conversations



Objectives

- Identify who is at risk for eating disorders
- Describe how to screen for eating disorders
- Discuss interventions for eating disorders and when to refer for specialized treatment
- Examine the strengths and challenges of caring for eating disorders in the virtual space

Why talk about eating disorders?

- Eating disorders have a high morbidity and mortality
  - All eating disorders carry increased risk of death, both as a result of suicide and medical complications
  - Anorexia has one of the highest fatality rates of all mental illnesses

Why talk about eating disorders?

- With 30 million people in the US with eating disorders, you will see these patients regardless of your clinic setting
  - In adolescents, eating disorders are the third most common chronic condition
- These patients are at high risk for medical complications

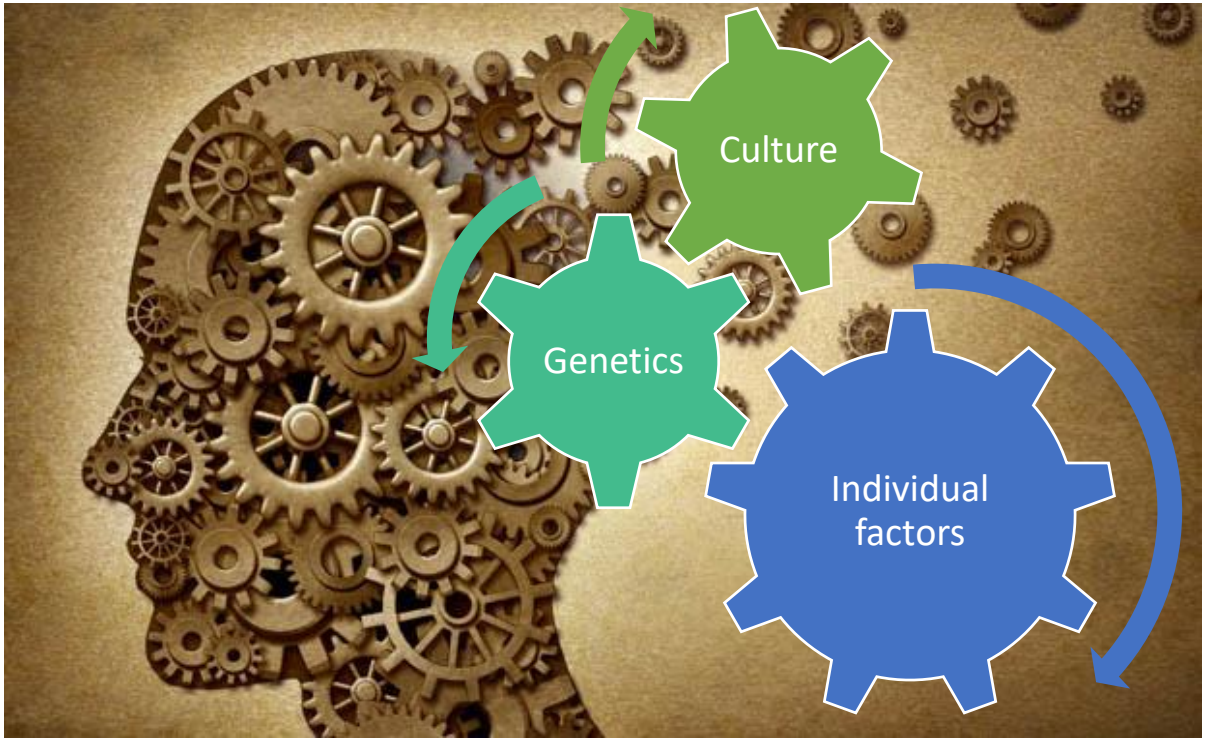
Why talk about eating disorders?

- These patients fall through the cracks
  - We hold certain assumptions about who has eating disorders
  - Because of this, we miss diagnoses

Why talk about eating disorders?

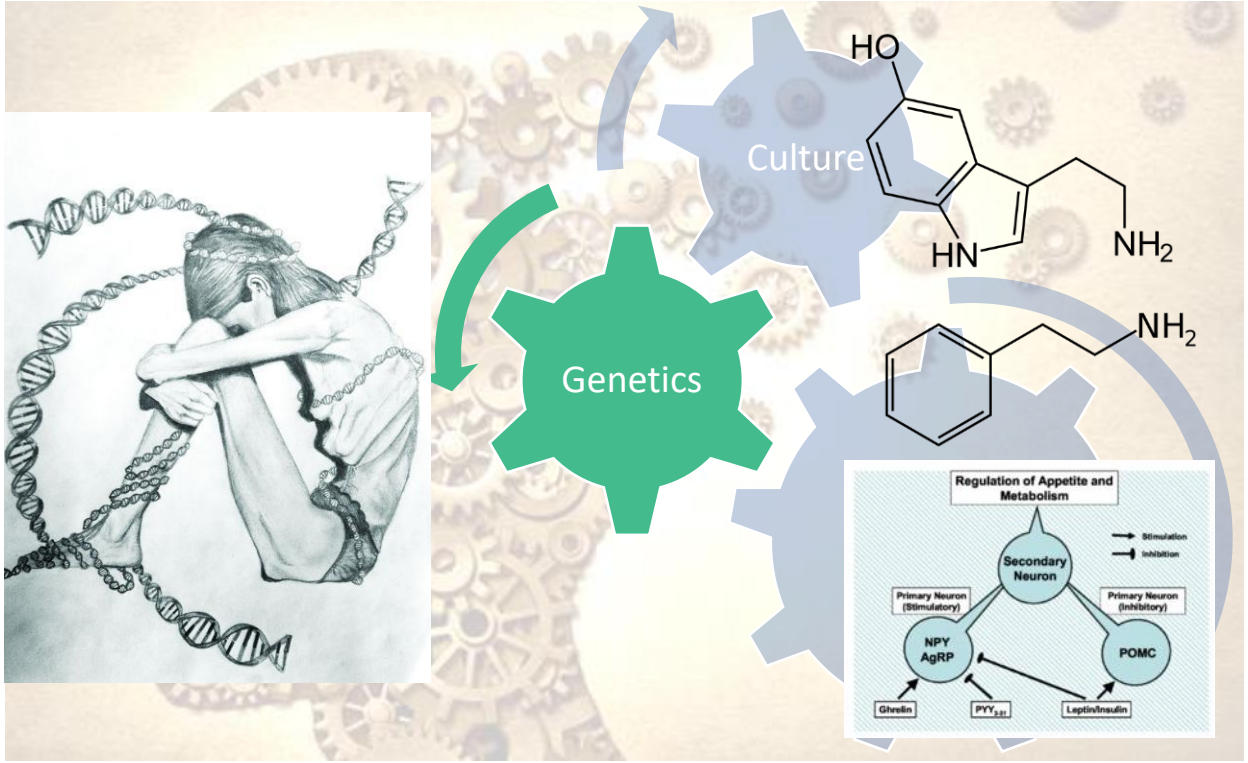
- Medical and mental health education perpetuates our cultural beliefs about food, weight, shape and health
  - The idea that thinness is so closely tied with wellness is a deeply held “truth” that is less evidence based than we are led to believe
  - We cause harm to patients based on their body shape

Development of eating disorders

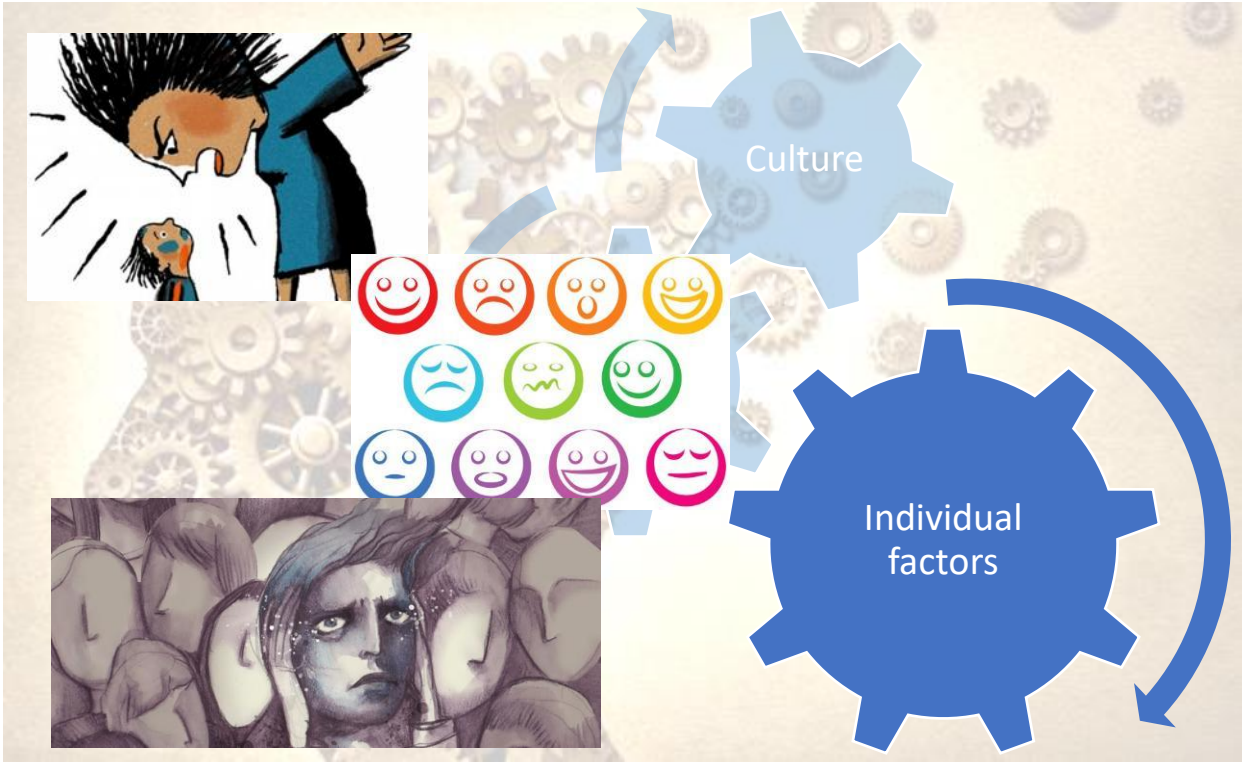


Development of eating disorders

Development of eating disorders



Development of eating disorders



Diagnosis

- Eating disorders: Persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that **significantly impairs physical health or psychosocial functioning**.

Diagnosis

Anorexia nervosa

- Restriction of energy intake leading to low body weight
- Intense fear of weight gain or behaviors that interfere with weight gain
- Excess concerns about weight and shape

Bulimia nervosa

- Recurrent binge episodes associated with eating an excess amount in a discrete period and lack of control
- Compensatory behaviors to prevent weight gain
- Binge eating and purging occur on average at least weekly for 3mo
- Excess concerns about shape and weight

Diagnosis

Binge Eating Disorder

- Recurrent binge episodes associated with eating an excess amount in a discrete period and lack of control
- **No** compensatory behaviors to prevent weight gain
- Binge eating occurs on average at least weekly for 3mo

Avoidant/Restrictive Food Intake Disorder

- Eating disturbance (i.e. concern about eating certain food types/textures) that prevents patient from meeting nutritional needs leading to:
  - Weight loss
  - Nutrient deficiency
  - Dependence on supplements/feeding tube
  - Interference with psychosocial
- Not in the setting of AN or BN or explained by other medical condition

Diagnosis

Other Specified Feeding & Eating Disorder

- Symptoms of an eating disorder that cause clinically significant distress or impairment but do not meet the full criteria for any of the other disorders
- i.e. Atypical anorexia, purging disorder, BN or BED of short duration/ low intensity

Unspecified Eating Disorder

- Symptoms of an eating disorder that cause clinically significant distress are present but diagnosis is unclear

Making a diagnosis: Who to screen?

- "Eating disorder" is rarely the chief complaint (unless they are dragged in by a worried family member)
- Instead…

Sleep disturbance
Low energy
Depression
Fatigue
Anxiety
Difficulty concentrating
Low self-esteem
Anhedonia
Changes in weight
Failure to launch
Interpersonal conflict
Emotional numbing
Fertility issues

- American Academy of Pediatrics advocates the routine use of screening questions for all preteen and adolescent patients

Who to screen?

- In adults, APA recommends screening as part of a psychiatric assessment
- In other settings, screen high risk groups
  - Young adults
  - LGBTQ individuals, particularly genderqueer
  - Women, LGBTQ patients under stress, with anxiety
  - Everyone with a family history of eating disorders
  - Everyone with rapid changes in weight or those seeking help with weight loss
  - Athletes

Screening tools for eating disorders

- SCOFF
- Screen for Disordered Eating
- Eating Disorder Screen in Primary Care
- Nine Item ARFID Screen (NIAS)

Eating disorders: Quick Screen

- Eating disorder screen for primary care
  - Are you satisfied with your eating patterns?
  - Do you ever eat in secret?
  - Does your weight affect the way you feel about yourself?
  - Have any members of your family suffered with an eating disorder?
  - Do you currently suffer with, or have you ever suffered in the past, with an eating disorder?

2 “abnormal” answers considered a positive screen

Assessment tools

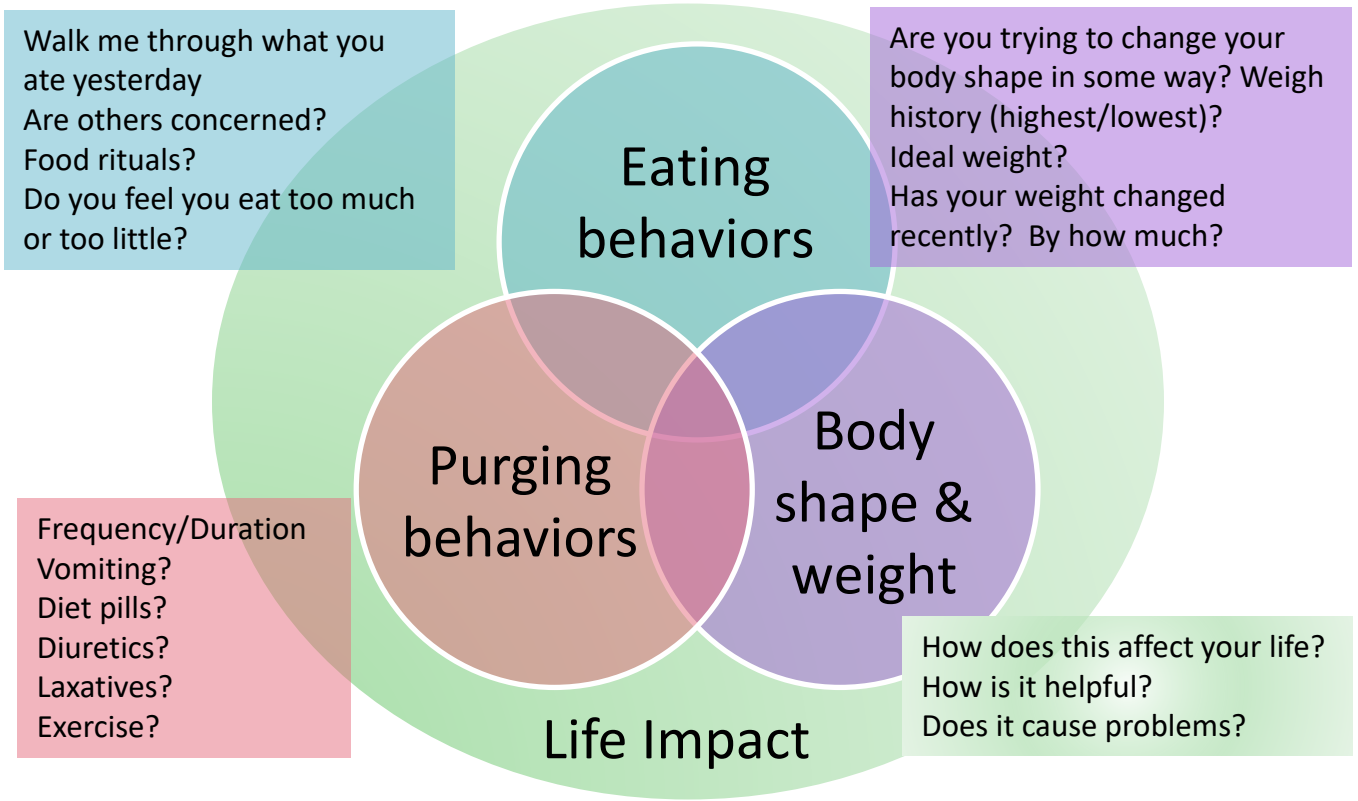
- Eating Disorder Examination Questionnaire (EDE-Q)
  - 28 questions
  - Available in regular (ages 14+), adolescent (ages 12+), short version (QS)
- Questionnaire on Eating and Weight Patterns-5
  - 26 question
  - Available as adolescent version (QWEP-A ages 12-18yo), parent
- Eating Attitudes Test-26 (EAT-26)
  - 26 questions screening for eating disorder
- Nine Item ARFID Screen (NIAS)
  - 9 questions specifically focused on ARFID
- Pica, Arfid, Rumination, Disorder Interview (PARDI)
  - PARDI-AR-Q longer assessment to fully assess ARFID symptoms and subtype

Eating disorders: Starting the conversation

Start with normalizing:

"Often, when people are under a lot of stress, they will eat more or less than they would otherwise. Does this happen to you?"

Making a diagnosis



A note on rapport

- It can be difficult to start the conversation, particularly when the patient is in denial about the severity of the illness
- Convey genuine empathy and curiosity while avoiding judgement
- Check your emotional reaction
  - We all have preconceived notions about patients with eating disorders
  - We all have our own relationship with food, weight and our body

Eating disorder do's and don'ts

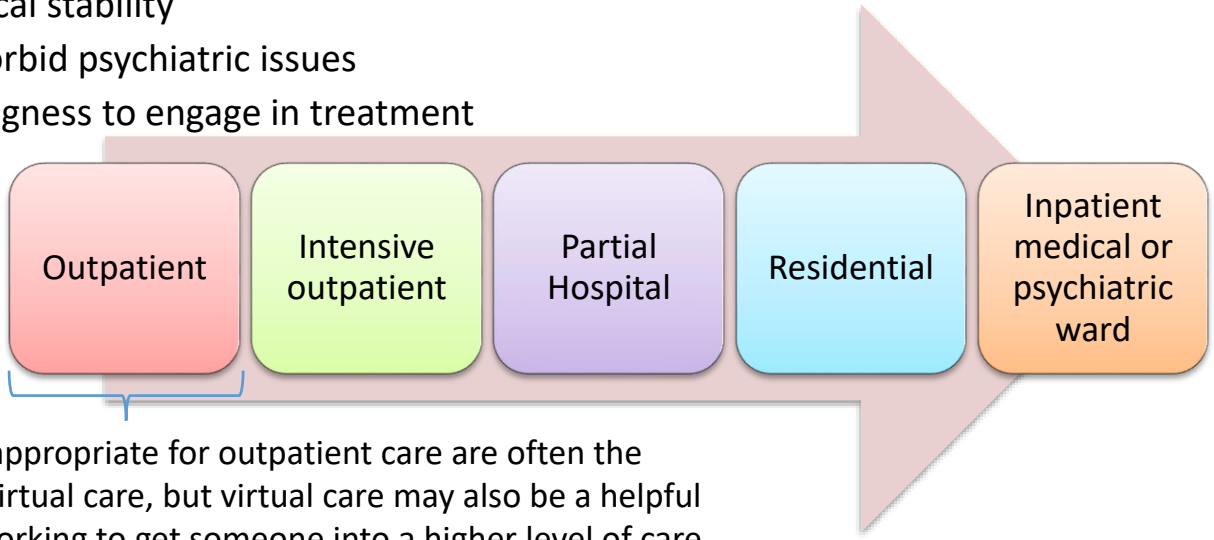
- Do:
  - Share your concern with the individual
  - Acknowledge the emotional distress changing these behaviors may cause
- Don't:
  - Reduce this to "you just need to eat more" or "you just need to stop binging" or "put down the food"
  - Make weight and shape comments as the patient begins to recover
  - "You look good" or "You look so much healthier" will be heard by the patient as "You've gained so much weight" and "You're fat"

Don't forget:

This is a mental illness, not a choice

Where to treat

- ED treatment occurs across a care spectrum
- Important to determine if someone is appropriate for virtual care
  - Medical stability
  - Comorbid psychiatric issues
  - Willingness to engage in treatment



Individuals who are appropriate for outpatient care are often the best candidates for virtual care, but virtual care may also be a helpful intervention while working to get someone into a higher level of care

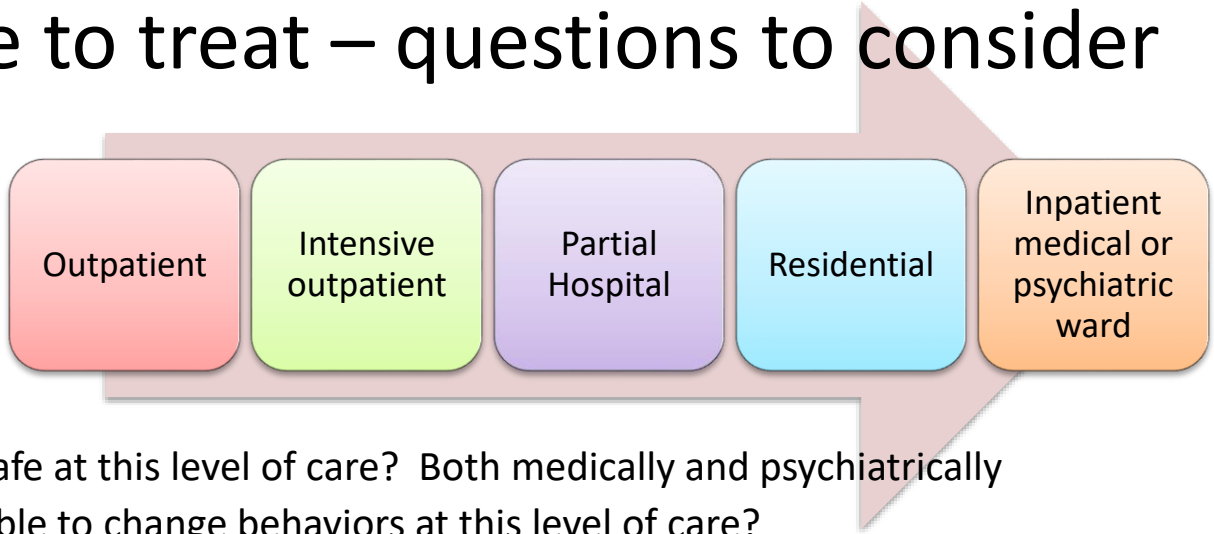
Eating disorders in the virtual space

- Virtual care of EDs can provide unique challenges in and opportunities

Opportunities	Challenges

• Reduces barriers
  • Geography
  • Financial
• Ability to do in home exposure work
• Inclusion of support people
• Access to specialists
• Increase inclusivity
	• Safety
	• Accountability
	• Interrupting behaviors in the home space
	• Measuring progress/ behaviors
	• Monitoring medical stability

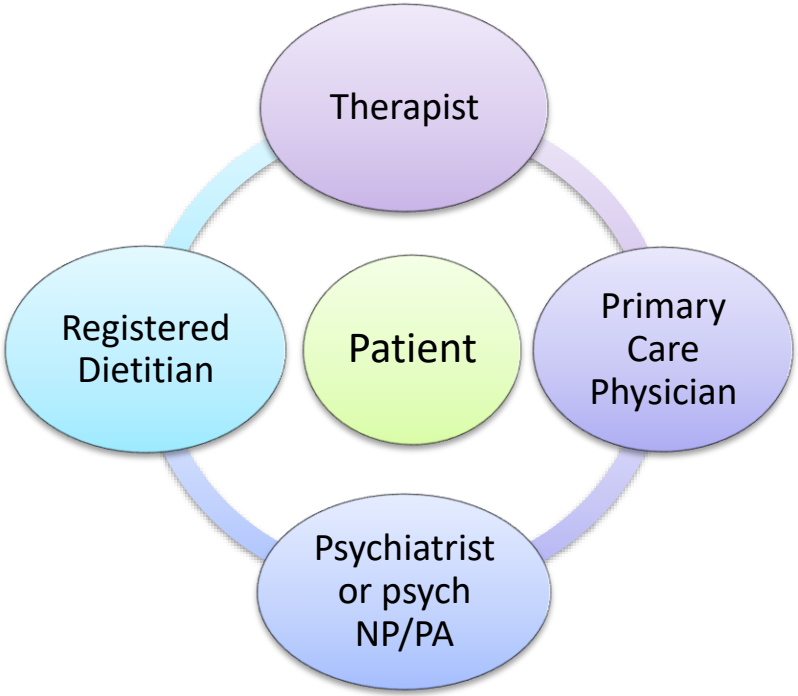
Where to treat – questions to consider



- Are they safe at this level of care? Both medically and psychiatrically
- Are they able to change behaviors at this level of care?
  - Is there sufficient support? Family, friends, etc.
- Is there willingness to change behaviors?
  - This is a bit of a bell curve – truly unwilling may also end up managed in outpatient
- Do they have access to specialist care?
  - If no one on the care team has ED experience/interest, consider step-up
- Once someone is engaging in treatment, are they getting better?
  - Assess progress – decreased behaviors, expected weight trajectory

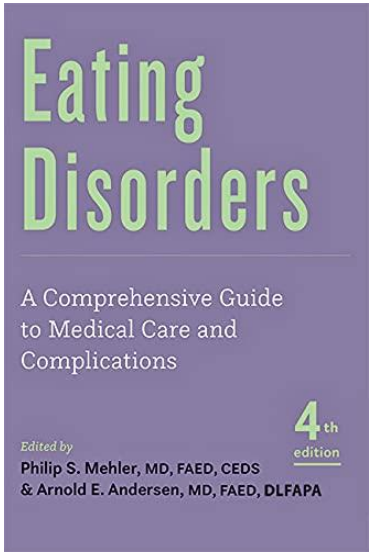
Treatment team

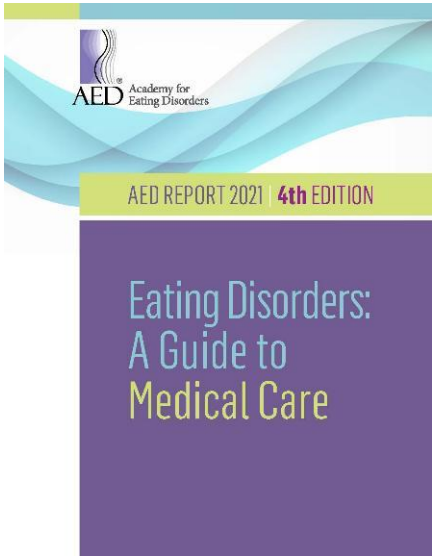
- Consider a hybrid model for care
  - May be helpful for some providers (i.e. PCP) to be in person, at least for initial medical assessment and labs
- It's ideal if at least one person on the care team has ED experience/ interest or can seek consultation



Medical evaluation

- These patients can have serious medical complications secondary to starvation or binge/purge behaviors
- Don’t make assumptions about medical stability based on weight

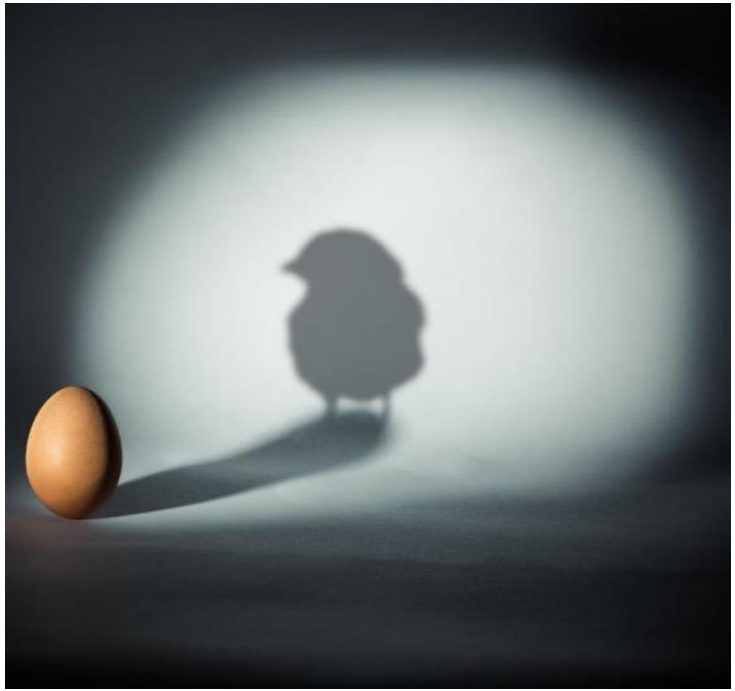




Medical management resources

- Academy for Eating Disorder's *Eating Disorders: A Guide to Medical Care*
  - Free: https://www.aedweb.org/resources/publications/medical-care-standards
- Philip Mehler's book: *Eating Disorders: A Comprehensive Guide to Medical Care and Complications fourth edition*

Co-occurring disorders



- Increased rates of many psychiatric disorders: anxiety, mood disorders, trauma, OCD, neurodivergence
- Increased rates of other health concerns, including celiac, DM1, GERD, IBS, IBD, POTs, EDS
- Comorbidities may be predisposing factors to the ED, sequalae of the ED or simply co-occurring that can be impacted by disordered eating
- Careful medical and psychiatric eval are important to understand the full picture and deciding on LOC
- Consider including specialists (i.e. GI, endo, etc)

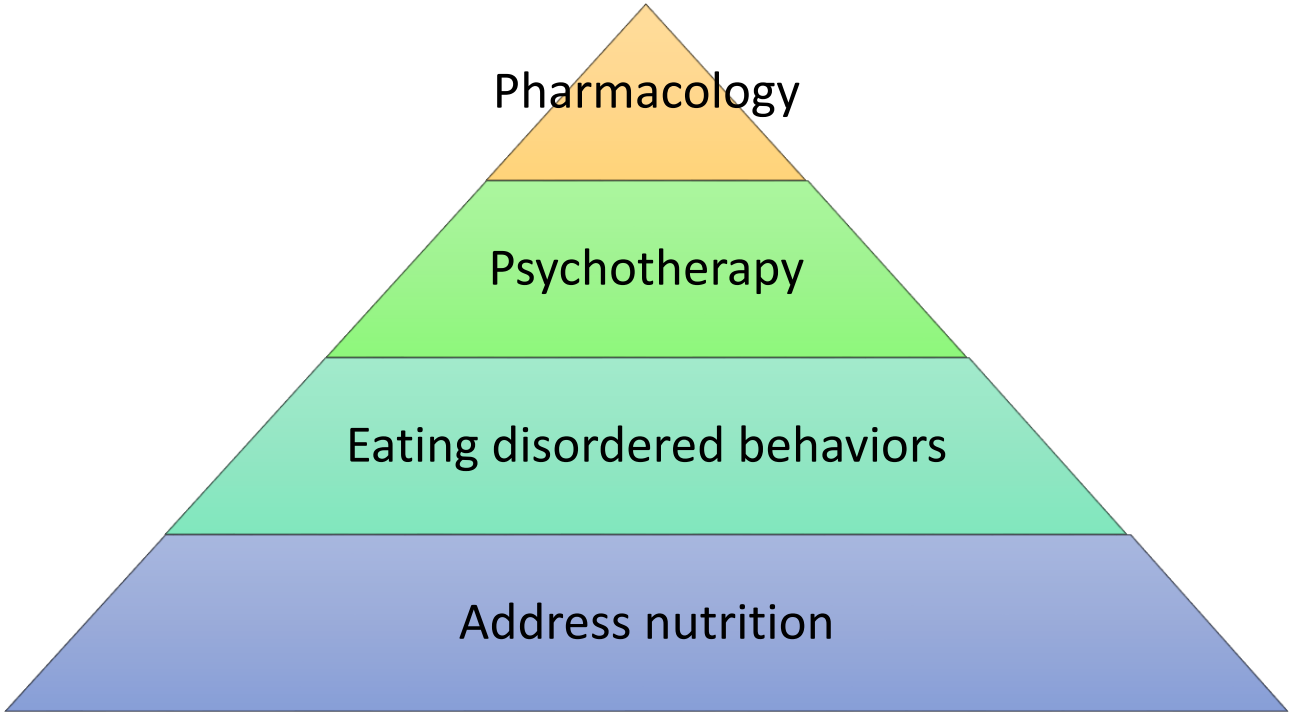
Factors supporting hospitalization

912 Table 5. Factors supporting hospitalization include one or more of the following:

	Adults	Adolescents (12-19 years)
Heart rate	<50 bpm	<50 bpm
Orthostatic change in heart rate	Sustained increase of >30 bpm	Sustained increase of >40 bpm
Blood pressure	<90/60 mmHg	<90/45 mmHg
Orthostatic blood pressure	>20 mmHg drop in sBP	>20 mmHg drop in sBP
Glucose	<60 mg/dl	
Potassium	Hypokalemia	Hypokalemia
Sodium	Hyponatremia	Hyponatremia
Phosphate	Hypophosphatemia	Hypophosphatemia
Magnesium	Hypomagnesemia	Hypomagnesemia
Temperature	<96.0 F	<96.0 F
BMI	<15	<75% of median BMI for age and sex
Rapidity of weight change	Greater than 10% decrease in body weight within the last 30 days	Greater than 10% weight loss in 6 months or greater than 20% weight loss in 1 year
Compensatory behaviors	Occur multiple times daily and have either caused severe physiological consequences	Occur multiple times daily and have either caused severe physiological

The American Psychiatric Association Practice Guideline for the Treatment of Patients With Eating Disorders, Fourth Edition

Eating Disorder Treatment:



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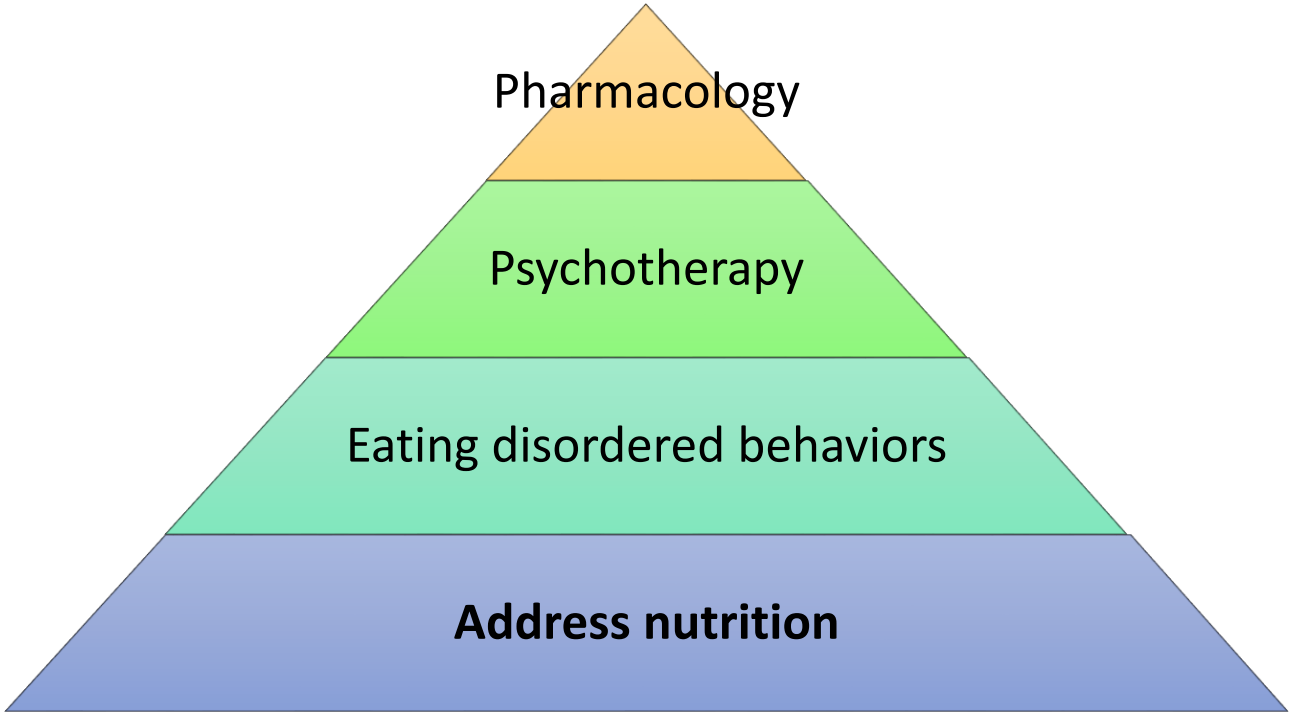


Address nutrition

- Nutrition is a non-negotiable part of ED treatment
- Symptoms WILL NOT get better without regular intake of sufficient nutrition (this is true for binge eating as well)
- Patients almost always want to change their thoughts and feelings first and then address nutrition
- Collaboration with an ED-savvy RD is extremely helpful

Address nutrition

- RD will identify a target weight – based on weight history and trends
  - Target weight may or may not be near someone's "ideal" body weight
- For those restricting, initial treatment focuses on increasing caloric intake
  - Gradually increased to 3,000-4,000+ kCal/day depending on rate of weight gain
- Target weight gain:
  - 2-4lb/wk inpatient
  - 0.5-1lb/wk outpatient
- Exercise is severely limited

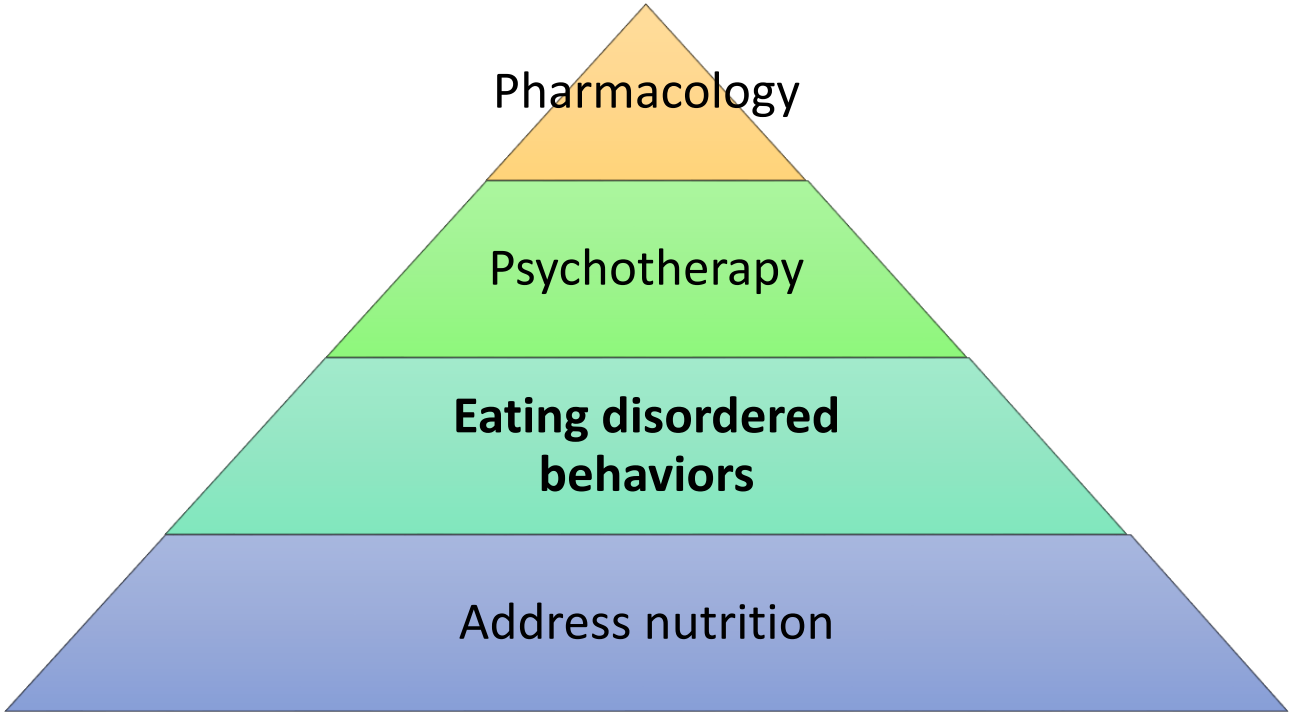
Address nutrition: virtual interventions

- Consider timing of sessions to challenge ED behaviors
  - For individuals who restrict, can provide supported meal sessions or family coaching around meals
  - For those struggling with purging behaviors, consider after meal support
- Check in on meal intake for that day – they haven't eaten? That's the first order of business
- Work with the individual to track ED behaviors and meal completion
- Collaborate with family and social supports to bolster accountability; consider having them join sessions
- Create a plan on how weight will be tracked

Address nutrition: virtual interventions

- Meal coaching tips
  - Keep prompts positive, short and direct
  - ‘I know you can do this’
  - ‘You are doing a great job, let’s keep it going’
  - ‘I see you are taking small bites, please take some larger bites’
  - ‘It is important to give your body the fuel it needs’
  - ‘We are halfway through the mealtime and you have had less than half of your meal – let’s try to take some bigger bites so you can complete your meal’
  - Shift back into conversation unrelated to the meal

Treatment:


Pharmacology
Psychotherapy
Eating disordered behaviors
Address nutrition

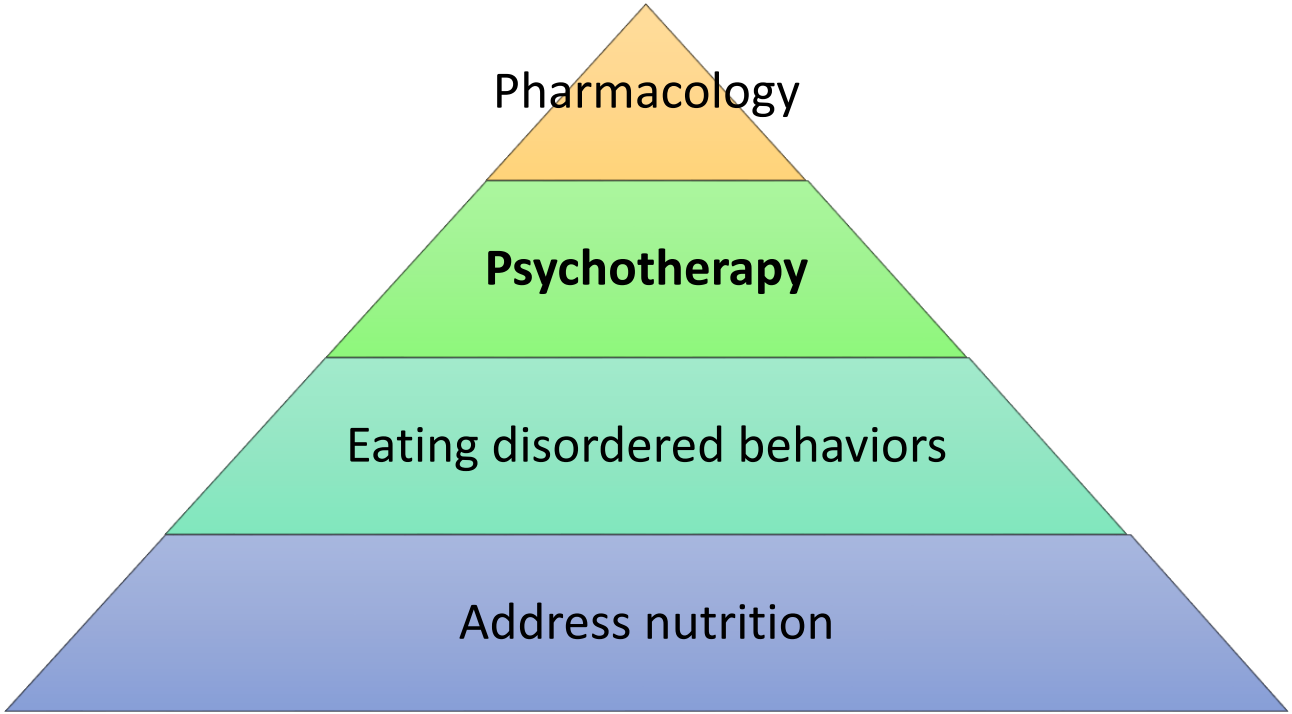
Interrupt eating disordered behaviors

- Much of this work is exposure therapy – patients benefit from validation and support while doing hard things
- Treatment plans include:
  - Family support, structured meal plans, exposures to places like restaurants and grocery stores
  - Goals around expanding the quantity and variety of food intake
  - Plans around exercise and joyful movement

Eating disordered behaviors: virtual interventions

- Being able to do supported exposures in the home environment where the ED behaviors have been occurring can be really powerful
- Consider exposure work that can be done via telehealth
  - Eating challenge foods together
  - Ordering meals in
  - Cooking during session
  - Engaging in some gentle movement if medically appropriate to do so
  - Exposures around going into the bathroom and not purging
- Opportunity to develop coping strategies and distress tolerance in the home environment

Treatment: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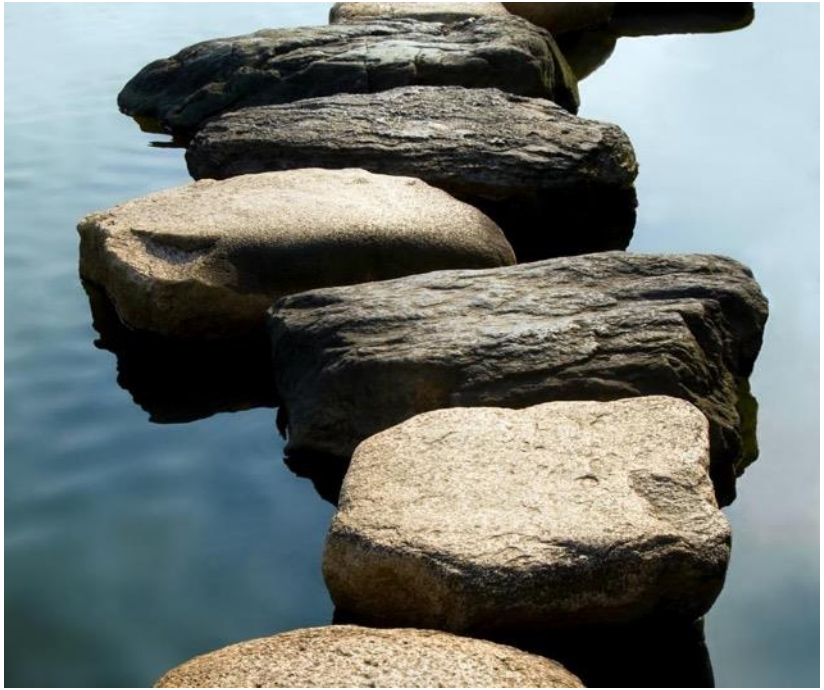
Anorexia nervosa: Adolescents

- Family Based Therapy has the most robust evidence
  - Caregivers take control of eating choices
  - Teaches the family how to support the child as food habits are normalized
- Telehealth can help decrease barriers to family engagement

Anorexia nervosa: Adults

- Evidence for a variety of different approaches
  - Enhanced CBT (CBT-E)
  - Motivational interviewing
  - ACT
  - Interpersonal therapy
  - DBT & RODBT
  - Also: EMDR, yoga, mindfulness
- Nutritional counseling + Therapy is better than nutritional counseling alone
- Much less research around atypical AN, but we typically take a similar approach

Bulimia nervosa & Binge eating



- Most evidence for Cognitive Behavioral Therapy*
- Also evidence for interpersonal therapy for BED

*Often these folks have significant trauma and other comorbidities that also must be addressed to really treat the ED

Therapy: virtual interventions

- Identifying emotions:
  - These patients can be alexithymic and struggle to identify emotions
- Skill building and increasing distress tolerance:
  - Identify and build (non-eating disordered) coping skills

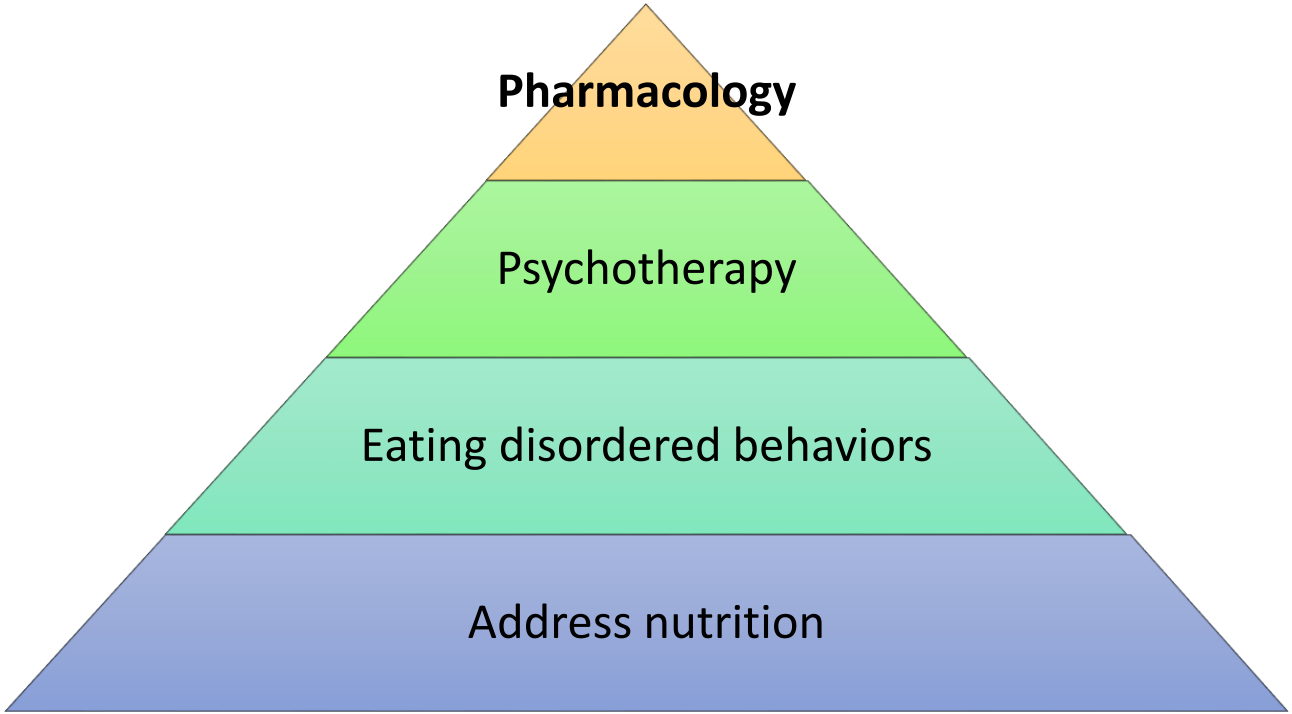
Therapy: virtual interventions – body image

- This work is hard – can be very distressing
- Helpful for patients to have some basic therapeutic skills and knowledge before diving in

Interventions

- Creating an understanding for how we got here
  - Creating a body image timeline
- Separating personal values from ED values
  - Value sort; current life vs what you want
- Exposure work
  - Mirror exposures, imaginal exposures
- Addressing and acknowledging cultural stigma
  - Creating space to acknowledge the very real antifat bias in society and medical spaces

Treatment: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Pharmacology: Anorexia nervosa

- No FDA approved meds
- Underweight: more prone to side effects
- SSRIs
  - Typically ineffective at low weight
  - Limited evidence to support use of Prozac once weight-restored to decrease risk of relapse (60mg/d)
- Avoid bupropion in patient with binge/purge type – increased risk of seizures
- Antipsychotics results mixed (but we use them anyways. . .)
  - Most evidence for olanzapine with limited evidence of other 2nd gen
- Medications may be started for comorbid issues (i.e. SSRIs for depression)

Pharmacology: Bulimia nervosa

- SSRIs are first-line treatment (particularly if CBT unavailable)
  - Fluoxetine is FDA approved for treatment of BN
  - Sertraline also has good evidence
  - Doses typically high (i.e. 60mg/d of fluoxetine)
- Also evidence for topiramate & TCAs

Pharmacology: Binge eating disorder

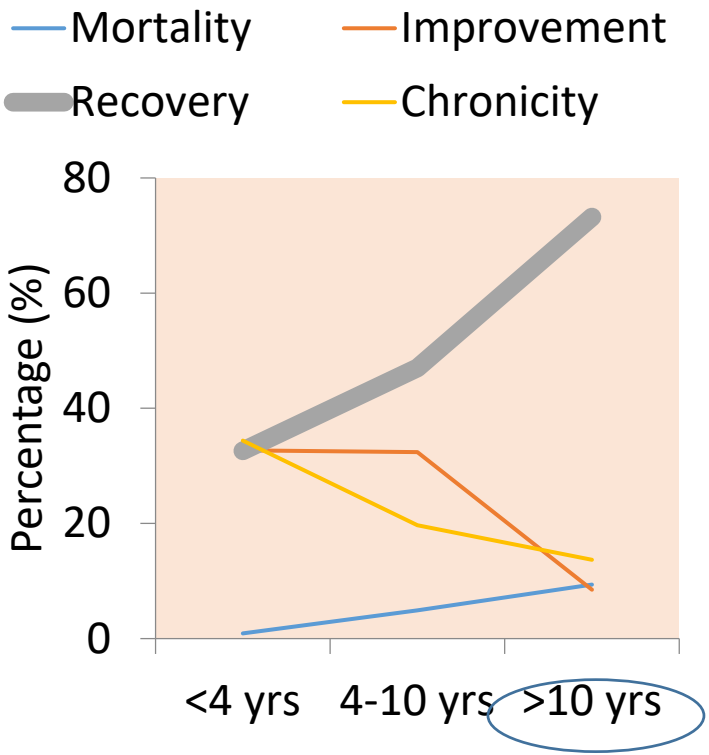
- CBT is generally more efficacious than meds
- SSRIs are typically tried first
- Lisdexamfetamine (Vyvanse) is FDA approved – works less well if binges are mostly at night…
- Also evidence for topiramate

Recovery

Recovery is often
non-linear – like with all mental illness

Recovery: Anorexia nervosa

It just takes time!



(Steinhausen 2002)

Local Treatment Resources

- Local treatment programs (also have sites around the country)
  - Eating Recovery Center (IOP, PHP, Residential; IP and ACUTE in Denver): https://www.eatingrecoverycenter.com/
  - Emily Program: https://www.emilyprogram.com/
  - Center for Discovery: http://www.centerfordiscovery.com/
  - Opal: https://www.opalfoodandbody.com/
  - Liberating Jasper: https://www.liberatingjasper.com/
  - Equip (all virtual): https://equip.health/

Resources for you

- Resource guides:
  - APA Practice Guidelines for treatment of EDs: https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890424865
- Books
  - Fat Talk – Virginia Sole-Smith
  - Sick Enough – Jennifer Gaudiani
  - Eating Disorders: A Comprehensive Guide to Medical Care and Complications fourth edition – Phil Mehler
- Podcasts
  - On antifat bias
    - Maintenance Phase (also Aubrey Gordon's books are great)
    - Burnt Toast (not the food 52 one…)
  - On eating disorders
    - Food Psych
- Websites
  - International Association of Eating Disorders Professionals : www.iaedp.com
  - ERC Academy : https://www.eatingrecoverycenter.com/professionals/education-events
  - Academy for Eating Disorders : www.aedweb.org
  - National Eating Disorders Association(NEDA): https://www.nationaleatingdisorders.org/
- Me! Megan.Riddle@ERCPathlight.com

Conclusions

Eating disorders are relatively common – screen for them

A person of any size body or gender can develop an eating disorder

Treating eating disorders is a team sport

Early treatment is associated with better outcomes

Please feel free to reach out to me for questions on cases!!
Megan.Riddle@ERCPathlight.com

Essential medical workup

- History and Physical
- Longitudinal height/weight data (GROWTH CHARTS!!)
- CBC
- Electrolytes (Potassium, Chloride, Sodium, bicarbonate) with BUN, Cr, Ca, Phos, Mg
- Liver function tests
- Blood glucose
- Urinalysis
- Thyroid tests (Free T4, TSH)

Medical complications

Restriction*

- Usually related to organ dysfunction due to malnutrition
- Starvation affects all organs of the body

Binge-purge behaviors

- Usually related to the type of purging used, frequency, and duration

Eating disordered behaviors

- With weight restoration and consistent nourishment, some of these behaviors fade. Typically:
  - Food choices increase
  - Food hoarding decreases
  - Obsessions about food diminish
- Distortions about body image and compulsive exercise are some of the more difficult thoughts and behaviors and often the last to improve (and it can take years)
  - Often important to target these directly in therapy

Pharmacology

What's been tried? Basically, everything. . .

What's effective? Ehhh

Questions?

TeleBehavioral Health On-Demand Training Series

In partnership with the NRTRC, the **TeleBehavioral Health 101, 201, 301, 401, and 501** series are available **on-demand and free of charge.**

- Series 101, 401 & 501 are **accredited for Continuing Medical Education (CME)** and are clearly marked as such. Nominal fee applies.
- A Continuing Education (CE) certificate will be provided for ALL sessions, at no cost.
- Series 101: Module 1 meets Washington State Telehealth Training requirement.

Access the trainings at: bhinstitute.uw.edu/tbh-on-demand

Looking for free On-Demand Health Equity & Ethics Training?

Cultural Humility in Behavioral Health Care

- Free two-hour module
- On-demand & self-paced
- Meeting Health Equity training requirements in WA State

Empowering Recovery: Ethics & Collaborative Decision Making in Behavioral Health

- Free two-hour module
- On-demand & self-paced
- Meeting Law & Ethics training requirements in WA State

Access the trainings at: bhinstitute.uw.edu/learn-online

Advancing Health Equity through Cultural Humility – Partner Training

Free On-Demand Continuing Education Course for Health Professionals

Offered by our partners at the Area Health Education Center for Western Washington at Whatcom Community College

AHECWW
AREA HEALTH EDUCATION CENTER
FOR WESTERN WASHINGTON AT WHATCOM COMMUNITY COLLEGE

Access the training at: ahecww.thinkific.com

Additional Free Resources for WA State Behavioral Health Providers (1 of 2)

TeleMental Health Guides (8) for Infancy to Young Adult: uwcolab.org/tmh-guides

CME/CNE Accredited Educational Series:

- UW Traumatic Brain Injury – BH ECHO
- UW Psychiatry & Addictions ECHO
- UW TelePain Series

Cannabis & TBI

Charles Bombardier PhD

TODAY: 12-1:30

tbi-bh-echo.psychiatry.uw.edu

Additional Free Resources for WA State Behavioral Health Providers (2 of 2)

Provider Consultation Lines:

> UW Pain & Opioid Provider Consultation Hotline (WA, MT & AK)

> Psychiatry Consultation Line
> Partnership Access Line (pediatric psychiatry)
> Perinatal Psychiatry Consultation Line

Access the resources at: bhinstitute.uw.edu/bh-provider-resources