Chapter 10
Treating Eating Disorders During COVID-19: Clinician Resiliency Amid Uncharted Shared Trauma

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Introduction

The emergence of the novel coronavirus has brought unparalleled fear, worries, and mental-health struggles to the forefront of the clinical landscape. The human race has been plighted with individual experiences of loss, fear, and grief. As clinicians, the experience of shared trauma is extremely relevant. Shared trauma is defined as a community trauma that is completely and wholeheartedly experienced with aspects of primary and secondary trauma by both clinician and client (Tosone et al. 2012). COVID-19 has presented a paradoxical challenge for clinicians who treat eating disorders (EDs), whereby their clients were told to shelter-in-place with food. Used for nourishment, security, and safety for most, food often becomes a method of self-punishment, control, and self-loathing for those with the diagnosed eating disorder. Food serves as a way to navigate the uncertainties and unfamiliarities of this crisis, while also moonlights as a coping mechanism, a self-soothing yet self-hatred agent, and a voyeuristic form of escapism.

While numbing one's emotions with television, wine, and online shopping has become socially acceptable, ED clients suffer deeper isolation, shame, and feelings of failure. Furthermore, risks to the population include "food insecurity, fat-phobic messaging, and restricted healthcare access" (Cooper et al. 2020, p. 1).

COVID-19 has halted the lives of many, but a particularly vulnerable client is one whose recovery hangs in the unfamiliarity between pre-pandemic and the "new normal." This chapter will serve to describe the setbacks in the clinical landscape as a result of COVID-19, and how clinicians can tap into their own experiences of

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trauma, find clinical resiliency, and effectively treat eating disorders with their struggling clients.

Clinical Landscape and Developing Risk Factors

Structure in the Absence of Routine

In times of uncertainty or strife, it is common human behavior to engage in routine and structure. "Highlighted as being crucial for patients as a way of coping with change and preventing boredom…[routines and structures] often led to increased ED preoccupations" (Fernandez-Aranda et al. 2020, p. 241). During the COVID-19 pandemic, the absence of the normal routine allows individuals to relapse into ED behaviors. "Self-regulation" or "coping" takes the shape of becoming hyper-focused and rigid about routines designed around food and exercise. Coping skills can mimic escapism for some such as those suffering with bulimia nervosa (BN) or binge eating disorder (BED). Routine can also take the shape of denial of bodily needs and appetite, such as in anorexia nervosa (AN). *For the ED client, to do either is normal.* The quarantine, and the pandemic itself, has posed a great risk to the population.

Clinicians should be reminded that EDs are brain based and eating behaviors can be reinforced by continued symptom-use. Recovery is often aimed at decreasing symptoms, first and foremost, as a way to interrupt the patterns in emotion regulation and the "positive" albeit detrimental effects that eating pathology provides. During the COVID-19 pandemic, it is a tremendous challenge to extinguish symptoms that are designed specifically for mechanisms of control and security in times of unknown. How can we expect our ailing clients to commit to decreasing symptoms when they know symptom-use can aid in emotional stability and feelings of safety in a crisis?

Specifically, the health risk correlating COVID-19 and symptomatic AN clients is not yet known. There is evidence that those with AN enter a vicious cycle whereby calorie restriction spurs lapses in typical dysphoric feelings. Sufferers find that the food-restrictive behaviors provide relief from an otherwise depressed mood (Kaye 2008). AN clients are aware that they feel better if they restrict their food intake, often citing that restriction numbs their emotions. "Very low weight people with anorexia nervosa may be particularly vulnerable to COVID-19 because of emaciation and their compromised physical health, although it isn't clear that the degree that this applies to those less physically compromised" (Touyz et al. 2020, p. 19).

BN and BED sufferers are also struggling with symptomatic difficulties. Touyz et al. (2020) write that "many people with bulimia nervosa and binge eating disorder are now at home for 24 hours a day seven days per week. There is no escape from distancing oneself from food at home and there are limited opportunities to leave home to buy food. Bingeing on the family's food when restocking is problematic,

may lead to further family conflict, heightened emotional arousal, depression and anxiety as well as the likelihood of increased self- harm or even suicidality" (p. 19). The risk factors of increased symptom-use for these clients during the pandemic are prevalent and warrant further research as the pandemic continues.

Lack of Available Interventions for Symptom-Use

Eating disorders are typically understood as manifestations of deeper anxieties, and fears, which bubble to the surface as control and preoccupation with food, shape, and/or one's appearance (Fairburn 2008). EDs are considered serious physical diseases whereby one's food pathology and manipulation creates cognitive impairment, emotional instability, and affects the daily life activities of sufferers. Furthermore, EDs, and anorexia nervosa specifically, are some of the most deadly psychiatric disorders (Klump et al. 2009). The juxtaposition between the trauma of the COVID-19 pandemic and those previously diagnosed with EDs is profound. Clients with concurrent EDs and a history of trauma have more severe eating pathology, more psychosocial impairment, and more psychiatric comorbidity of depression and anxiety than eating disordered patients without a history of trauma (Backholm et al. 2013). Since trauma, anxiety, depression, and eating disorders are linked with eating pathology and psychosocial impairment, it is estimated that social distancing and stay-at-home orders in the midst of a global trauma have posed greater risks.

Pre-COVID treatment interventions are challenging to implement in the age of COVID-19. Some interventions, such as employing "opposite action" – whereby clients would seek social inclusion when urged to self-isolate – have become impossible due to the stay-at-home orders. A therapist might suggest signing on to social media or the use of phone or virtual communication platforms to combat isolation. In actuality, both methods tend to be risky for the ED client, whereby bodily appearance and self-image are intertwined with both methods of communication. Studies reflect "a strong correlation between social media use and body dissatisfaction, as well as symptoms congruent with eating disorder pathology"; thus, social media often poses as a trigger for many when they engage with it (Lenza 2020, p. 47). The use of phone or virtual tele-therapy is not always comforting. Clients have found it feels less supportive than in-person treatment (Fernandez-Aranda et al. 2020). This creates a cycle of social isolation with little relief, paving way for the urge to isolate.

A preliminary study on the effects of COVID-19 in the ED unit of a Spanish hospital demonstrated that clients were distressed by phone or virtual tele-health, and felt increased bodily awareness as a result of moving to virtual tele-therapy models (Fernandez-Aranda et al. 2020). Researchers correlated their lack of clinical engagement due to body image dissatisfaction, which is an emotional experience that often triggers ED symptom-use.

There are many emerging fears regarding symptom-use during the COVID-19 pandemic and the lack of assurance in the tele-therapy modality. As a provider, it has become increasingly difficult to track the progress, or lack thereof, of clients on their recovery journey. Without this vital knowledge, ED clients have been able to use symptoms, "under the radar," overeating or undereating without the direct confrontation of tangible data.

First, it is near impossible for ED clinicians (therapists, dietitians, and ED physicians) to assess stability through the form of taking a client's weight or vitals. Without access to a scale in-session, along with the shutdown of many primary care offices, it is not feasible to capture weight or vitals as a snapshot of a client's overall health and recovery. Second, seeing clients face to face is undeniably more beneficial; the point of contact gives clinicians the general sense of how a client is faring. In-person sessions provide clinicians with some basic markers of the client's health, such as personal hygiene or cleanliness, fullness of the cheeks and the face, coloring in the face, or the general experience of the client as *looking healthy on the whole,* a phenomenon lost in the tele-therapy model where one typically sees the client's face. Clinicians have suggested finding an ally in the client's recovery, such as a caregiver or loved one, to assist in obtaining "blind weights" (e.g., taking the weight of a client without them witnessing the number on the scale) for clinicians who need more physical measurements of progress (Waller et al. 2020). This puts additional burden on the caregiver.

Ultimately, it is crucial diagnostic criteria if the clinician is fearful of someone's declining physical health. It may be important to explore with the client a higher level of care, such as a day treatment program, whereby their weight and symptom-use can be monitored more closely. Even so, recommending a client to attend an in-person day program poses its own health risks; "because of physical distancing and the mantra around the globe of 'staying at home' the running of face to face programs becomes at the least challenging" (Touyz et al. 2020, p. 19).

Such setbacks to recovery do not come without consequence. It is a common experience for clients to experience immense feelings of failure and self-hatred for losing their grips on their recoveries and for struggling with the battle against their EDs. Clinicians must remind themselves of the characterological traits inherent to those who suffer with eating pathology. Relapses or slips in recovery may ignite feelings of failure, self-loathing, and general ambivalence toward recovery in the future. Such as in the case of a BED client, "body dissatisfaction leads to pathological overeating, which then results in being overweight…people are then more likely to experience further symptoms of depression and body image distress, entering a repetitive cycle in which they use their eating pathology to self-regulate" (Lenza 2020, p. 47). When working with clients, it is disheartening to navigate the true despair that clients face when experiencing their recovery efforts as thwarted by a global pandemic. Self-loathing, self-hatred, and clinical ambivalence due to these obstacles have emerged as thematic norms.

The Physicality of the Fridge

The lack of readily available therapeutic interventions when paradoxically food has become increasingly available is a pain point for clinicians. As human beings who all thrive under behavioral intervention models, we have conditioned ourselves to remove the stimulus of food, when snacking or emotional eating is not appropriate. This has been rather difficult during the pandemic, especially in the early days of the crisis, when individuals and families began stocking their pantries and filling their fridges in response to sheltering-at-home.

Food delivery, snacking, and "putting on the quarantine 15" are social norms during the age of quarantine; social media has highlighted the reality of weight gain for many in the pandemic (Yu 2020). While the physicality of the fridge is now known to us all, those with eating disorders experience stocked cabinets, full fridges, and pandemic preparations as direct threats to their recoveries, challenging all they know as safe and comfortable. For the average individual, food-stocked homes have provided a sense of security in the pandemic. However, clinicians lack proper interventions for this new reality as food-in-bulk is often a behavior trigger for ED clients. The normal therapeutic routes, such as suggesting to "take a walk outside," "get a pre-packaged meal from the grocery store," or even "step completely away from food and try the movie theater" do not apply here. Clinicians are now tasked with getting inventive with their therapeutic interventions, which often rely heavily on removing the stimulus, the physicality of the fridge, rather than coping alongside it.

A group-think of clinicians who treat EDs was compiled for preliminary research exploring adaptation of ED treatment for tele-health modalities. Examples of available interventions include the use of virtual social eating opportunities (e.g., book dates with friends to eat on a webcam, or catch up over coffee and a snack) and the use of therapy session as an opportunity to conduct food exposure activities (Waller et al. 2020). Another helpful idea is assisting BED clients to break free from the notion that social isolation must then spiral into eating-in-secret, "given the tendency for binge-eating episodes to occur in social isolation, stress to the patient that the current social climate is an opportune time to utilize cue exposure to break the association between social isolation and binge eating" (Waller et al. 2020, p. 1132). These interventions help clients create appropriate distance from the fridge and their urges to eat; instead, they motivate the client to create new pathways of eating that are much healthier.

Clinician Resiliency Amid Uncharted Shared Trauma

Clinicians have now been tasked with altering and adapting to the new treatment environment, a promising byproduct. Clinicians are extremely resilient and will be able to integrate new knowledge while adapting treatments and interventions. It

may be crucial to first connect with the experience of shared trauma, and work with one's own pandemic experience to further understand and empathize with clients in crisis.

Clinicians should first acknowledge their own experience in the pandemic; this could present itself as symptoms of shared trauma or one's own countertransference regarding maladaptive food patterns and/or behaviors. Systematic review of countertransference in eating disorder treatment reveals that therapists often demonstrate negative attitudes toward their ED clients (Forget et al. 2011). Future research should focus on whether countertransference effects have increased in the age of coronavirus. Still, if a clinician is struggling with their own relationship to food, with their bodies, or with exercise, it is certainly the time to be mindful of how one's challenges may skew the clinical work at hand. A clinician should be especially wary of prescribing a diet mentality out of one's own personal parallel, such as pandemic weight gain. It is not the clinician's job to help suss out weight gain or weight loss, to give advice, or to provide solutions to the client regarding their weight and appearance issues. Clinicians can altogether remain authentic, however, and emphasize to clients that clinicians, too, are experiencing their own discomforts in this traumatic environment.

Resiliency Through Adaptation of Known Methods

Clinicians can assert shared resiliency, a phenomenon whereby clinicians experience increased personal resiliency, confidence, and self-growth with clients by demonstrating adaptation of the interventions that they are trained to use in-person (Nuttman-Shwartz 2015). Effective treatments in tele-therapy may take trial-and-error and an individualized approach, and clinicians are encouraged to remain innovative and exploratory. For closer monitoring of client symptoms and engagement in recovery, use a Health Insurance Portability and Accountability Act (HIPAA)-compliant phone application, such as "Recovery Record," whereby clients can regulate eating by food monitoring, a key principle of Cognitive Behavioral Therapy (CBT) for EDs. An explanation of the application is as follows:

> Building on the foundation of paper-based CBT self-monitoring forms, a central meal-monitoring feature was built into the application. This feature digitized the original question set and also included a range of optional additional questions to accommodate the diverse symptoms and experiences of eating disorder patients. Because regular eating is the foundation on which other changes in eating are built. Reminders were added to the application, prompting users to eat and log their meals six times per day by default. To enable flexibility and personalization, options to change the default reminder times, sounds, and messages were included (Tregarthen et al. 2015, p. 974).

Preliminary research of the efficacy of this application demonstrated that users benefitted from the application (Tregarthen et al. 2019; Cooper et al. 2020). By participating together in the smartphone application, clients and clinicians feel as though they are maintaining accountability and focus in recovery, even when in-

person therapy is not an option. "Recovery Record" can also link other treatment providers; that is, clients can have their doctors, dietitians, or coaches on the application, also tracking their progress in real-time.

"Road-mapping," a new clinical intervention developed out of Acceptance and Commitment Therapy (ACT; Hayes 2004), can help clients combat feelings of failure when they succumb to their ED urges. ACT is a known effective therapeutic intervention for eating disorders (Lenza 2020). To properly implement ACT, the conceptualization should be that "while most clients come into therapy hoping the therapist will help them decrease whatever emotion they are experiencing…ACT is about living a vital life, and sometimes that means living that life with difficult emotions." A client who desires perfect and uninterrupted control can be understood as taking a "detour that never gets back to the main highway" (Hayes and Twohig, 2008, p. 22). Road-mapping encourages the client to seek self-compassion and self-understanding that their treatment journey resembles a road that is winding and confusing, and not altogether straight and simple to navigate. Reviewing the "highway" analogy is helpful. Hayes (2004) demonstrates that when individuals live in accordance with one's true values, such as self-worth, then one is actually moving on their version of the ACT highway, not on the detour.

By way of road-mapping, clients can begin to provide themselves with self-compassion. Self-compassion is known to be helpful for clients to navigate distress and body image issues in their recoveries (Cooper et al. 2020). Clients can come to understand that their recovery mindset can remain a positive one even if there are struggles, obstacles, or detours. By simply desiring recovery and by engaging with their own motivations, exploring available treatments, and attending their tele-therapy appointments, they are indeed moving in the right direction toward recovery. Clinicians may be accustomed to the motivational reflection that "progress is not linear," and this can serve as a reminder when implementing this notion of self-compassion as a direct clinical intervention.

Future Practice

As clinicians navigate next steps, and researchers continue to determine the lasting consequences of the COVID-19 crisis, exploring and comprehending the parallel processes of shared trauma and shared resiliency remain beneficial. Especially in ED treatment, clients have indeed become adaptive to tele-therapy and non-traditional support. It is now the responsibility of the clinician to do the same, challenging the notion that their own therapeutic work is less successful when not conducted face to face. Eating disorder professionals, who have dedicated their careers to treating these life-threatening diseases, must remain hopeful. By exemplifying the notion of shared resiliency, or rather, the clinician's authentic desire to forge ahead despite their own traumatic response, the client/clinician relationship will survive this untraveled "highway," that is the new pandemic reality.

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