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Virtually possible: strategies for using telehealth in eating disorder treatment learned from the COVID-19 pandemic

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ABSTRACT

The COVID-19 pandemic resulted in an abrupt shift from in-person to virtual treatment, and clinicians continue to offer telehealth due to its advantages. Telehealth may be a viable, effective, and safe treatment modality for many clients with eating disorders. We consider contemporary issues regarding the use of telehealth in eating disorder treatment and identify strategies to enhance its delivery. First, we emphasize key factors when choosing therapy delivery (telehealth, in-person, or hybrid). Second, we address telehealth-specific planning, preparation, safety, and privacy considerations. Third, we discuss how eating disorder assessment and evidence-based interventions can be adapted for telehealth delivery. Fourth, we raise telehealth-specific challenges related to group-based delivery and the therapeutic alliance offering alternative avenues for connection and engagement. We conclude with a discussion of how additional research is needed to refine the presented strategies, develop new strategies, and assess their efficacy and effectiveness.

CLINCIAL IMPLICATIONS

- We offer clinicians interested in conducting telehealth within ED treatment recommendations to enhance delivery.
- We help clinicians choose their therapy delivery approach (telehealth, in-person, or hybrid) based on client issues and concerns within ED treatment.
- We offer clinicians ways to plan and prepare for effective telehealth delivery while also considering client safety and privacy within ED treatment.
- We suggest ways that clinicians can adapt assessment and interventions for telehealth delivery within ED treatment.
- We pinpoint challenges specific to telehealth in ED treatment and offer alternative avenues for client connection and engagement.

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While clinicians have incorporated technology into eating disorder (ED) treatment for decades, a significant increase in videoconferencing services occurred as a result of the COVID-19 pandemic, when many individuals receiving outpatient treatment were transitioned from face-to-face to telehealth delivery and new clients were only offered virtual treatment (Linardon et al., 2022). Concurrently, treatment demand increased due to worsening of ED symptoms secondary to lockdown measures (e.g., restricted access to food, healthcare, and social contact), emotion dysregulation (e.g., from trauma, illness uncertainty, changes in routine), and weight-stigmatic media messaging (Cooper et al., 2022; Datta et al., 2022, 2023; Termorshuizen et al., 2020; Vuillier et al., 2021).

The rapid transition to telehealth and worsening symptoms were met with a sudden need for expert recommendations so that clinicians who previously had not used telehealth widely could provide effective ED treatment. To meet this need, several articles presented strategies that could ease certain COVID-19-related challenges/disruptions. For example, Waller et al. (2020) compiled a list of problems, recommendations, and considerations for therapists needing to utilize telehealth as their in-person offices were shut down. Additional articles addressed barriers unique to virtual ED treatment, such as lack of telehealth delivery training and issues surrounding client safety and privacy (Taylor et al., 2020), or offered specific recommendations for transitioning clients requiring a higher level of care to online treatment (Datta et al., 2020) and delivering Family-Based Treatment (FBT) online (Matheson et al., 2020). While these articles provided a helpful roadmap for clinicians lacking training and experience in telehealth implementation, the recommendations are limited by time (the start of the pandemic, forced shutdowns), focus (one type of therapy, one clinic's transition to virtual therapy), and scope (rapid transition to telehealth). Updated strategies grounded in research and clinical experience could shape ED treatment via telehealth moving forward.

Although telehealth guidelines were urgently needed at the start of the pandemic to ensure that clinicians had access to fundamental telehealth tools and strategies (Couturier et al., 2021; Gorrell et al., 2022), many healthcare fields have utilized—and *will continue to utilize*—telehealth due to its distinct advantages. Table 1 presents numerous benefits of telehealth for clients with EDs, their families/supportive persons, and clinicians. For clients, telehealth reduces travel, wait time, and cost; increases opportunities for family involvement and treating individuals who are underserved and located within areas experiencing healthcare shortages; facilitates sharing of their home environment to enhance tailored treatment; and demonstrates treatment effectiveness (Asbury, 2023; Brothwood et al., 2021; Gajarawala & Pelkowski, 2021; Hilty et al., 2020; Linardon, 2021; Scott et al., 2022). Clients with EDs who were transferred from in-person to telehealth at the onset of the pandemic generally report that telehealth was effective, safe, and comparable (or even advantageous in select ways) to in-person treatment (Levinson et al., 2021; Plumley et al., 2021; Raykos et al., 2021;

Table 1. Client (including family) and clinician benefits of telehealth delivery within eating disorder (ED) treatment.

Client (and Family) Benefits of Telehealth ED Delivery	Clinician Benefits of Telehealth ED Delivery
• Reduces cost compared to in-person care, as cost of in-person treatment may be a barrier for specialty ED care (Zhou et al., 2022).	• Allows clinicians to observe features of clients' living spaces and lived experience, leading to experiential insight into the day-to-day routines and interactions of the client's family system (Hyland et al., 2022; Pruitt et al., 2014).
• Improves access compared to in-person care (Zhou et al., 2022).	• Allows clinicians to individualize treatment interventions based on the unique features of the client's eating environments (e.g., kitchen, dining hall at college), available cooking appliances, and food storage spaces.
• Expands access to a wider geographical network of specialty providers (Young & Badowski, 2017).	• Facilitates delivery of educational tools to clients, their families, and supportive persons (e.g., self-paced models on topics such as ED etiology and neurobiology, the effects of starvation, the importance of regular and adequate nutrition for mood regulation, tips for supporting clients during mealtimes, the importance of each member's roles in treatment, and how to manage collaboratively the client's symptoms (Hill et al., 2016).
• Increases access to those who live in rural communities, with limited or no access to transportation (Hilty et al., 2020). • Eliminates commuting time (Hilty et al., 2020).	• Increases the pool of potential clients who are no longer limited by geographic location alone. • Enhances the provision of treatment from various locations (e.g., home, alternate secure locations) which promotes the balance of professional and personal demands.
• Caters to those who are medically compromised/immunodeficient (Wosik et al., 2020). This feature may be especially relevant to EDs given the prospective link between infections and subsequent ED diagnosis (Breithaupt et al., 2019). This feature may also be relevant to those with EDs who need to limit energy expenditure during the refeeding process, including those on medical bedrest, thereby minimizing the potential for disruption in treatment (Datta et al., 2020).	• Provides continuity of care when potential unexpected disruptions arise (e.g., medical concerns, illness, weather).
• Facilitates client sharing of their home environment and lived experience with the clinician (Pruitt et al., 2014). • Facilitates client sharing of the landscape of their eating environments (e.g., kitchen, dining hall at college) including available cooking appliances and food storage spaces.	• Reduces administrative tasks via use of telehealth platforms (e.g., online scheduling, session reminders, secure messaging, and electronic payment). • Promotes timeliness of appointment start and end times, bypassing external factors (e.g., travel delays from weather and traffic conditions) and reducing "doorknob" revelations whereby clients provide critical disclosures and revelations on their way out of the office (Gitlin, 2022).
• Allows clients to introduce their pets who may provide a source of emotional support during therapy (e.g., stroking a pet can ground clients who have difficulty with mindfulness, being aware of their bodily sensations, and emotional regulation).	• Lowers overhead costs (e.g., maintaining a physical office, renting space on a limited basis).
• Enhances inclusion of family members and other supportive persons who wish to participate but may be unable to attend in-person sessions (Carretier et al., 2022; Datta et al., 2020). • Enables viewing self-paced educational modules on various ED topics.	• May improve client attendance (Childs et al., 2021). Many of our clients elect to participate in a telehealth appointment when unable to attend in-person as a way to offset the potential fee associated with no-show and/or late cancellations. • Offers an alternate way to provide therapy, and clinicians may appreciate the diversity in treatment modalities.
• Access free virtual ED-related support groups and/or education for carers: National Eating Disorder Awareness Network Virtual Support Groups, Morningside Chats in the Living Room, National Alliance for Eating Disorders, New Maudsley Carers-Kent, and Butterfly Webinar Program for Carers	• May create a natural buffer to the intensity of emotion experienced on a clinician-level, thereby minimizing the potential for compassion fatigue.
• Increases client comfort in certain situations, such as discussing sensitive topics (Carretier et al., 2022; Zhou et al., 2022). • Improves the balance between ED treatment, work, and family responsibilities due to reduced travel and transition time (Brothwood et al., 2021).	• Build a caseload of clients across jurisdictions secondary to federal legislation and insurance reimbursement (Stewart, 2023). • Promotes less formality and a laid-back atmosphere for both the client and clinician (Pruitt et al., 2014).

Spigel et al., 2021; Steiger et al., 2022). In a review and meta-analysis comparing randomized controlled trials of telehealth with in-person therapy treating mental health conditions including EDs, Greenwood et al. (2022) found no differences in symptom severity (after treatment or at follow-up), overall improvement, working alliance, and client satisfaction.

The provision of telehealth services may provide benefits for clinicians. In our practice, client attendance appeared to improve. We emphasize that telehealth is a viable option if/when unforeseen circumstances impact our clients ability to attend in-person sessions as a way to offset the potential fee associated with no-show and/or late cancellations. The ability to make a timely switch from in-person sessions to telehealth has proven especially helpful to reduce the potential risk of illness or virus transmission (Wosik et al., 2020). We also enjoy having an alternate way to provide therapy. Learning how to deliver telehealth across a variety of client issues/concerns offers enrichment in learning and mastery. The nature of virtual interactions correspond with less formality, and as a result, promote a laid back atmosphere for both the client and clinician (Pruitt et al., 2014). While we understand that this experience might not be applicable to all providers and/or therapeutic situations, in some instances we have found that the inherent physical distance associated with telehealth creates a natural buffer to the intensity of emotion experienced on a clinician-level, thereby minimizing the potential for compassion fatigue. We have found that scheduling time between telehealth appointments for self-care and rejuvenation can be helpful for us as well as our clients.

The advantages and acceptance of virtual care has opened the door for innovative treatment approaches such as 100% virtual, evidence-based treatment programs for disordered eating (Equip, 2023). Virtual care innovations have created increased access to multidisciplinary treatment teams (i.e., therapist, dietitian, medical provider, and peer mentors [individuals in recovery] providing evidence-based treatments such as FBT, Cognitive Behavioral Therapy for Eating Disorders (CBT- E), and Dialectical Behavioral Therapy (DBT). Virtual care is conducted via coordination with the client's primary care physician for physical exams and, when necessary, the family is coached on how to conduct blind weights and measure orthostatic vitals. Full service virtual care yields several logistical advantages for clients including reduced financial and time-commitment costs related to commuting, increased access to ED care for those who live in smaller cities or rural areas, and accommodations for families impacted by separation or divorce.

Due to the continued interest in using telehealth for ED treatment, the purpose of this *How I Practice* article is to provide readers with an updated discussion of current issues surrounding telehealth delivery preference and preparation. We focus solely on synchronous video-based telehealth given its similarity to in-person therapy and clinician preference of video-based delivery (Molfenter et al., 2021). We provide recommendations for telehealth delivery

based on research (specific to ED treatment, general to mental health) and strategies found to be useful in our practice. We move beyond the valuable recommendations provided at the onset of the pandemic to provide strategies adapted for telehealth delivery that may enhance the experience for clients, families, and clinicians.

Feasibility and delivery preference

Now that telehealth is no longer necessary to offset COVID-19 transmission, we can consider prudently how to assess feasibility and preference for telehealth as part of informed consent. Telehealth may not be feasible for clients given a variety of reasons such as the severity of ED symptoms and need for a higher level of care (Carretier et al., 2022). If clinicians deem that telehealth is a viable option for clients, they can dialogue to determine preferences. Below, we offer recommendations that we have found to be useful in our practice.

For positive uptake of telehealth, client engagement is key (Lieneck et al., 2021). Prior to entering into a therapeutic arrangement, we suggest that clinicians offer a phone or video consultation with potential clients to discuss advantages and disadvantages (see Table 2) of adopting a complete virtual, hybrid, or in-person model of treatment as part of informed consent. As part

Table 2. Examples of advantages and disadvantages associated with complete virtual, hybrid, and in-person models of delivery.

	Complete Virtual	Hybrid	In-person
Advantages	• Access to a wider geographical network of specialty providers • Attend sessions in various environments & contexts • Reduce hassles and fees (e.g., traffic, travel, parking) • Allows family members from various geographical locations to participate	• Vacillate between in-person and virtual models based on changing needs (e.g., scheduling issues, weather/traffic problems)	• Able to transmit and read non-verbal information (e.g., observe a client's gait, how their clothes fit, and how they carry themselves) • Enhances therapeutic alliance
Disadvantages	• Discomfort with technology • Lack of privacy • Internet or technology issues • Difficult to transmit and read non-verbal information • Clients engaging in sessions distracting locations or locations in which they cannot be fully emotionally engaged (in car, in office at work on a break)	• Difficulty transitioning between in-person and virtual session which may impact the therapeutic alliance	• Lack of access to ED specialty providers nearby • Lack of flexibility • Increased time or resources needed to attend appointments

of post-pandemic practice, it is important to make selection of the treatment delivery method intentional and based on client needs and goals. If clients request telephone services in lieu of videoconferencing, we recommend that clinicians address the reasons for this request (e.g., avoiding video-based communication due to appearance-specific issues), whether this format is in the best interest of the client's recovery, how to problem-solve the eventual transition to videoconferencing, and potentially undesirable aspects of telephone-only services (e.g., whether third-party payors authorize this form of treatment). If clients report discomfort with video-based technology, clinicians can offer training to improve clients' comfort, self-efficacy, and use (Sieck et al., 2021). For example, clinicians can offer guides on how to use the technology platform for the sessions (e.g., installing necessary software, how to log on), a telehealth checklist with suggestions on how to prepare for appointments (e.g., be in a private and safe location), and even offer a brief demonstration of how sessions telehealth work.

When appropriate, clinicians can discuss treatment feasibility and preferences with the client's support system, as family variables may be important when considering telehealth delivery (Yaffa et al., 2021). Family resources such as Internet access, functional and private electronic devices, and allocation of private space can impact the feasibility of, resistance to, and engagement/compliance with telehealth. When telehealth is utilized, clinicians need to assess client and family satisfaction and treatment effectiveness throughout. Many evidence-based ED treatments (e.g., FamilyBased Treatment, Enhanced Cognitive Behavior Therapy, Cognitive Behavioral Therapy-Ten, Cognitive Behavioral Therapy-Avoidant/Restrictive Food Intake Disorder) recommend periodic check-ins to gauge the effectiveness of treatment modality, and telehealth effectiveness could be assessed simultaneously at this time. If satisfaction and/or effectiveness with treatment delivery are compromised, clinicians, clients, and families can problem-solve modifications to promote adherence and recovery.

Preparation for telehealth delivery

Preparation, planning, and organization are essential for telehealth-delivered ED treatment, and clinicians must ensure that clients understand the process and expectations. We recommend a contract of agreement that clearly outlines expectations for both the client and the clinician (e.g., cancellations, treatment adherence) and specifies when it might be pertinent to revisit the appropriateness of telehealth (e.g., if the client is not progressing or distracted, predetermined sessions). Our contracts often specify that clients must show themselves on screen in real-time, position their camera so their face and upper torso can be seen, be actively engaged and facing the computer, and minimize interference (e.g., viewing other websites) so that they are fully present and engaged during therapy.

Ensuring that clients have a comfortable, safe, private, well-lighted, and distraction-free therapy space is essential. In one study, adolescent clients spoke about their need for space distinctly separate from their parents (Carretier et al., 2022). An adolescent explained "I am always afraid that someone nearby will hear me" (p. 6). Some parents agreed that holding the telehealth session at home may limit their teen's trust and privacy. A parent described her daughter's experience as, "Having her psychiatrist, or any other therapist, come by Skype, into her private space, it's complicated for my daughter" (p. 6). Accordingly, we have found it useful to brainstorm with adolescent and adult clients and family members (when appropriate) on how to create a special place for therapy at home that assures privacy and feels a bit like an escape (e.g., creating a meditation/therapy nook and using a relaxing virtual background on both computers) or choosing to complete sessions apart from others at home (e.g., in a stationary vehicle). The American Telemedicine Association Practice Guidelines for Telemental Health with Children and Adolescents (Myers et al., 2017, see Table 3) is an essential resource when coordinating telehealth services outside the home specific to minors.

We recommend that clinicians and clients create a collaborative agenda at the beginning of the virtual session to ensure that therapy appointments are utilized effectively and address all necessary topics, consistent with evidenced-based therapies (e.g., CBT-E). For minors, we recommend that parents join a portion of the virtual session to offer updates about client progress (e.g., meal plan compliance, use of skills), identify concerns (e.g., increase in restricting, medication non-compliance), receive updates on themes addressed within therapy, learn how to support their loved one effectively, and recommend potential areas of treatment focus (Myers et al., 2017). For minors, a responsible, trusted, and capable adult needs to be present onsite. In the event of a medical or mental health emergency, clinicians can collaborate with this adult to ensure client safety.

Privacy and safety issues

Before offering telehealth services, clinicians need to be knowledgeable about and receive training on applicable local/state/national/international laws (including inter-jurisdictional practice), professional standards of care, licensing issues according to their respective professional board(s), and handling of ethical and emergency issues (see Table 3). Some licensing boards now require continued education credits focused specifically on telehealth services, and we recommend ongoing colleague consultation to ensure clinicians are up-to-date on the provision of telehealth services.

Table 3. Clinician resources.

Resource and Link	Purpose
Technology in Social Work Practice, Standard 2.06 (Competence: Knowledge and Skills Required When Using Technology to Provide Services) NASWCulturalStandards2003.Q4.11 (socialworkers.org)	Summarizes required knowledge and skills when using technology to provide services.
Stanley Brown Safety Plan Forms—Stanley-Brown Safety Planning Intervention	Facilitates the development of a safety plan.
Cognitive Therapy for Suicide Prevention	Offers information on Cognitive Therapy for Suicide Prevention as well as resources for clinicians who wish to implement this therapy.
CAMS-care	Offers information and training on the Collaborative Assessment and Management of Suicide (CAMS) therapy approach, an evidence-based, suicide-focused treatment framework.
Suicide Prevention Resource Center	Offers many resources on suicide prevention.
Brief Mental Health Professionals' Duty to Warn	The National Conference of State Legislators website that articulates Duty to Protect/Warn Laws.
Digital Health Technologies | AMA	Education and training on how to assess physical symptoms via telehealth offered by the American Medical Association (AMA)
NQF Action Team: Virtual Healthcare Quality—Description	Offers guidance from experts and recognized leaders who are committed to addressing the delivery and quality of virtual care.
https://www.liebertpub.com/doi/pdf/10.1089/tmj.2017.0177?casa_token=-8lF8UQk5ocAAAAA:ENg5Gb_YBRuflrPuc8CnOVDMwP3Lor4JFNoTRGTRAfHkreQ8_VAEWDQAi4N4RGiqKmqlEGVGdC-_	The American Telemedicine Association Practice Guidelines for Telemental Health with Children and Adolescents (Myers et al., 2017) is an essential resource when coordinating telehealth services outside the home specific to minors.

Ensuring client privacy and safety has unique implications for telehealth. Clinicians should confirm the client's exact location, phone number, emergency contact information, and local emergency resources including an identified hospital and police department at the beginning of each session. Additionally, clinicians should confirm that unintended others cannot access audio or visual components of the telehealth session unless agreed upon in advance by both client and clinician for therapeutic reasons.

Because of the potential for additional risks when delivering telehealth services, clinicians need to complete a risk-benefit analysis for each client that prioritizes client welfare. Knowing that individuals with EDs can have elevated risk for suicide (Udo et al., 2019), we recommend that telehealth services include screening and ongoing assessment for safety-related issues similar to in-person sessions (for resources, see Table 4). When safety concerns arise, it is important for clinicians to identify therapeutic risk management (low, intermediate, high) for both acute and chronic factors. We recommend that clinicians employ the following safeguards: discuss how emergency situations will be handled if they arise, create a Safety Plan that is ideally shared with supportive persons, and integrate an evidenced-based treatment modality addressing suicide-specific issues in addition to ED treatment (e.g., DBT, Collaborative Assessment and Management of Suicide; see Table 3 for additional resources).

Table 4. Standardized measures for assessment.

Standardized Measure	Description
Ask Suicide-Screening Questions, ASQ	Four brief suicide screening questions for both youths and adults that takes 20 seconds to administer
Body Appreciation Scale-2 (BAS-2; Tylka & Wood-Barcalow, 2015)	Ten-item self-report measure of body appreciation
Clinical Impairment Assessment Questionnaire (CIA 3.0; Bohn et al., 2008a, 2008b)	16-item brief self-report measure of the impairment resulting from current eating disorder psychopathology to be used following Eating Disorder Examination-Questionnaire
Columbia Suicide Severity Rating Scale, C-SSRS (Posner et al., 2011)	Suicide risk assessment to identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs
Eating Attitudes Test-26 (EAT-26; Garner et al., 1982)	26-item standardized self-report measure of symptoms and concerns characteristic of eating disorders
Eating Disorder Examination Questionnaire 6.0 (EDE-Q; Fairburn & Beglin, 1994)	28-item self-report questionnaire based upon the Eating Disorder Examination interview
Eating Questionnaire- A (EDE-A)	36-item self-report questionnaire based upon the Eating Disorder Examination interview for use in children and adolescents ages 8+
Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006)	Seven-item self-reported questionnaire for screening and severity measuring of generalized anxiety disorder
Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001)	Nine-item depression scale to function as a screening tool, an aid in diagnosis, and as a symptom tracking tool that can help track a patient's overall depression severity as well as track the improvement of specific symptoms with treatment ages 12+
Suicide Assessment Five-step Evaluation and Triage, SAFE-T	Five-step plan involves identifying risk factors and protective factors, conducting a suicide inquiry, determining risk level and interventions, and documenting a treatment plan
Suicide Behavior Questionnaire-Revised, SBQ-R (Osman et al., 2001)	Four items each tapping a different dimension of suicidality
Working Alliance Inventory Short Form Revised (WAI-SR; Horvath & Greenberg, 1989)	12-item self-report measure that assesses the relationship between clients and clinicians in terms of trust and respect, along with acknowledgement of the ability to work toward mutual goals and change

ED interventions via telehealth

Many ED interventions historically delivered in-person can be ethically, effectively, and intentionally delivered via telehealth with planning. We offer suggestions on how to adapt selective ED interventions within a virtual context.

Assessment

Assessment of general mental health functioning, ED symptoms, and body image issues throughout treatment is integral for evidence-based care to gauge client progress which can be relayed to third-party payors when necessary. These assessments can be delivered via telehealth, and below we share ways that we use assessment within our virtual work with clients.

Telehealth can be used interactively to administer scales or instruments to gauge client ED symptoms, body image, and mental health. Sample body image instruments can be accessed via the Positive Body Image Workbook (see Wood-Barcalow et al., 2021), and additional instruments we have found useful in our practice are provided in Table 4. For each instrument, we recommend sharing items and response scales via the "share-screen" feature

for clients to read and refer to, which ensures the client's attention on each item, while recording their responses and asking follow-up questions to facilitate greater depth and breadth. Clinicians can use information from assessments to create individualized treatment goals and objectives and, in session, share the client's previous responses while engaging in dialogue about struggles and advances in the recovery process.

Evaluating clients' medical health and functioning is also important to assess clients' reported (e.g., dizziness, last menstrual cycle, energy levels) and observable (e.g., gait, balance) physical symptoms and concerns, with the latter being a challenge within a virtual environment (see the AMA link in Table 3). Monitoring weight trajectories is another aspect of evidence-based ED care. Suggestions are to connect with primary care providers or hospital satellite clinics near clients or offer families a refined protocol to calibrate home scales in order to collect open or blind weights that can be forwarded to the treatment team (Barney et al., 2020). If medical deterioration is of concern secondary to increased restricting, purging, and overexercising, clients can be seen within their local clinic for measuring weight, vital signs, and bloodwork. Within CBT-ED, Waller et al. (2020) offers suggestions on how to garner and process open weights specific to virtual treatment.

Accountability with nutrition intake and disordered eating behaviors

Telehealth may afford opportunities for clients to better transition to the "real world," as they can practice eating meals or access virtual support while at home (Brothwood et al., 2021; Couturier et al., 2021). We encourage scheduling telehealth appointments during typical meal/snack times to offer support as clients choose, prepare, and eat meals/snacks while in their natural environment. In our experience, clients generally express a preference for their clinicians to eat with them similar to the process that occurs in higher levels of care so it is important to have food readily accessible. Clinicians can help clients identify specific eating concerns/challenges unique to their home environment, provide encouragement, and reinforce skills garnered in therapy.

Family meals are key interventions in evidence-based approaches such as FBT and CBT-AR and can be facilitated virtually. Similar to nutrition support in individual therapy, clinicians can provide specific feedback to clients and family members in-vivo as they eat meals in their own home. When family members are eating together in one location, we suggest using multiple devices logged into one virtual room to offer the clinician various viewing options to survey the full landscape.

Many clients also are in need of support and accountability for binging and purging after mealtimes (Crow et al., 2009). For clients with these concerns, we recommend the judicious timing of appointments following typical meals and

snacks. In these instances, clinicians can assist with identifying and challenging ineffective thoughts, providing nutrition education, validating discomfort associated with fullness and reinforcing concepts from CBT-AR (fullness is temporary, tolerable, and has only short-term consequences), managing urges (using the CBT-T Diary of Potential Triggers to Using Unhealthy Eating Behaviours), and implementing distress tolerance skills from DBT (e.g., urge surfing, distraction, self-soothing). Overall, telehealth has been found to decrease binging and purging and sustain these decreases at rates comparable to in-person treatment (Crow et al., 2009).

Eating-related exposure

A hallmark component of many evidence-based ED treatments is exposure work (Butler & Heimberg, 2020). Telehealth can be especially beneficial for exposure-based interventions such as tolerating uncomfortable physical sensations within a naturalistic environment, eating "fear foods" common within the home, and addressing body image issues. One example is to facilitate interoceptive exposure techniques to decrease discomfort with physical sensations, a common precipitating factor that corresponds with compensatory restriction and purging. Using identified techniques in CBT-AR, clinicians can guide exposure work by asking clients to push out their abdomens to mimic bloating, gulp several glasses of water to mimic fullness, and spin in a chair to mimic nausea. Clinicians can help clients assess their discomfort (using Subjective Units of Distress ratings) and sit with uncomfortable physical sensations, emotions, and thoughts using Acceptance and Commitment Therapy (ACT) defusion techniques within their home. Because clients are in their naturalistic environments, they can practice utilizing comforts and supports that are present in the home setting and share, in real time, household triggers and challenges.

Clinicians can offer other creative virtual interventions to challenge and eradicate disordered eating behaviors that generalize across naturalistic environments. For example, clients can tackle fear foods at home with support from clinicians. In our experience, parents of children and adolescents appreciate having live instruction and coaching in these moments. College students can receive clinician support while navigating potentially stressful environments like selecting and eating avoided foods within the dining hall or dorm room. Clients with binge eating can practice purchasing food from triggering environments, and eating adequate amounts while addressing hunger and satiety cues in the moment. For those clients with chewing and spitting behaviors, they can eat fear foods during a session while receiving compassionate instruction from clinicians on how to identify and tolerate uncomfortable emotions and thoughts without resorting to undesirable behaviors. Clinicians can offer clients assistance with navigating the grocery store or coach clients to nourish themselves during session if they have not adequately fueled prior.

Body image interventions

Understanding that body image issues are symptoms of many ED presentations, it is important for clinicians to address these issues as part of ED care within a virtual environment. Telehealth may be uniquely useful for the delivery of mirror exposure therapy, as clients can do exposure within their own homes. To prepare clients, clinicians need to instruct clients in advance what to wear (e.g., form-fitting clothing) and to focus their cameras so that the clinician can see the client as they engage in the full-body mirror exposure exercise viewing themselves from different angles. Using their own mirror may be more impactful for clients versus completing this work within an artificial environment.

The dynamic of seeing themselves on screen positions clients to observe themselves in ways that can activate self-objectification (i.e., critiquing their appearance as if they are an observer of themselves; Fredrickson & Roberts, 1997). Self-objectification can be especially problematic for clients with EDs and may disrupt concentration within virtual therapy as they focus on their facial appearance, engage in mental comparisons with how they used to look prior to treatment, use "touch-up" features, and/or adjust camera angles (Harriger & Pfund, 2022; Hart et al., 2023; Pfund et al., 2020; Rodgers et al., 2020). The "hide self-view" virtual tool offers a unique opportunity for exposure work for self-objectification. Clinicians can facilitate gradual exposure by helping clients transition from using the "hide self-view" feature to using the self-view (without filters or adjustments) for increasing amounts of time as they note aspects of their appearance in neutral or positive terms, and/or comment on their emotions as they look at themselves. Importantly, clinicians can reflect on their own experiences with self-objectification and can mindfully choose whether to use technology features (e.g., filters) as a way to model self-acceptance. Telehealth may inadvertently limit engagement in full-body comparison with others, as clients only see faces on the screen (Datta et al., 2020) and thus enable clients to be more present and engaged within sessions.

We do not advocate the use of telehealth to enable clients to avoid situations where self-objectification and appearance comparisons are likely. Rather, we recommend clinicians incorporate the focus on self-objectification appearance comparison into additional aspects of their treatment, such as helping clients identify when they engage in maladaptive dynamics within and outside of session and problem-solving how to reduce these tendencies (see Wood-Barcalow et al., 2021 for talking points during session and treatment plan goals and objectives for reducing self-objectification and appearance comparison that can be delivered virtually).

In addition to addressing indicators of body image disturbance, telehealth can be used to foster body appreciation, which includes appreciating one's body irrespective of its appearance and ability to function well (Linardon et al., 2022; Tylka & Wood-Barcalow, 2015; Tylka et al., 2022). Targeting body

appreciation for ED treatment is associated with lower odds of experiencing disordered eating at 8-month follow up (Linardon, 2021). Specific interventions for addressing body appreciation have been identified by Wood-Barcalow et al. (2021), including identifying reasons to be grateful for the body and what it means to respect the body, which can be delivered virtually.

Collaboration

Telehealth allows family members from various geographical areas to participate remotely and be actively engaged within a full or partial session (Brothwood et al., 2021). In our practice, clients and families report satisfaction in their ability to join together virtually. We have found this experience to be especially true for our emerging adult clients who are moving toward independence while simultaneously requiring support from parents (e.g., emotional, financial). In these instances, emerging adult clients can invite their parents to participate in portions of virtual treatment.

Telehealth also offers the opportunity for clinicians on the same treatment team in *different locations* to facilitate *joint sessions* with the client. For example, therapists and dietitians can demonstrate solidarity in reinforcing concepts and recommendations about nutritional intake, exercise/physical activity levels, and more. We recommend that clinicians coordinate in advance the following topics: select which clinician will lead the session including setting the agenda and maintaining time, identify 1–3 talking points pertinent to the client, allow time for the client to ask questions, and synthesize main points that translate into action items and/or between-session work.

Group-focused treatment

For therapists typically renting a large space for group interventions, telehealth is cost saving and can increase group member diversity in terms of demographics and perspectives. Although the recommendations for one-on-one interventions are relevant in group telehealth settings, there are unique issues to consider.

Group participants need to trust not only the clinician(s), but all participants. Trust is typically established through identifying and adhering to group norms that are maintained by all members. Similar to the contract recommended for individual therapy, clinicians need to orient group participants in advance on how to use virtual technology and safety. Examples include educating what constitutes a private location, that recording sessions is not an option, the benefits of using headphones or earbuds, and how to restrict the view of their screen. Using the speaker view can help reduce the tendency of participants to engage in comparative thinking while at the same time reducing the felt sense of an in-person group in which all members can be viewed continuously.

Flow of communication and management of group dynamics are additional challenges. Group guidelines need to include specific ways to reduce ambient background noise, participate (e.g., raising hand emoji), and utilize features effectively (e.g., taking polls, sharing links). Disabling the chat feature at specific times reduces the need for managing side conversations and interruptions. Clinicians can communicate how they will manage the flow of conversation to ensure all participants have an opportunity to contribute and offset the potential for some to dominate the conversation. Group leaders can facilitate peer interactions by using the breakout room feature. Although not as seamless as in in-person group settings, leaders can drop into breakout rooms to facilitate discussion and redirect discourse. Hyland et al. (2022) offer helpful instructions on how to facilitate group skills training virtually as part of DBT.

Therapeutic alliance

Therapists may experience unique challenges establishing and maintaining a therapeutic alliance using telehealth. In a qualitative study, both parents and adolescents indicated that the therapeutic alliance was the central factor in the success of telehealth (Carretier et al., 2022). Clients who met in-person, pre-telehealth, were more accepting of a transition to remote sessions and perceived the continuing care to be as effective as in-person sessions, while adolescents who met their therapist first in a virtual context dropped out of care more rapidly. Many adolescents believed that their therapist could not decipher their feelings unless they specifically verbalized them, which may be especially relevant to ED treatment given the links between alexithymia and disordered eating (Westwood et al., 2017) and the lack of emotional clarity and psychological distress among individuals with EDs (Vuillier et al., 2021). To increase the ability to notice and decipher nonverbal gestures and movements, clinicians could encourage clients to position the camera so that their entire upper torso can be seen. Additionally, it is helpful to "exaggerate body language" via different methods (e.g., leaning in to camera, overemphasizing facial responses, changing volume of voice) to convey emotions virtually (Hyland et al., 2022).

A lower therapeutic alliance within telehealth sessions compared to in-person delivery may be particularly likely for clients in day programs or group therapy. One study found that clients rated telehealth as less personal and cited fewer opportunities to connect with other group members as a drawback (Brothwood et al., 2021). In ED day treatment programs, clients often form relationships with others between groups, during mealtimes, and other opportunities for downtime, whereas clients participating in telehealth log off in between sessions which limits opportunities for relationship building. Additionally, client communication and attention was lower in telehealth than in-person treatment (Datta et al., 2020).

Given these challenges, we recommend that clinicians determine alternative avenues for engagement, connection, support, and relationship building for clients in day treatment programs or group therapy who utilize telehealth. For example, treatment teams can ensure that a transition occurs from a client seeing one member of a team to the next (e.g., the clinician stays online with the client until the client's next meeting). Additionally, the use of breakout rooms during or between group sessions could facilitate increased opportunities for clients to connect with peers in treatment (e.g., moving all clients into a private breakout room where they can informally meet prior to the next group session, or dividing clients into smaller groups where they can dialogue). Of note, we recommend that clinicians do not offer clients either the option of logging out between sessions or joining a breakout room, as clients may exit due to discomfort. In response, clinicians can provide prompts for discussion in breakout rooms.

We recommend that clinicians continue to seek out opportunities to increase engagement and connection with clients, their families, and supportive persons using telehealth, as strong therapeutic alliance is linked to more positive views of telehealth for clients (Lewis et al., 2021). To address the unique aspect of the therapeutic alliance, we recommend the Working Alliance Inventory (Horvath & Greenberg, 1989, see Table 4). Outcomes from the Working Alliance Inventory can be reviewed with clients to help elucidate areas of strength and growth for the therapeutic relationship.

Conclusions and future directions

This manuscript provides updated and specific strategies grounded in research findings and our clinical work for the utilization of telehealth for ED treatment. Overall, full or partial use of telehealth may be a viable, effective, and safe treatment modality for many clients with EDs.

Yet, there is much to learn about the use of telehealth in ED treatment. Current recommendations and guidance are based on clinical experience, client and family satisfaction, and a limited number of efficacy studies conducted during the pandemic. According to Linardon et al. (2022, p. 33), the existing research on virtual therapy outcomes for EDs during the pandemic is " ... limited, inconsistent, and based on small sample sizes." Many published telehealth studies regarding client and family satisfaction and preference do not indicate whether the delivered ED treatment is evidence-based and/or effective which impacts the conclusions that can be inferred. To our knowledge, no instrument has specifically addressed the effectiveness of telehealth from the perspective of clients, family members, and/or clinicians. We urge researchers to develop and evaluate such instruments.

More research is needed to further refine the interventions presented in this article, develop novel strategies specific to telehealth, and assess efficacy and

effectiveness. In the ED field, we need to determine which clients (e.g., personality characteristics, specific symptomatology) would benefit most from virtual therapy, more fully understand the impact of telehealth on ED symptoms and client engagement during the full progression of treatment, identify additional advantages and disadvantages to telehealth as well as unique features that may enhance or detract from treatment effectiveness, examine the effectiveness and satisfaction of telehealth treatment compared to other forms of virtual treatment (e.g., apps, text-messaging, online modules), and evaluate the effectiveness of evidence-based treatment in relationship to client and family preference and satisfaction. To move toward this knowledge, we need randomized controlled studies with larger sample sizes and adequate power that follow clients for extended periods of time and assess participants' experience with (and their expectations regarding) virtual therapy, treatment effectiveness, and client satisfaction (Linardon et al., 2022). Additionally, the majority of studies include samples of clients who have received ED treatment via telehealth that are limited in demographic and geographic characteristics. The very populations most likely to benefit from telehealth (e.g., those with limited access to transportation, financial resources, lacking daycare) are therefore underrepresented.

Development of professional training on telehealth delivery of ED treatment is recommended (Reay et al., 2020). As a prerequisite, we recommend careful screening of client symptoms and consideration of a risk-benefit analysis to determine whether telehealth would be a safe option for all or certain components of treatment. We further underscore the importance of considering client and family treatment preference and need, as well as monitoring client satisfaction and engagement throughout treatment. Clinicians need to engage in broader outreach efforts that can inform and educate underserved populations about possible telehealth options for ED treatment. We also urge clinicians to consider telehealth as either a stand-alone or hybrid option when a client's symptoms do not require in-person therapy, travel and time commitment is a burden to the family, and/or a client steps down in level of care.

Overall, telehealth has been widely integrated into ED treatment since the pandemic, and this trend will likely continue. Indeed, certain features of video conferencing platforms may enable clinicians to better reach, treat, and support clients and their families. We spotlight unique characteristics about telehealth that can benefit ED treatment and illustrate how clinicians can implement them. We identify challenges that could interfere with treatment and offer potential solutions. We call for researchers to design effective strategies to enhance the telehealth experience within ED treatment.

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