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Level of Care Considerations for Severe and Extreme Eating Disorders

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Determining what level of care a patient with an eating disorder needs can be one of the most challenging aspects of referring to treatment. Between client resistance and the body's ability to feign stability, it can be easy to accept the least intensive route.

The eating disorder industry has an ongoing need for even more definitive level of care guidelines, supported by empirical evidence and embraced by the eating disorder community. Historically, there has been reliance on the guidelines published by the American Psychiatric Association (APA), but there remains some degree of deficient integration of changing diagnostic criteria, as well as definition of what each level of care means. Additionally, the APA guidelines outline the five levels of care between outpatient and inpatient, but fail to completely outline a sixth level of care - medical treatment. The provision of additional information for the eating disorder community about all levels of care, appropriate admission guidelines, as well as appropriate treatment options, is critically important to optimize a successful outcome for the patient suffering with an eating disorder.

Using the *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5)*

Positive strides towards appropriate diagnosis and referrals were made in 2013, when the *DSM-5* was updated and released. It included several clinically relevant criterions. One of the most important changes was adding the severity index for evaluating one's body mass index (BMI, kg/m²), which primarily impacts the diagnosis of anorexia nervosa (AN). The index is as follows: **Mild** (BMI > or = 17.0), **Moderate**(16.0-16.99), **Severe** (15.0-15.99), and **Extreme** (< 15.0). This not only helps clinicians to diagnose Anorexia Nervosa in someone above 85% of ideal body weight (previous marker), but it also highlights the concerning fact that there are also a number of patients with extremely low BMIs. We often think about eating disorder treatment as singularly behavioral in nature, but the "extreme" category should compel families and clinicians to consider a patient's needs beyond that.

Severe and extreme eating disorders can cause life threatening medical complications including dangerous electrolyte imbalances, re-feeding syndrome, severe dehydration, edema, gastrointestinal complications, superior mesenteric artery syndrome (SMA), bradycardia and organ failure, to name but a few. It is important that there is appreciation and consideration that these potential complications exist not infrequently, especially at lower BMIs, and thus the need to intervene in a timely fashion.

Intervention should include medical stabilization in a highly sophisticated and specialized medical unit, prior to a patient starting traditional eating disorder treatment. Many experts espouse that this should happen when a BMI is < 14.0, or when that patient's weight is < 70% ideal body weight (IBW). Thus, in general, patients with AN or Avoidant/Restrictive Food Intake Disorder (ARFID) who are below 70% IBW, should first be treated in a specialized medical unit for the medical stabilization of those patients.

In general, if the patients' weight is between 70-84% of IBW, they are best served in an inpatient or residential treatment center, and if they are 85% to 95% of IBW, a partial hospitalization program (PHP) will generally suffice. But nothing is absolute, and thus the frequency of purging behaviors and other physical or psychiatric considerations can further qualify the

level of care that may be needed.

Considerations with Normal to Higher BMIs

More recently it has been being recognized that harm may occur by assuming that those with a “normal” or “higher” BMI are stable enough to access lower levels of care. Not only can these patients be presenting with a falsely elevated weight, but they can also be at risk for dangerous complications due to excessive purging behaviors followed by abrupt cessation or significant and rapid “weight disruption” from weight loss. Thus, the need to consider the severity of purging behaviors (also outlined in the *DSM-5*) and the severity of absolute weight loss when choosing an appropriate level of care. Again, consider medical stabilization first for those showing severe weight disruption as well as those needing to safely “detox” from severe substance, laxative or diuretic abuse. Starting in the appropriate level of care can have a significant impact on the patient’s health, success in recovery, and satisfaction with treatment.

Suggested Reading

1. *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition* (DSM-5).
2. Garber, A. K. (2018). Moving beyond "skinniness": presentation weight is not sufficient to assess malnutrition in patients with restrictive eating disorders across a range of body weights. *Journal of Adolescent Health*, 63(6), 669-670.
<https://doi.org/10.1016/j.jadohealth.2018.09.010>
3. Academy for Eating Disorders (2016). *Critical points for early recognition & medical risk management in the care of individuals with eating disorders (3rd ed.)*. Reston, VA: Academy for Eating Disorders.
<https://community.aedweb.org/learn/publications/medical-care-standards>
4. American Psychiatric Association (2006). *Practice guideline for the treatment of patients with eating disorders (3rd ed)*. Washington, DC: American Psychiatric Association.
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf

About the Authors



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From Across the Desk

Working toward Better Guidelines for Severe and Extreme Eating Disorders

It is well known that the mortality rate from anorexia nervosa makes it the most deadly of psychiatric illnesses. Two articles this month turn to the challenging task of matching the level of care to severe eating disorders. Jeana Cost and Philip Mehler, of the Eating Recovery Center in Denver (“Level of Care Considerations for Severe and Extreme Eating Disorders”) note that historically clinicians have followed the guidelines from the American Psychiatric Association but, as the authors note, the guidelines fail to outline medical treatment for these patients. The authors offer helpful guidelines, including considerations for patients with normal to higher body mass indices, and stress the importance of medical stabilization.

In the article, "Finding a Better Definition for Severe and Enduring Anorexia Nervosa," Phillipa Hay and Stephen Touyz lament the lack of consensus for clear-cut definitions of severe AN and for recovery. They offer three components of severe and enduring anorexia nervosa. They would also like to delete the term "treatment resistant," which they feel blames the physician and patient for the disorder. The first-look release of the *ICD-11* at the World Health Assembly in May might offer some solutions, according to Drs. Hay and Touyz.

— MS

UPDATE: Another Possible Cause Linked to BED and Obesity

Two seemingly polar opposites, food insecurity, or lack of food, often due to poverty, and binge-eating disorder, or BED, are associated, according to a recent report by Janet Lydecker, PhD, of the Department of Psychiatry Yale School of Public Health, New Haven, CT. She and her colleagues reported their findings in the *International Journal of Eating Disorders*, published online December 19, 2018.

The study recruited 1,2651 participants using Amazon's Mechanical Turk, a web-based recruitment platform; participants then reported their weight and height, and the researchers calculated body mass index (kg/m^2) for each. After this, the study participants were divided into three groups. More than half (56.8%; $n=710$) were classified as having a healthy weight with no eating disorder; 85 participants (6.8%) had diagnoses of BED, and 456 patients (36.5%) were obese but had no eating disorder.

The researchers defined food security in three categories (1) if the individuals were able to afford regular nutritious meals, (2) low food insecurity if they modified food quality, variety, or desire to satisfy hunger, and (3) very low food security if they reduced their food intake or quality to the point of having physiological hunger. One-third (33.7%; $n=422$) were found to have food insecurity; 18.5% ($n=231$) had low food security; and 15.3% ($n=191$) had very low food security. Compared with persons who had healthy weights, those deemed to have low food security were 2.5 times more likely to have BED. The same pattern was associated with an increased likelihood of being obese. Other researchers, such as Tomoko Udo, PhD, of the School of Public Health at SUNY University at Albany, NY, have noted that the dietary restraint model of binge eating suggests that when a person engages in dietary restriction as a way to control calories or due to lack of access to food, he or she is more likely to engage in binge eating due to deprivation.

Dr. Lydecker noted that clinicians traditionally associate self-imposed dieting, seen as skipping meals or cutting back on calories to lose weight, as one of the causes of binge eating. However, she added, externally imposed restrictions on food, skipping meals or cutting back on intake because food isn't available is also related to binge eating. "Food insecurity could be a factor making it more difficult for patients to get better if they cannot address it. By addressing it, clinicians and patients with BED can collaborate more effectively to treating binge eating," she said.

Loss of Control Eating Among Teens Linked to Perceived Family Function

Poor family function was linked with obesity in adolescent girls.

Loss of control (LOC) eating, a feeling that one cannot stop or control what or how much he or she consumes, affects approximately a third of children who are overweight or obese. It has also been linked to the development of partial or full-syndrome binge eating disorder, or BED (*J Abnorm Psychol.* 2011. 120:108; *J Abnorm Psychol.* 2013. 122:684).

Dr. Manuela Jaramillo, from the Eunice Kennedy Shriver National Institute of Child Health and Human Development at the National Institutes of Health, Bethesda, MD, and her collaborators recently concluded that among girls with LOC eating and high body mass indexes, poor family function plays a role in greater consumption of obesity-producing macronutrients during binge episodes (*Nutrients.* 2018. 10:1869). The researchers reported the connection after studying the relationship between perceived family functioning and energy intake during a laboratory test meal designed to model a binge episode. The team had hypothesized that lower levels of adaptability and cohesion would lead to greater total energy consumption, a larger percentage of energy consumed from fat and carbohydrates, with lower percentage of energy from protein.

The study group

The study group included 108 adolescent girls 12 to 17 years of age who were at high risk for developing eating disorders and excess weight gain, and who had experienced at least one LOC eating episode during the prior month. All were between the 75th and 97th percentile for body mass index (BMI, kg/m²). Then, family functioning was defined as the teen's perceived level of adaptability and cohesion of her family; this was assessed by the researchers with the Family Adaptation and Cohesion Scale III, a 20-item self-report that measures perceived levels of family adaptability. A sample item would be, "Family members like to spend time with each other." Higher scores equal greater adaptability and cohesion.

The test method used included analysis of energy intake, pre-meal hunger, depressive symptoms, and post-meal subjective evaluation of LOC eating. At 11 am participants were presented with a 9835-kcal buffet test meal with a wide assortment of foods, and were advised via a tape recording to "Let yourself go and eat as much as you want." Participants were left alone in the room until they signaled that they were finished eating. The test foods were then weighed and compared after the meal. A single item was used to measure pre-meal hunger with a question, "How hungry do you feel right now?" The Brunel Mood Scale was used to measure depressive symptoms, and a single-item assessment was used to measure post-meal evaluation of LOC eating.

The authors concluded that adolescent girls with diagnoses of LOC eating who perceived their families as being relatively less adaptable consumed significantly more carbohydrates and less protein from the test meal, which was designed to model an LOC episode. They also noted that the study findings underscored the importance of addressing family function in a clinical setting and, when possible, to include family members in interventions that may help modify adolescent girls' eating behaviors.

Finding a Better Definition for Severe and Enduring Anorexia Nervosa

Many patient variables make the definition challenging.

As the 11th edition of the *International Classification of Diseases* (ICD-11) is nearing pre-release this spring, Drs. Phillipa Hay and Stephen Touyz have commented on the lack of clear definitions for severe and enduring anorexia nervosa (AN). In an editorial in the *Journal of Eating Disorders* (2018; 6:41), the two well-known eating disorders experts lament the lack of consensus or clear-cut definitions for recovery or definitions of severe AN. (ICD-11 will be presented at the World Health Assembly in May, for adoption by member states, and will officially come into effect on January 1, 2022).

The authors point out three components of severe and enduring AN (Table 1): a decade or more years of a body mass index above the *DSM-5* severe range; marked morbidity from chronic starvation and longstanding illness; years of experiencing diagnostic level eating disorder symptoms with previous failed treatment attempts; and 3 to 10 years of illness; and treatment resistance. The criteria they propose are based on such factors as the clinically significant functional impact of the disorder (for example, poor quality of life and unrelenting symptoms, the duration of disease of several years of AN, and exposure to at least two evidence-based treatments delivered by an appropriate clinician or treatment facility, with a diagnostic assessment and formulation that incorporates an assessment of the person's eating disorder health literacy with an assessment of the patient's stage of change).

Both authors point out some of the problems with the term, "treatment resistant," which they are reluctant to use in the eating disorders field because it is viewed as pejorative and places blame on the physician and patient. Treatment resistance is also not well understood, according to the authors, and there is no real consensus on the definition—for example, how many attempts have been made at re-feeding or how many treatment sessions are felt to be enough before they are discarded?

Table 1. Proposed criteria for severe and enduring AN

1. A persistent state of dietary restriction, underweight, and overvaluation of weight/shape with functional impairment.
2. A history of more than 3 years of AN
3. Exposure to at least two evidence-based treatments appropriately delivered, with a diagnostic assessment and formulation that incorporates an assessment of the person's eating disorder health literacy and stage of change

Links Between Binge Eating Disorder and Suicide

New information in a largely unexplored area

Binge eating disorder (BED) is still the most common eating disorder in the US, with a lifetime prevalence of 3.5% for women and 2.0% for men. Despite this, much of its course and correlation to other factors remain relatively unknown, compared to other eating disorders such as anorexia nervosa and bulimia nervosa, for example. A collaborative study found that both binge eating behaviors and body mass index (BMI) are independently related to suicidal ideation and suicide attempts among US adults (*BMC Psychiatry*. 2018; 18:196).

Dr. Kristal Lyn Brown of Virginia Commonwealth University School of Medicine, Richmond, and colleagues at the University of Michigan School of Public Health, Ann Arbor, reported that one impetus for their study was that the relationship between BED and suicidality had not yet been examined in a population-based study of adults in the US. In addition, unlike other eating disorders, patients with BED do not use compensatory or restorative behaviors such as excessive exercise or laxative abuse, and thus are at higher risk for gaining weight and becoming obese. The authors examined three hypotheses: 1) BED is linked to an elevated likelihood of suicidality; 2) BMI is associated with likelihood of suicidality in a nonlinear manner, and 3) the relationship between BED and suicidality is exacerbated by BMI, and any differences by gender.

One-third of adults were affected

The study results were based on the 2001-2003 Collaborative Psychiatric Epidemiologic Surveys, a set of three nationally representative cross-sectional household surveys. (The data used for the analysis are available at <https://www.icpsr.umich.edu/icpsrweb/ICPSR Studies/20240>.) The data were limited to persons with complete data on BMI, BED, and suicidality and the initial sample included 14,497 individuals. While BMI did not substantially explain the association between binge eating and suicidal behavior, there was evidence that suicidality was exacerbated by high BMI.

A third of the adults with BED had a history of suicidality, compared to 19% of those without BED. BMI was associated with suicidality in a curvilinear manner and this relationship was exacerbated by binge eating/BED.

Finding that binge eating/BED is associated with suicidality echoes the broader literature on eating disorders and associated psychiatric comorbidities: nearly a third of women with BED report a lifetime history of suicidal ideation and 15% reported having attempted suicide (*Arch Gen Psychiatry*. 2011; 68:714). Several studies have shown a link between binge eating and mood disorders, novelty seeking, and impulsiveness, all of which have been linked to suicidal behaviors. The researchers found that the relationship between BMI and suicidal thoughts did not differ by gender, unlike earlier reports. As for depression, there was an inverse relationship between BMI and suicide attempts among men regardless of depression history and a curvilinear relationship among women, with a higher incidence of attempts among those with low BMIs compared to normal-weight women without histories of depression.

Dr. Brown and colleagues hope that their findings lead to thoughtful integration of psychiatric care into weight loss programs for adults with a history of binge eating behavior.

BED and Food Addiction

Nearly all participants in one study had at least a mild food addiction.

It's unclear how binge eating disorder (BED) and the newer concept of food addiction are related. BED is very commonly assessed by eating disorder professionals; food addiction, somewhat less often. A new tool, the *Yale Food Addiction Scale*, has been developed to assess for food addiction (Gearhardt and colleagues, 2011). This scale measures addictive qualities of eating behavior. It was recently revised to become the *YFAS 2.0*, adjusted for changes to the diagnostic criteria from *DSM 5*. Carter and colleagues (*Appetite*. 2019; 133:362) recently described the results of measuring food addiction using the *YFAS 2.0* in a group of people with BED (n=71) and controls (n=79). In this study, participants completed the *YFAS 2.0*, as well as an *Eating Disorders Examination* (EDE) interview to establish an eating disorder diagnosis.

Interestingly, nearly all the BED participants in this study (overall, 92%) scored positive for at least mild food addiction, while very few of the controls who did not have an eating disorder endorsed food addiction symptoms (only 6%). Among those with BED and at least moderate food addiction scores, higher *EDE* subscale scores were seen (except for the Restraint Subscale), and indications of greater levels of depression and anxiety were seen as well.

These interesting findings highlight the frequency with which food addiction may be present in individuals seen in eating disorder settings. This should stimulate further interest in the use of such screenings to increase awareness about food addiction, and as we learn more about how food addiction, this may influence treatment approaches.

Disordered Eating in Middle-aged and Older Women

A large Norwegian sample highlights a sometimes overlooked community health problem.

Disordered eating, emerging from body dissatisfaction, weight preoccupation, and dysfunctional eating patterns, has generally been described as a problem of younger patients. However, the fact that disordered eating can occur at any age, from childhood to advanced years, has been reinforced in a cross-sectional study of more than 90,000 middle-aged Norwegian women (*PLoS ONE* [oi.org/10.1371/journal.pone.0211056](https://doi.org/10.1371/journal.pone.0211056)).

When Dr. Marie Sigstad Lande and colleagues at the Arctic University of Norway, Tromsø, analyzed disordered eating among 90,592 women 46 and 76 years of age (median age: 55 years) who had completed questionnaires from the Norwegian Women and Cancer study from 2002 to 2005, they found the prevalence of disordered eating was 0.28%, and this was highest among women older than 66 years of age. Disordered eating was strongly associated with a history of depression, being unemployed, and single. In this study, depression was the strongest correlate of disordered eating: women with disordered eating had three-fold higher odds of also being diagnosed with depression. Women with disordered eating were also more likely to report low energy intake, and less likely to be moderately physically active. Just as in earlier studies, Dr. Lande and colleagues' finding that the oldest age group—women 66 to 76 years of age—had the highest prevalence of disordered eating.

This large-scale study confirms the findings of earlier smaller studies showing that disordered eating can arise in mid-life and older age. The authors feel that their study "underscores a somewhat under-communicated community health problem that needs attention in terms of age-specific treatment and prevention."

An Algorithm to Match Patients to Level of Care

A new test instrument includes measures of readiness for patient and family.

The complex course of eating disorders, marked by refusal to accept treatment, premature termination of treatment, and relapse, can lead to significant health care costs. There is also little consensus about specific factors in medically stable patients can point to specific treatment. For example, should the patient be treated as an outpatient, or in day treatment, or in residential care?

The Short Treatment Allocation Tool for Eating Disorders (STATED) is a new evidence-based tool that was developed to help match eating disorders patients to the most appropriate and cost-effective care (Geller et al., 2016). Josie Geller, MD, St. Paul's Hospital, Vancouver, British Columbia, and colleagues (*J Eat Disord.* 2018; 6:45), who developed the STATED algorithm, use three patient factors to assign a patient to specific care: (1) medical stability, (2) severity of symptoms/life interference, and (3) readiness/engagement to assign individuals to a specific level of care. The STATED instrument is similar to American Psychiatric Association guidelines, except that the STATED includes a treatment option that focuses on quality of life.

Finding study participants

The authors sought to determine how closely current allocation of patients to a level of care aligns with STATED recommendations. To find participants, letters describing the authors' study were sent via email to eating disorders listservs.

Healthcare professionals who self-identified as providing care for youth and/or adults with eating disorders were eligible to participate.

Most health care professionals who participated in the study were psychologists (n=47), followed by physicians (n=40), nutritionists and registered dietitians (n=27), and therapists (n=23). Thirty-seven percent of participants reported working in centers with intensive treatment programs, including inpatient or residential programs. More than 30% were allied with outpatient treatment centers that worked with a larger eating disorders team or network; others worked in a practice affiliated with an academic institution.

Correlations were found in many areas

Most practices were in accord or alignment with the STATED. recommendations. Patients with poor medical stability were seen as being more suited for in-hospital medical stabilization treatment than for other less intensive forms of care; those with more severe symptoms were seen as more suited to care in day programs, inpatient, or residential or quality of life-focused treatment options. Patients with higher readiness ratings were seen as more suited to recovery-focused treatment options.

Despite the correlations in many areas, the authors reported high levels of inconsistency, particularly in the readiness dimension (58% for adults and 6% for families). Possible explanations for this included a lack of understanding of the implications of low readiness, the absence of validated measures, and a lack of research on family readiness. Another possibility was lack of alternatives to action-oriented programs, such as care that focused on quality of life for very ill individuals whose readiness levels were very low.

Improving readiness for care

A first step, according to Dr. Geller and her associates, would be to help build awareness of the importance of readiness among patients and families. Among clinicians, improving the analysis of readiness by training collaborators and improving readiness would involve providing training to assessors, who could use a collaborative/motivational interview style to accurately assess patient and family readiness. In addition, it would be helpful to ensure that a menu of treatment options be available, with clear program guidelines for each level of care.

Questions and Answers: Self-Harm After Gastric Bypass Surgery

Q. We have an unusual problem, and hope you can help. One of our patients, a woman in her late 20s, recently had successful bariatric surgery, but then shortly afterward began harming herself, and has shown suicidal thoughts. Prior to her surgery she was obese and had a history of binge eating disorder (BED). Of course, after her surgery, bingeing was no longer possible. (S.W., Charlottesville, NC)

A. Recent reports have documented an increase in self-harm behaviors after gastric bypass, which affects about 20% of those who undergo this surgery (*Curr Opin Psychiatry*. 2016; 29:340). The American Society for Metabolism and Bariatric Surgery estimates 228,000 persons underwent gastric bypass surgery in 2018.

Dr. Louise Taekker and colleagues at the University of Copenhagen have reported a case very similar to yours (*J Eat Disord*. 2018; 6:24). Their case involved a 24-year-old patient who was a participant in a research project, the GO Bypass study (*Cont Clin Trials Communications*. 2018; 10:121), which aimed to identify factors that contribute to variations in weight loss after gastric bypass. GO study participants were followed for about 2 years, and were seen at 5 time points after surgery. At the time of surgery, the woman weighed 101 kg (220 lb) and had a body mass index (BMI, kg/m²) of 37. Eighteen months later, she had lost 27 kg (59.5 lb), and had a BMI of 31.

Eighteen months after surgery, during one of the follow-up visits the patient admitted that she had begun cutting herself on both forearms. She disclosed that her 7-year relationship had ended and the breakup led to a relapse into depression, followed by two suicide attempts. An important earlier finding on the pre-surgical psychosocial assessment was the woman's severe history of restrictive AN and BED. The patient had a high degree of body dissatisfaction, which had bothered her since childhood.

The patient was very forthright about how her cutting behavior functioned as a substitute for binge eating, which was now impossible after the gastric bypass. While some have advocated that addiction transfer, cross addiction, or symptom substitution may be the underlying cause for such a substitution, the authors dispute this because “there is no evidence for a theoretical rationale of unresolved psychological problems causing one compulsive behavior after the other.” Instead, in this case the authors prefer describing their patient’s behavior from a coping perspective.

In their case, the transfer of binge eating to cutting could be traced to the patient’s eating disorder, which was driven by negative affect; in recent years this was less active due to her stable relationship with a partner. When the relationship broke up, the woman’s difficulties with emotion regulation reappeared. Now the patient substituted a rapid self-destructive way of dealing with her emotions, substituting cutting for her earlier binge eating.

Thus, you might also consider the possibility that your patient has substituted self-harm for binge eating, in which difficulty in regulating emotion plays a central role.

The authors point out that their case is a clear example of the insufficiency of merely measuring weight loss and the absence of physical complications as criteria for successful gastric bypass surgery. A thorough clinical pre-surgery psychosocial assessment with a prolonged follow-up are needed for vulnerable patients.

— SC

In the Next Issue

Highlights of the 2019 iaedp Symposium in Palm Desert: “Instilling Passion Into Treatment and Recovery.”

Plus

- **Living in the Intersection Between Eating Disorders and Pregnancy**
- **Altered Function in BED and Bulimia Nervosa: A Resting-state fMRI Study**
- **Eating Disorder Symptoms and Proneness in LBGT Patients**
- **Can Recovery from an Eating Disorder Be Measured with a Questionnaire?**
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