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# Eating Disorders Review

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#### Scott Crow, MD, Editor-in-Chief

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## Involuntary Hospitalization for Anorexia Nervosa

By Mary K. Stein, Managing Editor

One of the most daunting aspects of anorexia nervosa arises when a patient refuses treatment despite being seriously ill. Due to the egosyntonic nature of AN, a patient may feel the “disorder” is a part of her, and doesn’t want it to go away.

Involuntary admission and treatment are particularly controversial for eating disorder patients, particularly for those with AN, the deadliest eating disorder. Even if the disorder is life-threatening, patients often refuse to be hospitalized, and are only admitted for treatment after pressure from clinicians, friends, teachers, or employers (*Am J Psychiatry*, 2007; 164:108). As Schreyer and colleagues note, ethical guidelines require clinicians to provide care that benefits patients, avoids harm, and enhances self-determination, but treatment rejection by patients seriously ill with AN presents an ethical dilemma because simultaneously upholding these core principles is not possible (*Int J Eat Disord*. 2016; 49:407).

Vigorous debate continues over compulsory treatment of severely ill patients with AN. Numerous studies have sought to clarify or to offer guidelines for admitting such patients or for finding alternative care.

### **Clinical, Medicolegal, and Ethical Challenges**

Admission for treatment poses clinical, medicolegal, and ethical challenges, according to Dr. Terry Carney and colleagues (*Psych Clin N Am*. 2019; 42:299). The authors note that there are few studies involving relatively small numbers of patients, and these studies show that short-term weight restoration does save patients and 'turn them around.' However, the outcome shows that long-term follow-up shows that their outcomes are considerably worse than for patients who voluntarily seek treatment. Patients who are involuntarily admitted for treatment are also much less likely to seek care after being discharged. Thus, involuntary admission may be futile or contraindicated for some persons with severe and enduring AN; these patients have impairments in quality of life that can equal those seen in patients with depression or schizophrenia. The experience of Guardia and colleagues with voluntary admission of 139 patients with eating disorders to Johns Hopkins University’s eating disorders program provides interesting information (*Am J Psychiatry*. 2007; 164:106). Many of these patients felt that they had been coerced into treatment. The patients’ average age was 25 years, 55% had AN, and a perception of coercion was strongest among the 35 patients under 18 years of age than among the other 104 adult patients.

### **A Medicolegal and Human Rights Challenge**

Age is an important consideration for medicolegal considerations, according to Dr. Carney and his co-workers. Involuntary treatment of an adolescent with AN is governed by the same laws that apply to other important decisions; parental consent is required as defined in common law. The laws also differ by location and by definition—for example, in Israel and some parts of Australia, AN does not qualify as a mental illness warranting involuntary mental health admission and treatment. Three forms

of involuntary treatment are authorized by civil commitment laws in 46 states and the District of Columbia. Two forms of involuntary commitment are available in Connecticut, Maryland, Massachusetts and Tennessee, where court-ordered outpatient treatment has not yet been adopted.

One study of 75 admissions to a specialist Australian anorexia program over nearly 5 years, provided some helpful information (*Int J Psychiatry Relat Sci.* 2006; 43:159). Twenty-seven admissions were made under mental health committal by adult guardianship orders; 7 admissions considered for coercion resulted in patients agreeing to informal admissions, following a “strategic” initiation and abandonment of resorting to law. Slightly more than a third (36%) of admissions were for patients younger than 20, and just one-third of admissions occurred as sole events; one-fourth had four or more admissions for treatment. Three-fourths of the patients had comorbidities, and one-third had 2 or more comorbid conditions. About 40% of admissions were for less than 3 weeks (mean: 49 days).

Some patient characteristics suggested that coercion was necessary, such as young age at admission, critically low body mass index (BMI, kg/m<sup>2</sup>), multiple prior admissions, and comorbid conditions. Neither gender nor the type of AN was significant in this study; statistically significant associations were found between use of coercion and the refeeding syndrome, the use of tube feeding and locked wards. Coerced admission was also tied to critically low BMIs. Nearly 28% of patients had a BMI lower than 12 when they were admitted; nearly two-thirds of that sample had a BMI less than 14.

Multiple prior admissions also were a predictor of coercion. According to the authors, coerced patients (80%) are more likely than voluntary patients (57%) to have been admitted before for treatment of AN or related conditions. More than a third of the coerced patients had been admitted 6 or more times previously, compared to 1 in 10 of the voluntarily admitted patients.

The often dire medical status of (BMIs usually 10-12) and the presence of the refeeding syndrome places clinicians under pressure to take action to keep the patient from becoming critically ill and even facing death. Persuading patients that they are gravely ill and medically compromised is one more challenge because while they may not wish to die, many of these patients don’t have the “insight” to understand the very serious threat to their survival. Because of the nature of AN, and due to the possibility of brain atrophy, most patients will resist any attempts at refeeding. Then, clinicians are faced with minimizing feelings of anger or breach of the therapeutic relationship.

So many questions remain and need to be addressed, such as how mental health committal can be made more productive and more acceptable to patients. Other questions include: how long should a patient be committed, and how can treatment be monitored through advocacy protections? Psychiatrists Drs. Athanasios Douzenis and Ioannis Michopoulos, of the University of Athens, Greece, conclude that in some cases, involuntary treatment can save the lives of young patients with AN but in other cases it can break the therapeutic relationship and lead patients to abandon treatment altogether (*Int J Law and Psychiatry.* 2015;39:31). There is no scientific consensus on the correct course of action. Ultimately, the authors note, “It is the clinician who has to decide for whom and when to approve involuntary treatment or not.”

(See also an excellent article, “Involuntary Treatment of Patients with Eating Disorders,” by Watson, Bowers, and Andersen in the March/April 2019 issue of *EDR*.)

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## From Across the Desk

Our Editorial Board members are a group of eating disorders experts who work quietly behind the scenes to help us bring accurate and up-to-date information to *EDR* readers. Our Board members also write lead articles and suggest authors and topics of interest, even as they keep up with their academic lives, research, and busy practices.

This month we reluctantly say farewell to long-time Board member Kathryn J. (“Kassy”) Zerbe. Kassy, who has a private practice in Portland, OR, is Professor of Psychiatry at Oregon Health and Science University. Her practice includes longer-term psychotherapy, psychoanalysis, short-term consultation, and supervision of mental health professionals. Kassy is a Distinguished Life Fellow of the American Psychiatric Association, and has a special interest in eating disorders among adults and older women. Readers will remember her excellent articles on eating disorders in mid-life in past issues of *EDR*. She is also the author of *The Body Betrayed* and *Integrated Treatment of Eating Disorders: Beyond the Body Betrayed*, as well as many book chapters and articles, to name but a few of her activities in the world of eating disorders. Kassy will continue her practice, writing and teaching, but will be concentrating on areas other than eating disorders alone. We will miss her but won’t be far away.

— MS



**Kathryn J. Zerbe, MD**

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## **Update: Legislation Seeks to Improve Treating Eating Disorders among the Military**

U.S. Senators on the Armed Services Committee introduced bipartisan legislation on October 23 designed to expand access to eating disorder treatment for service members, their families, and retirees as well.

The proposed bill, the “Supporting Eating Disorders Recovery Through Vital Expansion Act,” or SERVE, is similar to one introduced last May by combat veterans and House members Brian Mast (R-Florida), and Seth Moulton (D-Massachusetts). SERVE would require military leaders to be trained to recognize the signs of eating disorders in service members and to expand coverage for care.

The legislation would also require Tricare, the military medical insurance plan, to cover inpatient or residential services, partial hospitalization, and intensive outpatient or outpatient services at facilities certified by the military health program that can demonstrate their treatment programs are effective. The bill also seeks to provide services to military family members “without regard to the age of the dependent.”

While eating disorder diagnoses among active duty personnel remain relatively rare, they do carry grave consequences for those who struggle with eating disorders. Between 2013 and 2017, 1,788 active duty service members were diagnosed with an eating disorder--AN, BN, or an unspecified eating disorder , according to the Armed Forces Health Surveillance Branch.

The rate among military women was 11 times the rate among men. At highest risk for developing eating disorders were white women aged 20 to 24 (*Medical Surveillance Monthly Report*, June 2018). Female Marines had the highest rate of diagnosed eating disorders, nearly twice that of the other military services, or 20.4 per 10,000 persons. The Army was second, at 11.9 per 10,000, the Navy third, with 11.4 per 10,000, followed by the Air Force, with 10.4 per 10,000.

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# Can Fracture Risk in AN Be Reduced with Adrenal Hormones?

## *Patient age plays an important role.*

Establishing and maintaining healthy bones is an important topic for everyone, and particularly for teenage girls with anorexia nervosa, where the disorder reduces bone mineral density (BMD) and skeletal strength, and thus drastically increases the risk of future fractures. This risk is striking: a patient with AN has a 7-fold greater incidence of fractures at various sites than does the average healthy teenager. Some of this has to do with delayed closure of the physes (also known as closure of the epiphyses). The growth plate, or physis, is the translucent, cartilaginous disc separating the epiphysis from the metaphysis and diaphysis (bone shaft) and is where longitudinal growth of long bones takes place. The loss of BMD and skeletal strength in these young patients is believed to be irreversible, and no effective therapies have yet been discovered.

Dr. Amy D. DiVasta and colleagues recently tried counteracting loss of BMD in teen patients with AN by using adrenal hormone supplementation. The authors designed a 12-month, randomized, placebo-controlled study of 70 girls 11 to 18 years of age (*J Adolesc Health*. October 2019. 65:462). The authors hypothesized that prescribing two adrenal hormones, dehydroepiandrosterone (DHEA) and estrogen replacement therapy (ERT) might slow or at least interfere with BMD loss among these young patients. The authors followed changes with serial measurements of BMD with dual-energy x-ray absorptiometry (DEXA) scans and peripheral quantitative computed tomography (pQCT).

Seventy female adolescents were enrolled in the study and randomized to hormone therapy or placebo. Those in the treatment arm (n=35) were given oral micronized DHEA (50 mg daily) for the first 3 months, to minimize side effects related to estrogen. Then they received 9 months of DHEA and ERT (20 ug ethinyl estradiol/0.1 mg levonorgestrel). The other group (also n=35) were given a placebo for the 12 months of the study. All participants were assessed at 3, 6, 9, and 12 months, and all were advised to take a daily dose of calcium (1300 mg) and vitamin D (400 IU). If participants were vitamin D deficient at baseline, they received a treatment dose of 2000 IU of vitamin D3 daily for 3 months. All participants also had additional measurements of height weight, and BMI-Z scores were established for each girl.

### **BMD did not improve in younger patients**

For the teens with AN and open physes, the combination of DHEA and ERT supplementation did not improve bone density, geometry, or strength compared with teens in the control group. Attenuation of bone loss and enhancement of bone strength was limited to older teens and young adults.

In this study, the authors recruited only girls who were postmenarcheal or who had a bone age of at least 13 years. Based on their earlier studies, they expected that these girls would have already gone through their growth spurt, would now be in the growth deceleration phase, and would have attained 96% of their final height. Older adolescents and young women in the authors' previous studies had arrested bone loss determined by DEXA scans, and had improved after 18 months of the same ERT regimen.

Nearly half of the participants in this study had at least one open physis shown on magnetic resonance imaging, and, in these girls, the adrenal supplementation regimen was not beneficial. The authors added that if AN occurs before puberty, more profound skeletal effects occur, especially compromised osteoblast activity with lower BMD measurements in both the axial and appendicular skeleton. In contrast, patients with onset of AN during adulthood are more likely to have bone deficits only in the axial skeleton.

The authors concluded that the DHEA and ERT supplements were ineffective for young women with AN and open physes, and that other strategies, such as using transdermal estrogen, should be considered for

these generally younger patients, in addition to standard care, including medical, nutritional, and psychological support.

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## **Mortality in Bulimia Nervosa**

### ***A study highlights risks of heart disease and death with BN.***

Mortality risk is known to be elevated in people with anorexia nervosa. Whether this is also true for those with BN is less clear; some studies have shown increased risks, but other have not, and overall there is less research on mortality in BN. Moreover, if there is increased risk, it is unclear if it represents medical risk or risk of suicide (or both). A recent study from Quebec shows that risk of heart disease and of death is elevated in those with BN.

In this study, Tith et al. (*JAMA Psychiatry*, published online, October 16, 2019) examined 818 women hospitalized for BN. About 415,000 women hospitalized for pregnancy-related reasons were used as the comparison group. All participants were followed for 12 years.

#### **Increased risks identified**

The results showed that there was a 4.25-fold increase in risk for heart disease, and a 4.7-fold increase in risk of dying overall. The authors note one caveat: participants were in the hospital for treatment of BN. Hospitalization for treatment of BN is not common, suggesting that these patients were severely ill.

These are important results that emphasize the magnitude of the risks related to BN. They also tend to question prevailing ideas about the lower severity of BN as opposed to AN. Finally, they seem to pose a strong argument for pushing to identify the presence of BN as early as possible. We know from experience that people with BN often first present in treatment 3 to 5 years after the onset of symptoms, but it seems very unlikely that medical risks are similarly delayed.

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## **The Effects of Long-Term Eating Disorders and Cognitive Impairment**

### ***Perception and nonverbal memory worsened with time.***

Eating disorders commonly lead to numerous social, physical, family, and psychological problems similar to that seen in schizophrenia or mood disorders. Is cognitive dysfunction part of this picture?

Dr. Antoni Grau and a team at the University of Barcelona and the ITA Foundation, Barcelona, Spain, recently found a positive association between cognitive impairment and eating disorder duration. This was particularly marked in cognition, including perception and nonverbal memory (*Neuropsychiatric Disease and Treatment*. 2019. 15:1329).

To test their hypothesis of the effects of long-term eating disorders and cognitive impairment, Dr. Grau and colleagues studied two clinical groups of women recruited at the Eating Disorders Institute of Barcelona, one of Spain's leading treatment programs for eating disorders. The first clinical group included 41 women who had their eating disorders less than 2 years; the second clinical group was made up of 41 women with chronic or long-term eating disorders, defined as disorders lasting longer than 10 years. Two control groups of 33 women each from the community were included, and divided by mean age: (junior group, 21 years of age, and senior group, 31 years of age). All women completed a series of tests, including the *Structured Clinical Interview for DSM-IV Mental Disorders (SCID-1)* and a series of

### **Few differences in the groups were noted--at first**

The clinical groups and their matched control groups were similar in terms of age, years of eating disorder development, and education, except that women in the short-term eating disorders group hadn't progressed beyond secondary studies than was true for the other 3 study groups. The women in the long-term eating disorders group had had eating disorders for a mean of 14.8 years, while those in the short-term eating disorders group had their disorders for a little more than a year. The results also showed that nearly half of the women in both clinical groups had psychiatric comorbidities (54% in the long duration group, 39% in the short-duration group). Cognitive impairment was more common in the women with long-term eating disorders, particularly for perception, cognitive flexibility, and nonverbal memory.

The findings underscore the importance of considering the effect of the duration of an eating disorder on its complications. The authors note that the cognitive inflexibility seen in the group with longer-term eating disorders, marked by a rigid and stereotyped eating style based on idiosyncratic rules, may be less likely to improve with therapy and may worsen prognosis. Future studies of the course of cognitive dysfunction of those with eating disorders might add new knowledge about cognitive impairment and direct us toward interventions. Some promising therapies, such as cognitive remediation therapy, which is used to improve **neurocognitive** abilities such as **attention, working memory, cognitive flexibility** and **planning**, and **executive functioning**, might also reverse some of the cognitive deficits and add more helpful information on the development and maintenance of the eating disorder.

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## **Diabetes and Binge Eating Disorder**

### ***Researchers urge better screening for disordered eating.***

There has long been interest, agreement, and disagreement about the co-occurrence of eating disorders, and diabetes. As noted in an editorial in a special issue of the *Journal of Eating Disorders* in July (*J Eat Disord.* 2019; 7:27), women with type 1 diabetes mellitus (T1DM) have more than twice the risk of developing an eating disorder than do women without T1DM (*Br Med J.* 2000;320:1563). A series of recent reports have sought to clarify the connections between T1DM and type 2 diabetes mellitus (T2DM), and factors that may increase the risk for developing binge-eating.

The reasons for increased risk of eating disorders among women with T1DM are still being investigated. Depression and changes in body mass index, or BMI, may play a role. Some aspects of diabetes management may also increase the risk of eating disorders. For example, management entails a focus on carbohydrate intake and portion sizes, which can parallel rigid thinking about food, weight, and body image often reported by women with eating disorders. These treatment basics can lead to feelings of deprivation, resentment, and shame and to binge-eating. In addition, the challenges of maintaining a relatively low hemoglobin A1c values (which can diminish risk of diabetes mellitus complications) can be discouraging to patients. Such a target may seem unattainable for some patients, and may lead them to give up on self-management of T1DM.

### **Objective binge-eating among adults with T1DM**

Objective binge-eating is common among those with T1DM and may negatively affect glycemic control. A team from Duke University Medical Center examined real-time emotional precursors assessing mood and eating behavior using a telephone-based survey system (*J Eat Disord.* 2019; 7:7). The 83 study participants, most of whom were middle-aged and female (mean: 42 years of age; 87% female) were prompted to rate momentary affect, including their level of diabetes distress. The surveys were done at random intervals; participants were also asked to report on eating episodes. The participants also wore



glucose monitors so the researchers could simultaneously (and continuously) assess glycemic control.

The authors reported that individuals who tended to experience negative affect and diabetes-related distress before eating were at increased risk of objective binge-eating at the next meal. The results also suggested that binge-eating may result in even greater subsequent negative affect, including diabetes distress, and can lead to elevated postprandial blood glucose levels. The authors suggest that interventions focused on helping individuals cope with negative emotions and diabetes distress may be helpful to incorporate into treatment for binge-eating.

### **Binge-eating and glycemic control in T2DM**

A team of Brazilian researchers led by Dr. Marcelo Papelbaum of Federal University of Rio de Janeiro and the State Institute of Diabetes and Endocrinology recently followed 70 consecutive patients (18 to 65 years of age) with T2DM to look for a relationship between glycemic control and binge-eating (*J Eat Disord.* 2019; 7:30). Previous studies have yielded inconsistent results, so more data are of value.

The study sample was mostly female (77%) and married (70%), and the majority had fewer than 9 years of education. The mean BMI was 30.6. Half the patients were obese (34.8); 22 were overweight (27.9) and 13 were of normal weight (mean BMI: 23.6). Overall, the participants had had their diabetes for a mean of 13 years, and had high rates of neuropathy (22%), retinopathy (42%), and nephropathy (52%); more than half were using insulin regularly.

Eating disorders were seen in 20%, and the most common was binge-eating disorder (BED), reported in half of those who had eating disorders. Three had been diagnosed with bulimia nervosa and 4 had an eating disorder not otherwise specified (EDNOS), with subclinical BED. The rate of an eating disorder was definitely linked with BMI: while those with BMIs <25 had a rate of eating disorders of 8%; obese individuals had a 26% prevalence of eating disorders.

In this study, levels of A1c and fasting blood glucose (FBG) were higher in those with an eating disorder. However, after controlling for BMI, the associations lost significance. The authors added that when evaluating glycemic control, levels of A1c and FBG can behave somewhat differently. However, they underscore that these levels measure different aspects of glycemic control. A1c levels represent 2-to 3-month average blood glucose concentrations. Regular FBG measurements, which indicate acute glycemic control, may not match A1c levels, due to such factors as late evening binge-eating, which raise FBG, coupled with daytime food restriction, which can lower A1c levels. Overall, the authors' findings match those of some previous studies that did not find an association between eating psychopathology and general diabetes clinical or treatment features. They concluded that although the objective negative clinical impact of an eating disorder on patients with T2DM is still being studied, "it is possible to speculate that the remission of binge episodes could play a major role in diabetes treatment."

### **The SEARCH for Diabetes in Youth Study**

In this large study of a diverse group of youth and young adults with type 1 or type 2 diabetes who were receiving insulin therapy, Dr. Angel S. Y. Nip and colleagues evaluated glycemic control, insulin sensitivity, and psychosocial functioning (*Diabetes Care.* 2019; 42:859). Disordered eating behaviors were identified in 21.2% of those with T1DM and in 50.3% of participants with T2DM. Most participants had challenges maintaining a healthy weight while controlling their diabetic symptoms. There were some symptoms in common in those with both types of diabetes, plus disordered eating, such as significantly higher BMIs, lower insulin sensitivity, more depressive symptoms, and poorer quality of life than those without disordered eating behaviors. Cases of diabetic ketoacidosis were more frequent in younger patients with T1DM and disordered eating behaviors than in those without disordered eating behaviors. This large and broad study underscores the high frequency of those with diabetes mellitus.

### **Disordered eating in early-onset, long-term diabetes in teens**

In another study, Dr. Christina Baechle and colleagues at the German Center for Diabetes Research, Dusseldorf, Germany, analyzed the prevalence and longitudinal course of disordered eating behavior in adolescents with early-onset, but relatively long-term diabetes (14.9 years duration on average) (*J Adolesc Health*. 2019; Aug 29: epub ahead of print). The authors searched for age-specific disordered eating patterns and for predictors of the current disordered eating pattern using a diabetes-adapted version of the SCOFF questionnaire.

Dr. Baechle and colleagues found an overall disordered eating prevalence of 10.8% (1318 observations), and a pattern of age-specific differences in the prevalence of symptoms. Onset of or persistence of disordered eating behavior was twice as common among female as among male participants.

As with the authors of the other studies, Dr. Baechle and her co-workers noted that their study results underscore the importance of regular screening for disordered eating among adolescents and young adults with diabetes.

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## **An International Study Compares the *ICD-11* and *ICD-10***

### ***Overall, many improvements for eating disorders diagnosis, and a few suggestions as well.***

After more than 25 years, the 11th *International Classification of Diseases and Related Health Problems*, or the *ICD-11*, was updated and released by the World Health Organization, or WHO, last June. It is planned to go into global effect January 1, 2022. The newest revision will change many codes and definitions of disease, and will be particularly better adapted to work with today's digital platforms. The field of eating disorders will be affected, too, for example, with the inclusion of binge eating disorder (BED) and avoidant-restrictive food intake disorder (ARFID).

A working group of clinicians from the Federal University of Sao Paulo, Brazil, and Columbia University, New York City, recently compared guidelines of the proposed *ICD-11* guidelines for several eating disorders with the *ICD-10* (*BMC Medicine*. 2019; 17:93). The vignette-based, case-control study was done over the Internet with a global multilingual and multidisciplinary sample of 2288 mental health professionals registered with WHO's Global Clinical Practice Network. The researchers posed eight research questions concerning the addition of ARFID in the *ICD-11*, clarification of the diagnosis of AN, subjective binge eating, and distinguishing BN from BED regardless of patient weight. Because BED and ARFID are new diagnoses in the *ICD-11*, the authors allowed study participants to state that the diagnosis was atypical or other specified or unspecified, which would not exactly fit the new case descriptions of BED and ARFID but would be the best diagnoses available.

### **Improved diagnostic accuracy was found in the *ICD-11***

Dr. Angélica M. Claudino and her team found improved diagnostic accuracy for all feeding and eating disorders in the *ICD-11*, and the new diagnosis of binge eating disorder improved diagnosis and reduced the use of "atypical," "other unspecified," or "unspecified," which had limited use or informational value, according to the authors.

The participants were very accurate when diagnosing AN using both the *ICD-11* and *ICD-10* guidelines (96.6% and 93.7%, respectively). Clinicians who used the *ICD-11* criteria guidelines were able to successfully differentiate cases of ARFID from cases of AN (89.9% vs 80.4%, respectively) and 88.5% of clinicians were able to differentiate ARFID from no diagnosis. Most clinicians correctly differentiated cases of BN from BED.



As for the clinical utility of the diagnostic guidelines of the *ICD-10* and *ICD-11*, the *ICD-11* was rated more favorably for each diagnosis in terms of how easy to diagnostic categories were to use, how well the guidelines fitted the case vignette, and how clear the guidelines were. At the same time, the study results also underscored several areas in which the initially proposed guidelines need improvement.

### **Suggestions for improvement**

The working group made several suggestions. First, defining AN recovery remains problematic. The authors suggested that the diagnosis of AN be continued until an individual reaches a healthy weight and has stopped behaviors aimed at losing weight without the support of ongoing treatment. (It is worth noting that the best cutoff for duration of recovery needed for such a determination has not been empirically established.)

The definition of recovery in AN was refined in the final guidelines by adding additional qualifiers related to a patient's underweight status. The researchers propose that individuals recovering from AN who have reached a healthy body weight should still be considered to have AN until a full and lasting recovery is achieved. "Full and lasting recovery" included maintaining a healthy weight and stopping behaviors aimed at reducing body weight for at least a year after intensive treatment is discontinued.

As for patients with BN, the study results indicated that further guidance is needed with the inclusion of subjective and objective binge eating when giving a diagnosis of BN. They recommend that in the "Additional Features" sections for both BN and BED, since binge eating episodes may be "objective," or "subjective," the core feature of a binge-eating episode is the experience of loss of control, rather than the size of the binge.

A third finding was that clinicians tend to associate BED with obesity, perhaps partially because most individuals who seek treatment for BED are overweight. The *ICD-11* clinical description of BED states that weight is not a determining factor feature of this disorder. Thus, obesity, although a consequence of BED, should be recorded separately.

Overall, according to the authors, the new *ICD-11* diagnostic guidelines for eating disorders are a significant improvement over those listed in the *ICD-10*. They added that the new categories of BED and ARFID "have the potential to facilitate the organization and delivery of services and to achieve better clinical outcomes over time."

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## **More on the Course of Eating Disorders in Males**

### ***Remission rates were similar in men and women.***

In the last issue we reviewed an observational study of ED in males, and noted that data are still relatively scarce in this area. A recent study expands what we know about the course of EDs in men. Strobel and colleagues describe outcome over 6 to 7 years in men with AN (n=119) or BN (n=60), and matched females (*IJED*. 2019:1-12). Participants entered the study while hospitalized for eating disorder treatment in Germany. Follow-up data were available for 72% of the men with BN and for 76% of those with AN.

The results showed many similarities between males and females. Remission from AN was similarly common (40% vs 41%, respectively). However, *Eating Disorders Inventory* subscale scores were lower at follow-up in males. Remission rates appeared similar in those with BN (males 44%, females 50%), as did other outcomes. The authors suggest there is a need for further research but note that outcomes currently appear similar among male and females.

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# QUESTIONS AND ANSWERS: Warning Signs and Risk of Suicide

**Q.** Is there any useful new research on the risk of suicide among eating disorders patients discharged from inpatient care? One of my patients, a 22-year-old with AN, has expressed suicide ideation more than once. (*J.L., Atlanta*).

**A.** Suicide is a risk following discharge from psychiatric treatment, as seen in a large cohort study of nearly 2.9 million patients discharged from psychiatric hospitals in Sweden (*J Clin Psychiatry*. 2019; 80:2). In that study, the risk was particularly high among males with depression and acute stress reactions as well as posttraumatic stress disorder. However, this study is somewhat typical of the general psychiatric literature in excluding those with eating disorders from the study.

This is especially unfortunate as we know that suicide is the leading and very important cause of death among people with AN, and patients with BN and BED have an increased risk of suicide compared to the general public or those with many other psychiatric illnesses, as seen in the National Comorbidity Survey Replication and in the Adolescent version of that same Survey. More longer-term studies are needed to identify meaningful warning signs, according to psychologist A.R. Smith and colleagues at Miami University, Oxford, OH and Auburn University, Auburn, AL (*Curr Opin Psychol*. 2018; 22:63). Smith and colleagues reported that about a fourth to a third of patients with AN, BN, or BED have thought about suicide, and one-fourth to one-third of those with AN and BN have attempted suicide.

A more recent study of suicide attempts among adults in the US with lifetime *DSM-5* eating disorders identified several distinct risk factors in specific types of eating disorders (*BMC Medicine*. 2019; 17:120). Drs. Tomoko Udo, Sarah Bitley, and Carlos Grilo identified the prevalence and correlates with suicidal attempts among 36,171 respondents in the National Epidemiological Survey on Alcohol and Related Conditions (*Soc Psychiatry Psychiatr Epidemiol*. 2015; 50:1609). They also examined the prevalence and correlation of suicidal attempts in the two main subtypes of AN, restricting AN and binge-purge type AN.

The authors' analysis showed that suicide attempts are common among US adults with lifetime diagnoses of AN, BN, and BED. The rates of previous suicide attempts were: 24.9% for AN, 31.4% for BN, and 22.9% for BED. They reported that the rates for suicidal attempts were substantially higher among those with binge-purge type AN—44.1%—compared to 15.7% for those with restrictive-type AN.

The study results also revealed a number of risk factors for suicide among eating disorders patients. For example, among those who had more than one type of lifetime eating disorder diagnosis, the prevalence and odds of such attempts were 41.5% and 10.63%, respectively. It seems unclear if this relates to a diagnostic conversion phenomenon or merely represents a duration of illness effect. In fact, among those with BN or BED, a history of suicide attempts was significantly linked with longer duration and younger age at onset. A history of ED symptoms interfering with daily normal daily activities, or interfering with fulfilling responsibilities were warning signs, and comorbidities were significantly increased in those who ultimately attempted suicide versus those who did not.

Better approaches for identifying and recognizing risk may help enhance suicide prevention strategies, according to Dr. Udo et al. They also expressed concern about certain groups of adults with diagnosable eating disorders in the general population, such as men and ethnic/racial minorities, who often do not seek treatment. Adding routine screening for eating disorders and a history of suicidal attempts could do much to improve treatment planning and referrals, and thus enhance suicide prevention.

# In the Next Issue

## **Dancing in the Unicorn Sprinkler: Finding the SPARK**

By Sandra Wartski, PsyD, CEDS

Silber Psychological Services, Raleigh, NC

Certain factors seem to be more common for clients who are in the more advanced stages of eating disorder recovery. Getting to this stage of more fully embodying recovery allows clients and therapists to move beyond a focus on symptoms alone. The author describes the progress of a client with decades of disordered eating who one day announced that she had recently “danced in a unicorn sprinkler!” The client became fully absorbed in the work of making very different, meaningful changes in her approach to food, body, movement, and life overall.

## **PLUS**

- **Rapid Early Intervention for Eating Disorders**
- **Food Addiction as an Indicator of Eating Disorders Severity**
- **Basic Body Awareness Therapy to Treat Binge Eating Disorder**
- **A Pilot Study of Internet-based CBT for Bulimia Nervosa and Binge Eating Disorder**
- **A Workbook for Treating Laxative Abuse in Patients with Anorexia Nervosa**

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