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More on COVID-19

As of mid-June, the number of coronavirus cases reported worldwide was 7,997,084, with 435,662 deaths. Better news: to date, more than 4 million persons have recovered.

All aspects of life have been impacted by COVID-19. This includes providing treatment for those who have eating disorders. Current modeling predicts continuing or recurring impacts from this pandemic over the next couple years (for example, see Kissler et al, *Science*. 10.1126/science.abb5793 (2020). For that reason, it makes sense to learn from how the pandemic has impacted some of the regions hit earliest, in order to plan evolving treatment approaches.

Perhaps the earliest report comes from a preliminary paper by Davis and colleagues regarding the experience in Singapore (*J Adolesc Health*. **https://doi.org/10.1016/j.jadolhealth.2020.03.037**). This paper describes the experience of an eating disorder service providing care, both inpatient and outpatient, to those 16 and under.

Adaptations have included "modular" staffing with dedicated inpatient providers, rather than crossing over levels of care; retraining of staff to new roles; and more use of telehealth. High levels of stress for staff members have been noted, including among those not caring directly for people with COVID-19.

Singapore was affected by the pandemic earlier than many parts of the world, so this report provides a useful look forward.

EDs can worsen or relapse during a quarantine

Riccardo Dalle Grave, MD, director of the Department of Eating and Weight Disorders at Villa Garda Hospital in Italy, recently noted that people with eating disorders are at high risk of relapse or the severity of their disorders can worsen because of infection, or the effects of the quarantine, and the shortage of adequate psychological and psychiatric treatments. His home country, Italy, has had a particularly high fatality rate: thus far, 34,405 deaths and 237,500 cases of the coronavirus.

According to Dr. Dalle Grave, patients' fears of infection tend to increase their efforts to not lose control by using dietary restriction or other extreme weight control measures or by turning to binge-eating episodes. Some specific elements of a quarantine, such as separation from others and restriction of movement, can contribute to maintenance of eating disorder psychopathology. For example, the limited possibility of normal walking and exercising can increase a patient's fear of weight gain, which can accentuate dietary restriction. Access to greater-than-normal food supplies can trigger binge-eating episodes.

With some adaptations, online technology can maintain the delivery of outpatient psychological

treatment, says Dr. Dalla Grave. He noted that in coming days the training group of enhanced cognitive behavior therapy (CBT-E) [see article elsewhere in this issue] is scheduled to release specific suggestions for delivering treatment online and for helping patients with eating disorders cope with the anxiety associated with infection fears and the effects of being under quarantine.

Adverse effects on the ED population

In an editorial in the *Journal of Eating Disorders* (2020.8:19), Drs. Stephen Touyz, Hubert Lacey, and Phillipa Hay raised questions about the adverse impact that COVID-19 may have on the eating disorder population. For example, in the short term, should people who are undernourished and who have compromised cardiovascular function be admitted for inpatient care? And, will the number of admissions decrease during the pandemic? Or, because of fears of transmission in the community, would there be a greater sense of safety with admission to an eating disorders program, increasing admissions and placing an increased demand on these facilities? And what about day hospital programs for ED patients during the pandemic? While group programs directed through videoconferencing are efficacious, the effects of adapting these to half-day and full-day programs have yet to be investigated. Online and alternate ways of delivering care, from brief guided CBT to more comprehensive care, are urgently needed, according to the authors.

Dr. Touyz and colleagues also single out people with bulimia nervosa and binge-eating disorder, who are now at home for 24 hours a day, seven days a week, with no escape from food, and only limited ways to leave home to buy food. Bingeing on the household's food when restocking is problematic, can lead to further family conflicts, emotional arousal, depression and anxiety, and even the risk of increased self-harm.

â€œBoth the long-term and short-term consequences of having an eating disorder and COVID-19 simultaneously are still unknown and in time will become more apparent,â€ the authors write. The situation calls for rapid development of a repository of comments, protocols, case histories, pertinent literature reviews, as well as empirical papers on this topic.

Telehealth and insurance coverage

Finally, another issue, raised by Lauren Muhlheim, PsyD, CEDS, is the question of health insurance coverage for telehealth services. Although many states and companies have announced telehealth coverage for behavioral health services, the overall question remains unanswered.

According to the website, *Medicare.gov*, Medicare telehealth covers services including office visits, psychotherapy, consultations, and certain other medical or health services that are provided by an eligible provider using an interactive two-way telecommunications system (like real-time audio and video). Starting in 2020, Medicare Advantage Plans may offer more telehealth benefits than did original Medicare. These benefits can be available in a variety of places, and patients can use them at home instead of going to a health care facility.

Medicare made these changes to telehealth in 2019:

- Medicare telehealth services are available at renal dialysis facilities and at home.
- Patients can get Medicare telehealth services for faster diagnosis, evaluation, or treatment of symptoms of an acute stroke, no matter where they live.
- If a patient is being treated for a substance use disorder or a co-occurring mental health disorder, he or she can get Medicare telehealth services from home.
- Medicare also covers **virtual check-ins** and **E-visits**.

- Scott Crow, MD, Medical Editor

Update: A Medicare Boon for those with EDs

Until very recently, Medicare did not cover programs and services that used remote audio-only telephone contacts. Now the Centers for Medicaid and Medicare have expanded Medicare coverage to ensure that audio-only telephone services are covered during the COVID-19 pandemic. This will help many eating disorders patients who don't have access to videoconferencing or who cannot use the existing technology. The decision was applauded by the Eating Disorders Coalition for Research, Policy & Action (EDC), a Washington, DC-based federal eating disorders advocacy organization. The EDC, in collaboration with 86 other organizations, had sent letters to Alex Azar, currently the Secretary of Health and Human Services, and to Seema Verma, Administrator for Centers for Medicare and Medicaid Services (CMS), advocating for Medicare coverage of audio telehealth services. The videoconferencing requirement was waived through the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Previous regulations restricted access to telehealth services to technologies with videoconferencing capabilities.

From Across the Desk

When An Annual Conference Is Cancelled

COVID-19 has delivered serious challenges to us all. Sometimes such serious medical challenges can lead to improved ways of delivering health care and continuing education, and may cast a new light on old problems that have been overlooked or never improved.

Many kudos go to iaedp, our publisher, and to Managing Director Bonnie Harken and her associates, who overcame a huge challenge when faced with cancelling the 2020 IAEDP Annual Conference in Orlando due to the coronavirus. The conference was cancelled just a few short weeks before it was to take place. A year of extensive planning, scheduling speakers and designing core courses, as well as handling registrations and hotel reservations seemed to be lost. It would have been easy to merely cancel the conference and reschedule it for 2021. Instead, Bonnie and her co-workers and the Executive Board have used modern technology to bring us the conference, speakers, and even the technical exhibits via virtual presentations. By visiting "The 2020 Virtual Symposium," the conference is just a few keystrokes away, and those taking the core courses for credit can do so from the comfort of their homes and computers (for conference registrants, see **https://gateway.on24.com/wcc/gateway/eliteIAEDP/2266259** and for more information, visit the association website, **www.iaedp.com**). This allows members and registrants to take their courses online, to hear and see the speakers, and to attend the conference at their convenience while sheltering in place. Look for highlights from the virtual conference in the July-August issue.

- MKS

Children and Teens Treated for Eating Disorders: How Many Seek Treatment as Adults?

A variety of factors come into play in the decision.

Most children and adolescents treated for eating disorders have clinically significant improvement of their symptoms, and many find no need to seek further care over time. However, as adults, other patients continue to have symptoms such as low weight, binge-eating and purging, and episodes of depression. A team of researchers at Maudsley National Health Service, London, found that when they become adults, a

sizeable proportion of young patients continue to have symptoms but do not seek treatment, despite needing further care. Because of a lack of research into this subject, Dr. Jessica McClelland and co-workers designed a study to follow youths treated at their eating disorders center who were then discharged from their hospital. One goal was to discover the characteristics of youths who did not seek further treatment (*BrPsych Open*. 2020; 6, e37).

The research team used a review of service use records of children and adolescents treated at the Maudsley Centre for Children and Adolescents from 2009-2014. The details of the patientâ€™s treatment included the type of treatment setting, such as outpatient, inpatient, or day treatment, and the duration of treatment. Attendance records were also studied. Body mass index at the first assessment and upon discharge from treatment was also recorded. The participants completed a series of questionnaires, including the *Eating Disorder Examination Questionnaire*, the *Mood and Feelings Questionnaire,* the child-rated version of the *Screen for Child Anxiety Disorders (SCARED),* and the *Obsessive-Compulsive Inventory (OCI)*, among others.

A total of 322 former patients were chosen for the study. About 20% of the young people seen at the Maudsley Centre had undergone inpatient treatment; 7% were referred to adult eating disorder treatment or referred to other treatment centers upon discharge. Slightly more than 68% of the original patients received no further mental health treatment as young adults, according to the authors. Although 13% had brief eating disorders treatment as young adults, 10% had more intensive treatment for their eating disorder.

What factors led former patients to seek treatment during adulthood?

A number of earlier factors prompted former patients to seek treatment as adults. Among these were: older age onset of the disorder, greater duration of the eating disorder and lower BMIs upon presentation for treatment. Young adults who were in the category of "higher users of services" were more likely to have diagnoses of anorexia nervosa, were older when first assessed as teens, and had lower weights at admission and upon discharge, along with higher SCARED (anxiety) scores. Young adults in the "low use" category for adult treatment included those with diagnoses of bulimia nervosa or eating disorders not otherwise specified.

Dr. McClelland and her fellow researchers suggest the results highlight the need for improved transition plans for older teens and for those with more severe eating disorders presenting at child eating disorders programs. In addition, the authors pointed out that identification of certain features exhibited during treatment in childhood and young adulthood, such as increased anxiety, could be better identified and could signal the need for more specialized treatment later.

A Brief Intervention for Early Eating Disorders

Taking action when a young patient didn't meet diagnostic criteria but still was at risk for an eating disorder.

Early intervention into suspected eating disorders can be one key to help identify and treat adolescents before their suspected eating disorders become established.

Evidence shows that "subsyndromal eating disorders," or those that do not currently meet *DSM-5* diagnostic criteria, are nonetheless impairing. The appearance of these disorders might offer an excellent opportunity to take preventive action. (*Early Interv Psychiatry*. 2007; 1:27).

Dr. Wendy Spettigue and colleagues at the University of Ottawa, Canada, recently reported a series of

cases in which 5 family-based therapy (FBT)-inspired sessions ("DREAMS" sessions) were given over 6 weeks (*Front Psychiatry*. 2020; 11:article 105). Earlier, the researchers had commented on the general lack of studies evaluating early eating disorders, and designed a program to address early signs of an eating disorder, such as restricting food, binge-eating, and purging.

Three phases of FBT

FBT for treating adolescent AN is an outpatient therapy with three phases. The first focuses on empowering parents to take control of the teen's nutrition, while siblings add support. The next phase includes gradually giving control over eating and physical activity back to the adolescent. The third phase allows the therapist to make certain that normal family life has resumed and to identify any developmental challenges and to offer coping mechanisms for the adolescent patient.

In this study, each session had a particular focus, such as nutrition and eating disorder symptoms, mood, relationships, and anxiety. The 7 patients and their families were not specially selected but were the first 7 people with moderate ED symptoms; normally they would have been rejected for eating disorder treatment due to less serious symptom levels. Then, they would have been referred back to their family physicians with their non-severe symptoms that had been present when the adolescent was between 13 and 18 years of age. Instead, they were offered the DREAMS intervention, and their charts were retrospectively reviewed.

Significant improvement was shown

Seven of the 8 patients first referred to the DREAMS program completed all 5 therapy sessions; 1 patient was found to have a more severe eating disorder and was referred for treatment (and thus excluded from the case series). The average age was 15, and the study group included 6 females and 1 male. Three of the patients had symptoms of restricting, binge-eating, and purging; 2 had symptoms of restricting and binge-eating, and 1 restricted food intake only. At the first session, when the teens were asked about the main problem that had brought them to treatment, 5 of the 7 reported that an eating disorder was their main problem. They all expressed their desire to recover. Six of the 7 patients were accompanied by their parents during all sessions.

At the end of the program, all 7 patients reported having significant improvements in their eating disorders and now described their eating as "completely normal." Six of the 7 had improvement in mood, and 2 declared that their depression was resolved. While 3 patients described improvements in their anxiety, 4 others noted that the degree of their anxiety had not lessened.

What contributed to the success of the DREAMS sessions?

The families felt that some key factors led to the success of the program. One factor was that the parents provided consistent praise and support, took control of family meals, and made nutrition a mandatory feature of those meals. For example, in one case a teen created videos to show her parents she had eaten when her parents could not be at home during the meals. Another example was use of some coping strategies that had been suggested during the sessions. Some not-so-helpful approaches identified by the teens were their feeling that their parents were â€œlecturingâ€ them instead of supporting them. In other cases parents were seen as overly controlling, insisting on telling the teen what to do.

Some limitations of the study included the small number of participants, the lack of a comparison group, and possible bias. The authors suggested that a larger study, with a randomized control design, might examine the effectiveness of the approach while also studying the effectiveness of the intervention as a training tool for community counselors, who often lack experience in treating adolescent eating disorders.

[Note: This is an interesting and useful report. As awareness of eating disorders grows, the likelihood of health-care providers identifying those with ED symptoms and referring them early likely climbs,

interventions such as this one, if supported by further research, could be a brief and useful approach.]

Perinatal Outcomes among Japanese Women with Eating Disorders

Low weight and smoking had negative effects.

Eating disorders have been increasingly recognized as an issue of relevance in Japan. The advent of the Internet, and effects of westernization, popular media, and cultural changes have brought a surge in eating disorders to a nation where conformity has always been highly prized. Over the past few years, eating disorders have been on the rise in Japan. A government survey in 2002 found that 2% of female high school students in Japan were anorexic. Doctors say that cases of bulimia are even more common (*Japan Times*, 2020).

Dr. Kyoko Kasahara and co-workers from Shiga University of Medical Science now report the results of the first perinatal eating disorders study from Japan. In the first report of its kind, these researchers assessed perinatal outcomes among 13 single pregnancies of 11 women with histories of AN and 240 healthy controls who had singleton births without a history of eating disorders or any other condition that might be related to premature birth or small for gestational age (SGA) infants (*Tohoku J Exp Med*. 2020; 250:191).

Patient profiles in a small study

Dr. Kasahara and colleagues identified 17 pregnancies among 14 women with AN, compiled from 20 years of hospital records. Two women with twin births and one with type 1 diabetes mellitus who delivered two singleton infants were excluded from the study, leaving 13 pregnancies among 11 women in the final study group.

Only 2 of the 13 women had regular menstrual periods and normal weights before becoming pregnant. Nine of the women became pregnant while their BMIs were less than 18. Among the study group, 3 underweight women conceived after fertility treatments and 1 underwent in-vitro fertilization. Seven women had anorexic symptoms before they became pregnant. Nine cases worsened during pregnancy and all but one woman had anorexic symptoms during pregnancy. Five appeared to have binge-purge type AN, and 7 were thought to have restricting type AN.

The effects of anorexia nervosa

The study showed that maternal AN was linked to an increased risk of premature birth and symmetrical growth restriction. Smoking during pregnancy was more common among the study group than among controls and could have had "an additive effect on adverse perinatal outcomes that resulted from a severe eating disorder," according to the authors. Among the nonsmokers, those in the case group showed lower pre-pregnancy BMIs and smaller gestational weight gains, but their infants were not smaller than normal. Among the pregnant smokers, one woman crossed over from AN to BN, and had excessive weight gain. She delivered a large-for-date infant, while other women in the study presented with extremely low body weights and delivered SGA infants.

Perinatal effects among smokers

Seven of the women were smokers, and 3 had stopped smoking once they became pregnant. The 4 women who continued to smoke during pregnancy had anorexic symptoms before pregnancy, deterioration of symptoms during pregnancy, and exhibited purging behaviors. Three had become pregnant while they were underweight and delivered small for gestational age (SGA) infants while they themselves were still underweight. One smoker became pregnant while she was at "normal weight," and

delivered a baby with a birth weight 1.5 SD from the mean. She had gained a sizeable amount of weight during pregnancy, probably due to her binge-eating. The authors concluded that smoking during pregnancy was involved with extremely disturbed eating behaviors, and was not always related to a low BMI and less weight gain.

Many reports have shown that smoking itself has detrimental effects on fetal growth (*PLoS One*. 2017; 12, e0170946; *Pediatr Perinat Epidemiol*. 2017; 31:144). The authors noted that smoking during pregnancy may be a marker of co-occurring abnormal eating behavior, and that both factors could adversely affect perinatal outcomes. While it is easy to advise mothers to stop smoking, interventions to stop smoking without considering problems involving eating behaviors can easily fail, say the authors. Instead, they suggest that successful psychiatric treatment and eliminating anorexic symptoms before pregnancy could improve perinatal outcomes and decrease the risk of poor health in infants. In addition, they write that women with a history of AN, particularly when the mother-to-be is underweight, should be advised to avoid fertility treatments until she has recovered from her ED.

Enhanced Cognitive Behavior Therapy

A highly individualized approach that was first introduced in the 1970s.

Enhanced cognitive behavior therapy (CBT-E) is a transdiagnostic treatment that is a revision of the original approach. CBT-E [MJD1] was first used in the 1970s to treat adults with bulimia within an outpatient setting.

CBT-E is not generally intended to be used in combination with other psychological treatments and is designed for delivery by one therapist. The primary goals of the CBT-E therapist are to keep the patient engaged and to maintain an effective therapeutic relationship. Therefore, a strong therapeutic alliance, collaboration, and active patient participation, and understanding the relationship between a patient's eating-disordered emotions and behaviors are essential to a good treatment outcome.

What is maintaining the eating disorder?

A major component of CBT-E is identifying the processes that maintain the eating disorder. For example, the vast majority of patients with an eating disorder tend to be extremely apprehensive about their weight and body image, and concerned about "being in control." For these people, negative self-judgments and critical self-evaluations become routine when striving for a "perfect" and "never-good-enough" body ideal. If these negative body image schemas are repeated frequently, they can become automatic, maintaining the eating disorder, and lead to greater eating disorder symptoms and behaviors.

With people who are not significantly underweight, CBT-E generally involves an initial assessment appointment, followed by twenty 50-minute treatment sessions held over 20 weeks. With people who are underweight, treatment needs to be longer, often involving about 40 sessions over 40 weeks.

CBT-E is a highly individualized four-stage treatment approach designed to fit the person's difficulties and to be modified in light of his or her progress (*Table 1*). In Stage One, the focus is on gaining a mutual understanding of the person's eating problem and helping him or her modify and stabilize their pattern of eating. There is also emphasis on personalized education and addressing concerns about weight. Generally, the initial sessions are conducted twice weekly.

In the brief second stage, progress is systematically reviewed and plans are made for the main body of treatment in Stage Three. Stage Three consists of weekly sessions focused on the processes that are maintaining the person's eating problem. Usually this involves addressing concerns about shape and

eating, enhancing the ability to deal with day-to-day events and moods, and addressing extreme dietary restraint.

Toward the end of Stage Three and into Stage Four, the emphasis shifts onto the future. There is a focus on dealing with setbacks and maintaining the changes that have been obtained.

Generally, a review session is held some months after treatment has ended. This provides an opportunity for a review of progress and the addressing of any problems that remain or have emerged.

CBT-E is suitable for a full range of eating disorders, and is based on a transdiagnostic theory of mechanisms that persist in eating disorders. According to this theory, a dysfunctional evaluation of self-worth, based on shape and weight, is central to all eating disorders, and as a result the focused version of CBT-E involves interventions to modify a patientâ€™s overvaluation of shape and weight. The approach of this treatment can be adjusted when additional mechanisms are obstructing change, such as low self-esteem, clinical perfectionism, and interpersonal problems (the â€œbroadâ€ version of CBT-E).

CBT-E vs. treatment as usual: a trial

Martie de Jong and co-workers in the Netherlands assessed whether the focused version of CBT-E for patients with an eating disorder and with BMIs greater than 17.5 was a more effective approach than treatment as usual (TAU) (*Int J Eat Disord*. 2020. 53:447). The authors designed a multi-center, controlled trial to test whether CBT-E could be used to provide less intensive and shorter treatment than TAU. The 143 adult participants were recruited at three specialized treatment departments. They were at least 18 years of age with a BMI >17.5 and <40 (to avoid possible medical complications).

Results

After the first 6 weeks of treatment, CBT-E was more effective for improving ED symptoms than TAU. After 80 weeks, there were no significant differences between the two groups in decrease in ED psychopathology or in symptoms of anxiety or depression, but CBT-E led to greater improvement in self-esteem. In addition, the recovery rate at 20 weeks (using a composite measure of recovery) was significantly better (57.7%) among those treated with the CBT-E approach than among those receiving TAU (36%). Last, the amount of treatment time was shorter for CBT-E than TAU.

The authors note that these results support the broader adoption of approaches such as CBT-E.

Table 1. A Model of CBT-E Treatment

Stage One: Starting well. Treatment planning and building a therapeutic alliance.

Stage Two: Patient evaluation, treatment evaluation, and progress.

Stage Three: Ongoing assessments of body image concerns, disordered eating patterns and behaviors, meal planning, regulating emotions and events.

Stage 4: Ending well. Planning and preventing relapses, continuation of care.

Abrupt Lisdexamfetamine Withdrawal in Adults with BED

The typical amphetamine withdrawal pattern was not

seen across 3 studies.

Binge-eating disorder (BED), now the most common eating disorder in the US, was officially recognized in 2013 by the *DSM-5*. Patients with BED eat a larger-than-normal amount of food at least once a week for at least 3 months, followed by a distressing sense of loss of control.

Lisdexamfetamine dimesylate (Vyvanase®), taken as a capsule once a day, is the first FDA-approved medication for treating moderate-to-severe BED in adults. Because it is a stimulant, lisdexamfetamine can be habit-forming and may be abused. Common side effects of amphetamine treatment include dry mouth and insomnia, but more serious side effects can occur. Some of the side effects reported by BED patients include: decreased appetite, increased heart rate, and constipation, and feeling jittery or anxious. The typical starting dosage recommended for adults is 30 mg once a day; the dosage is then increased to 50 mg to 70 mg once daily.

What happens with abrupt withdrawal?

Amphetamine use actually causes an initial spike in epinephrine and norepinephrine, followed by a lowered production of these naturally occurring hormones over time. As a result, the body develops a physical dependence on amphetamines to cause this spike in the development of naturally occurring hormones to make the individual feel good or to feel pleasure.

Physically, the body will go through a range of withdrawal symptoms when an amphetamine is abruptly stopped, including a boost in hunger and extreme fatigue. Most people who use amphetamines tend to binge on the drugs, feeling extensive highs followed by a â€œcrash and burnâ€ cycle that includes extreme fatigue and long periods of sleep. Psychologically, the individual becomes short-tempered, has drug cravings, anxiety, suicidal ideation, hallucinations, and other symptoms. Would those being treated with lisdexamfetamine, followed by sudden cessation of the drug, fit this pattern? A research team designed a large-scale study to find out.

Dr. Brigitte Robertson headed a multi-country study of the effects of abrupt withdrawal of lisdexamfetamine among men and women 18 to 55 years of age with BED (*Prim Care Companion CNS Disord.* 2020; 22:19m02540).

Three separate studies enrolled the adults with BED diagnoses in two 12-week randomized, double-blind, placebo-controlled studies from November 2012 to September 2013. Participants were either treated with placebo or dose-optimized lisdexamfetamine, at 50- or 70-mg doses for 26 weeks. Those treated with lisdexamfetamine were first categorized as responders after 12 weeks of open-label treatment.

The two short-term efficacy studies were randomized, double-blind, placebo-controlled parallel-group, 12-week studies. Each short-term efficacy study was identically designed and included a 2-week screening phase, a 12-week double-blind phase (dose optimization, 4 weeks); a 12-week double-blind phase (dose optimization for 4 weeks, dose maintenance 8 weeks), and a follow-up of at least 1 week. The third study, a maintenance of efficacy study, was a 38-week, double-blind, placebo controlled randomized withdrawal study conducted from January 2014 to April 2015. This trial included a 12-week open label phase, a 26-week double-blind, randomized withdrawal phase and a 1-week follow-up phase.

In the short-term efficacy studies, the pooled safety analysis set and pooled completer set included 372 participants who received a placebo and 373 who were given lisdexamfetamine. In the maintenance of efficacy study, the randomized safety analysis set and randomized withdrawal phase completer set, included 134 placebo participants and 136 lisdexamfetamine participants.

Results: Not a typical withdrawal pattern

Typically, amphetamine withdrawal is associated with a variety of physical symptoms, including

headache, constipation or diarrhea, irregular heartbeat, red and itchy eyes, muscle or joint pain, and a number of emotional and functional side effects, including increased appetite, and decreased motivation.

In Dr. Robertson and colleagues' studies, however, mean and median *Amphetamine Cessation Symptom Assessment (ACSA)* scores did not approach the maximum allowed by the scale and were similar in the placebo group and in the study groups over the entire study period. This included measurements made at baseline, on the day of the last dose, and over the 7 days after the last study drug dose.

According to the authors, their results suggest that abruptly stopping lisdexamfetamine after as long as 38 weeks of treatment was not linked to clinically relevant amphetamine withdrawal symptoms during a 1-week post-treatment assessment period. This is reassuring to prescribers. It is important, though, to note that general prescribing practice with any psychotropic (including, one assumes, stimulants), would involve gradually tapering cessation, if the clinical situation allows.

Disordered Eating Related to Military Deployment

When a parent is deployed for military service, stress can lead to obesity and disordered eating in teens.

Currently, more than 1.3 million American men and women serve in the military, and 1.1 million others are members of the National Guard and Reserve. Military deployment can be highly stressful for all family members, especially those who remain at home, due to uncertainty and worries about the deployed parent's safety, coupled with increased responsibilities and shifting roles at home.

The stress on family members when a parent is deployed for military action has also been linked to increased risk of developing disordered eating patterns, according to the results of a recent study by Dr. M.K. Higgins Neyland and colleagues at the Uniformed Services University of the Health Sciences and the National Institutes of Health, both in Bethesda, MD, and investigators from several other agencies (*Int J Eat Disord.* 2020; 53:201).

Noting that adolescent military dependents may be at high risk for developing eating disorders and obesity, the authors evaluated 126 teens before the teens entered either of two obesity and binge-eating prevention trials. The participants were 12 to 18 years of age (mean age: 14 years); 59.9% were girls, 44.4% were non-Hispanic Whites, and the mean BMI-z score was 1.91±.39. The authors used the *Eating Disorder Examination* to assess disordered eating among the teenagers. Study participants' parent/guardian/caretaker provided a deployment history that covered the participant's lifetime, and the total number of deployments was calculated by adding the total number of deployments across all caregivers.

Parental distress was measured with a 12-item distress subscale of the *Parenting Stress Index, Short Form* (Abidin, 1990). This survey uses a scale of 1 to 5 to measure perceived level of distress in their role as caregiver. Higher scores indicate higher perceived stress, and scores can range from 12 to 60 points.

Effect of the number of deployments

Eighty-seven (69%) of the 126 teens had parents who were deployed during their lifetime; these families had experienced an average of 3 deployments. Female participants were more likely than male participants to have had a parent deployed at least once. There were no other significant differences between the teens for age, race/ethnicity, BMI-z, or loss-of-control eating episodes during the past 3 months, or anxiety symptoms, parental distress, or *EDE* variables. Twenty-one participated in a pilot study, and 105 were included in the effectiveness trial. Two participants met the criteria for binge-eating disorder.

The key finding was the connection between the number of deployments and high parental distress. For parents with low or moderate levels of distress, there was a negative relationship between the number of deployments and weight and shape concerns. In contrast, for those with high parental distress, the number of deployments was associated with higher shape and weight concerns among adolescent dependents. For those with high levels of parental distress, there was a positive association between the number of deployments and global disordered eating.

The authors singled out one mechanism that might explain the relationships between deployment exposure, parental distress, and disordered eating among youths: a teen's ability to cope with parental distress. In one study not related to military deployment, Martyn-Nemeth et al. (2009) found that 25% of adolescents endorsed using food to cope with problems with their parents. Thus, according to the authors, a combination of deployment frequency and parental distress may exacerbate disordered eating among youths presenting for treatment at disordered eating and adult obesity prevention programs.

Restrictive Eating Among Obese and Overweight Teens

Disordered eating can be easily overlooked in this group.

"Some patients with [undiagnosed] restrictive eating disorders are hiding in plain sight," write Ellen S. Rome, MD, MPH, and Radhika Rastogi (*Cleveland Clinic Journal of Medicine*. 202087:165). The authors stress that patients who are overweight or obese are just as likely to have a pattern of disordered eating as their normal-weight peers, but restrictive eating disorders tend to be overlooked in overweight or obese patients.

Adolescents who have been overweight are less likely to have had inpatient treatment, even if their symptoms are similar to those of teens with anorexia nervosa, for example. Moreover, the duration of illness before the adolescent seeks help may be significantly longer among patients with higher premorbid BMIs.

Malnutrition affects every system

The malnutrition that results from restrictive eating disorders affects every body system and can occur even if the patient is obese or overweight. An individual who uses restrictive eating can have cardiovascular, gastrointestinal, hematologic, musculoskeletal, hormonal, and menopausal, and for boys, testosterone-related disorders, as a result of restrictive eating.

Previously obese patients with restrictive eating have a different course of recovery of menses than their healthy-weight peers, according to the few studies that have examined restrictive eating among obese and overweight teens. As one study showed, amenorrheic patients with a history of obesity or overweight resumed menses at a higher weight but with similar amounts of absolute weight restoration as other patients. The likelihood of menses returning decreases with greater weight suppression and increases with greater weight gain in both groups. This suggests that weight goals associated with resumption of menses may need to be higher for patients with previously higher weights.

Some helpful steps to take

Despite the high risk among this population, only one study has compared outcomes between adolescents and young adults with eating disorders by premorbid weight status. Few studies have outlined the treatment goals and course of recovery for these patients, according to Drs. Rome and Rastogi. They suggest several steps to take for patients with restrictive eating who are overweight or obese.

1. Encourage healthy forms of weight loss, but establish minimum requirements for protein, fat,

carbohydrates, calcium and vitamin D. Obese or overweight patients who are embarking on a ketogenic diet or a "clean-eating diet" should consult both a primary care physician and a registered dietitian experienced in treating patients with eating disorders. This will help avoid electrolyte imbalances and medical complications [and potentially help avoid the development of disordered eating as another complication].

2. Monitor for signs of caloric energy restriction. Some telltale signs include bradycardia, orthostatic hypotension, and amenorrhea.
3. Watch for unhealthy weight loss strategies in overweight and *underweight* patients as well. According to the authors, it is just as important to watch for the patient whose weight changes from 220 to 180 lb. as the one whose weight changes from 120 to 80 lb.

QUESTIONS AND ANSWERS:

A Patient Who Takes Extreme Risks

Q. I hope you can help. One of our patients, in her mid-20s, seems to be on a path of eve-riskier behaviors, from restrictive eating to anorexia nervosa, depression, anxiety, self-injury, and now to suicidal thoughts. Do you have any suggestions about how we can intercept and/ or stop this dangerous trend? (*J.R., Greensboro, NC*)

A. Your concern is well placed. Patients with eating disorders face significant medical complications, some of which are irreversible and potentially life-endangering (*J Adolesc Health*. 2003; 33:418). It is well known that AN is associated with the highest mortality rate among all mental disorders (*Arch Gen Psychiatry*. 2011, 68: 724). Perhaps the most dangerous symptom, of course, is attempted suicide. A recent article by Daniel Stein and colleagues (*Front Psychiatry.* 2020, 11:89) specifically investigates extreme risk-taking among 4 very different female patients. One was an adolescent with type 1 diabetes, one was in her mid-20s, one in her late 30s, and one was a 23-yr-old pregnant patient with AN.

The authors note that many factors are involved with the increased suicide risk in patients with AN, including disturbances in body image and body dissatisfaction. Another self-destructive behavior is non-suicidal self-injury, which is associated with an increased risk of suicide, according to the authors. As many as two-thirds of persons with eating disorders may engage in non-suicidal self-injury.

The 4 patients had very different presentations, but they had several things in common. First, they all were diagnosed with AN with binge-purge pathology. Next, 3 of the 4 women showed evidence of more than one purging behavior, including self-induced vomiting and laxative abuse, which suggested considerable impulsivity connected to the purging. Third, several behaviors had signs of non-ED-related impulsive behaviors. Most of the women had other comorbidities and multiple vulnerabilities.

The authors suggest that the most important finding that the women had in common was that multiple co-occurring non-ED motivations and faulty emotional handling might have been at the core of the extreme endangering behaviors the women exhibited. In all cases, the women seemed to be indifferent to the potential harm that their extreme risk-taking behavior caused. Such indifference might be related to the patients' deficient emotional, mentalization and theory of mind capacities, as well as their lack of attraction to life; they had no immediate or long-term goals.

What treatment approach makes sense? A logical fit would be dialectic behavior therapy (DBT). Developed by Marcia Linchan for patients with borderline personality disorder, it is highly useful for treatment of multiple co-occurring problems, as in the case described here. And, there is evidence that DBT is beneficial for ED symptoms.

In the Next Issue

Highlights from the IADEP Virtual National Meeting

Shortly before the annual IAEDP meeting was to open in Orlando, FL, COVID-19 intervened, and the meeting had to be cancelled However, rather than rescheduling the 2020 meeting to 2021, the Board of Directors and Managing Director Bonnie Harken and her staff speedily organized a "virtual" national meeting, including speakers and even exhibitors, online. Look for highlights from the virtual meeting, for-credit courses, and new treatment approaches in the July-August issue.

PLUS

- How Do Fitness Centers Respond to Clients with Suspected Eating Disorders?
- Canada Overhauls Practice Guidelines for Treating Children and Teens with Eating Disorders
- Maternal Factors and Weight Loss Attempts among Teens in Soweto, South Africa
- A Pilot Study of Dulaglutide and Type 2 Diabetics with BED
- And much more...

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