
Eating Disorders Review
November/December 2021
Volume 32, Issue 6
Scott Crow, MD, Editor-in-Chief

Parents Caring for Adult Patients with AN and BN Speak Out

'Wearing too many hats' is one of the most common problems among an oft-overlooked group.

Parents caring for their adult children with eating disorders carry a heavy burden and are under severe psychological stress, according to a recent report from Norway. In fact, such families share a number of the same concerns and needs as families caring for schizophrenic patients, according to a small study by Jannike Karlstad and colleagues at Nord University, Bodø, Norway (*BMC Psychiatry*. 2021. 21:338)

The authors studied parents' experiences with caring for an adult daughter with AN or BN. The parents reported confusion and insecurity in their parenting role when their child reached adulthood, when the focus of care changed from family-oriented care with frequent medical follow-ups to an individual focus with fewer or no healthcare follow-up visits.

The participants were mothers and fathers of women over 18 years of age with AN or BN. In most cases, the diagnosis had been made in the patients' teens or early 20s. Most parents had been caregivers for at least 10 years, and had experienced periods when the illness improved, then worsened. The authors used semi-structured interviews that explored coping strategies and the parents' experiences with healthcare services. The authors also included some findings from their earlier study of 11 parents who were interviewed and reported feeling isolated, as everything in their lives revolved around adjusting to their daughters' eating disorder (*Sykepleien Forskning*. 2020.15:81474). Common themes from the parents included "not being taken seriously by the health services" and "receiving help based on luck." Most interviews were done in person, then by telephone, due to COVID restrictions. The greatest concern expressed by the caregivers was their perception of the lack of adequate help from healthcare professionals. Some had received no help, and others reported that the care they received was inadequate.

Many parents had to fill multiple roles to make up for the lack of help from healthcare providers; they had to monitor weight loss, to make certain their daughter was taking her medications, and to follow their daughter's daily progress. Continuing to stay strong, and struggling with understanding from family and friends were major concerns, as were helping with food and meals and reducing their social contact with family and friends, as needed. The parents noted they played the roles of dietitian and guard as they followed their daughters' needs.

The parents managed to fill the multiple roles during the first phase of their daughter's illness and felt optimistic about the prospects of recovery during the early stages of illness. Most reported gaining psychological strength as they anticipated recovery. However, as the years passed and the daughters were not fully recovered, parents reported wearing the hats of 'survivor' and 'overcomer' as they

assumed the roles of mother, nurse, doctor, and psychologist. The fathers were more preoccupied with practical matters, while the mothers were more emotionally involved in the process of caregiving.

Effects on family life

The long-term nature of their daughters' illnesses had a profound effect on the families' lives. In time, the early optimism that parents originally felt faded, and some parents accepted that some AN and BN patients do not fully recover. Openness with one another helped family members stay strong; others found that being open about their daughter's illness at work was also a relief. Setting boundaries, particularly around social contacts, also helped some families. At the same time, parents had to combine care for their daughters with other family responsibilities, such as caring for other children and family members, and maintaining their jobs, friendships, and social life. The time required to care for the daughter with an eating disorder also took care and attention away from siblings, and parents reported feeling insecure about some of their regular day-to-day tasks. For example, they lacked the expertise of healthcare professionals and missed receiving confirmation whether their actions were correct. Normal life, including travel, was nearly impossible.

Those who were able to set boundaries in terms of how much their daughter's eating disorder affected their lives. Others set boundaries around their social lives and continued to expend all their energy upon their daughters. In one study, parents were living with their daughters, which added more tension and a greater need to establish emotional separation. Since the authors' second study involved adult patients, most parents were not living with their daughters, which made the need to establish distance between themselves and their daughters less urgent.

In one earlier study, parents caring for their adult daughters with AN experienced caregiving as a cycle. They struggled to understand AN and assumed a caring role; however, this often led to direct interventions and conflicts, and ultimately exhaustion for the parents. Ironically, when they took a less confrontational approach, more anorexic behavior followed (*Clin Psychol Psychother.* 2017. 24:103).

Needed: more help from healthcare professionals

One step to helping parents, according to the authors, would be to have more input and help from healthcare professionals. Individuals caring for adult patients with eating disorders need as much information as possible, as confidentiality allows, and most need professional support for themselves. Support groups and regular group discussions may help. The Norwegian researchers also concluded that openness within the family is "an important coping factor."

Update: Brain Signals Differ in Certain Mental Health Disorders

Symptoms of anorexia are affected by differences in the mid-insula.

Many people with mental health disorders experience physical symptoms differently, whether this is feeling uncomfortably full in AN or having a strong sense of lack of oxygen during a panic attack. These symptoms are associated with differences in function within the dorsal mid-insula of the brain, according to a research team at the University of Cambridge, England (*Am J Psychiatry.* 2021.178:761). Identifying these differences in the brain may be important for future treatment designs for persons with eating disorders.

Introception and internal conditions

Exteroception, or the senses of sight, smell, hearing, taste and touch, is readily apparent. In contrast,

interoception, sometimes called “the hidden sense,” is the body’s ability to sense internal conditions, and is not outwardly apparent. For example, in interoception, the brain models events occurring inside the body, such as a gurgling stomach, tightness in the chest, and even the beating of the heart. It also models other sensations from movements that we cannot feel.

A team led by Dr. Camilla L. Nord has found differences in activity in the dorsal mid-insula of the brain in a range of disorders, including depression, schizophrenia, eating disorders, and anxiety disorders.

Dr. Nord and her colleagues recently reported that individuals with disorders such as depression and eating disorders showed different brain activity from healthy individuals during interoception. Her group conducted a meta-analysis of neuroimaging studies comparing patients with psychiatric disorders with healthy control subjects, in an attempt to identify which brain regions showed convergent disrupted activation during interoception. Data from 33 studies were extracted for analysis for this analysis; the study included 610 controls and 626 patients with schizophrenia, bipolar or unipolar depression, substance use disorders, anxiety, eating disorders, and other conditions. Alterations in left dorsal mid-insular activation were seen. Interestingly, the authors note that the dorsal mid-insula does not overlap with other regions of the brain that are altered by antidepressants or brain regions change by psychological therapy.

Thus, this area might be a new target for future therapy. The researchers are planning studies to determine whether the disrupted activation in this area could be altered by new treatments, such as brain stimulation.

These are relevant findings for the ED field. People with AN often seem to have vastly different internal experiences; these results seem to identify a neural underpinning for this phenomenon.

From Across the Desk: Unsung Heroes

These are challenging times for clinicians, patients, and those who support ED patients. A few highlights of this issue include the challenges of caring for adult ED patients, the effects of the COVID pandemic, and choosing current refeeding guidelines or higher-calorie refeeding.

They are the unsung heroes of the battle against eating disorders, supporting ED patients in every way, every day, for years. The heroes include parents, especially parents of adult ED patients. In this issue, Norwegian researchers Jannike Karlstad and colleagues at Nord University found that parents of adult ED patients often had to fill multiple roles to make up for the lack of help from healthcare providers. The most successful parents remained open about their daughter’s or son’s illness, and also set boundaries around their social lives. All wished for more help from healthcare professionals.

And, even as we learn of another strain of the COVID virus, the omicron variant, an article by Otto and colleagues advises that those who care for adolescents with EDs in inpatient settings be prepared to handle the challenges of the pandemic. Admissions for EDs doubled during the last year at their institution, the University of Michigan. In spite of telehealth advantages, vital signs and lab studies and evaluation of signs of medical complications that may call for hospital admission “are essential in the primary care setting,” the authors write. This is essential because as the authors note, demand for treatment, challenged by lack of healthcare providers and facilities, may only increase as the pandemic continues.

Finally, Dr. Neville H. Golden and his colleagues have been proponents of higher-calorie refeeding (HCR) for AN inpatients for some time. Their earlier studies showed that HCR led to faster weight gain and a shortened inpatient stay without the risk of electrolyte disturbances usually seen with the refeeding

syndrome. When they tested their theory in a controlled study, there were no differences in clinical remissions, hospitalizations, number of medical readmissions, and number of days medically hospitalized one year after discharge. However, the authors defended use of higher calorie refeeding by pointing to the benefits of earlier release due to HCL, including faster weight gain and earlier release, with lower costs for care.

And on to 2022!

—MKS

Testing Higher-Calorie Refeeding for AN Inpatients

A recent study challenges the traditional start-low, go-slow approach to refeeding.

Early weight gain is an early predictor of outcome and is one goal of treatment in anorexia nervosa. By tradition, nutritional rehabilitation has been conservative, mainly to avoid the refeeding syndrome, with its electrolyte disturbances and negative effects on many organ systems. Thus, the standard approach for refeeding has been a conservative start-low, go-slow approach, associated with slow and gradual weight gain during longer hospitalization.

Proponents of higher-calorie refeeding

Drs. Neville H. Golden and colleagues have been proponents of higher-calorie refeeding (HCR) for AN inpatients for some time. Their earlier studies showed that HCR led to faster weight gain and a shortened inpatient stay without the risk of electrolyte disturbances usually seen with the refeeding syndrome. The authors cite The Study of Refeeding to Optimize Inpatient Gains (StRONG), the largest randomized controlled study thus far to compare low-calorie refeeding (LCR) and HCR approaches (*JAMA Pediatr.* 2021. 175:19). The study results reinforced the idea of HCR, but did not examine whether the early positive results were sustained over time.

Now, in a more recent randomized controlled study, Dr. Golden and colleagues reported that after one year there were no differences between HCR and LCR approaches among 120 AN patients (*Pediatrics.* 2021. 147 (4): e2020037135). There were no differences in clinical remissions, hospitalizations, number of medical readmissions, and number of days medically hospitalized one year after discharge. However, the benefits of earlier release from inpatient care pointed to several advantages of HCR, particularly faster weight gain and earlier release, with lower costs for care.

Comparing Weight Gain in Adults with ARFID Restrictive Food Intake with Those with Restrictive AN

A pilot study doesn't deliver the expected results.

Patients with Avoidant Restrictive Food Intake Disorder (ARFID) have a number of symptoms that differ from those usually seen in people with AN. For example, ARFID patients show an outward lack of interest in food or eating. They are concerned about the possibly negative effects of eating, or avoid food based on its characteristics, such as smell or taste. As a result, they lose weight and have significant nutritional deficiencies. Unlike those with AN, their eating behavior is not motivated by preoccupation with body weight or shape.

Because of the resulting low body weight and restrictive food intake, ARFID may easily be mistaken for

AN. Treatment for ARFID, similar to that for AN, includes weight restoration. However, it is unclear if that process is the same or different, depending on the diagnosis.

Danish researchers led by Dr. Magnus Fjellstad at the Psychiatric Center Ballerup, in Ballerup, Denmark, designed a pilot study to compare weight gain between people with ARFID and those with the restrictive form of AN (AN-R). The group recently reported their results as pilot findings from a longitudinal study (*Nutrients*. 2021. 13:871).

Between January 2016 and December 2020, the authors studied 7 adults with ARFID and analyzed data from 80 adult patients with AN-R who were participating in the Prospective Longitudinal All-comer Inclusion Study in Eating Disorders, or PROLED (clinicaltrials.gov). (The PROLED study is a clinically naturalistic 10-year annual follow-up of patients with eating disorders.) Participants in the PROLED study are all adults 18 to 65 years of age who were admitted to the eating disorders unit at the authors' hospital in Ballerup. In their pilot study, the research team hypothesized that weight gain would be slower among the ARFID patients than among the AN-R patients.

The diagnoses of ARFID and AN-R were made according to *ICD* criteria. All participants were enrolled in a weight restoration program, either as inpatients or as participants in intensive daycare treatment. Meals were provided 3 times a day to daycare participants and 5 times a day to inpatients; individual food intake was monitored by trained nurses. The dietitian-designed meals were planned individually to lead to approximately 1 kg weight gain per week up to ideal body weight—defined as a body mass index (BMI, kg/m^2) of 20 for women and 21 for men. Although there was no formal psychotherapy as a part of the study, all participants were offered individual meetings with psychologists and nurse.

After a complete diagnostic workup, including a comprehensive diagnostic interview by a psychologist, all participants had psychiatric examinations with either a specialist psychiatrist or a general practitioner with special training in eating disorders. Patients also were assessed with a series of questionnaires, including the *Eating Disorder Questionnaire*, the *Major Depressive Inventory*, the *Autism Quotient*, and the *Hopkins Symptoms Check List 92*. Participants also completed the *Readiness Ruler*, an 18-item self-questionnaire that reflects readiness to change, including eating restriction, weight, shape overvaluation, and binge eating, vomiting, laxative use, fasting, diuretic use, weight gain phobia and exercise. Two sections also measured readiness and motivation to change.

Unexpected results

Aside from anxiety, no baseline characteristics differed between the two groups. During the first 6 weeks of weight restoration, there were no differences between those with ARFID and those with AN-R. This result broadly echoed what previous studies of AN had shown, and the authors' hypothesis was not corroborated. Instead, patients with ARFID gained weight from the restorative treatment program designed for patients with AN-R.

Baseline anxiety was higher in patients with AN-R than in those with ARFID, but no other differences were reported. The authors concluded that this argues against the need for separate programs. One caution in interpreting these findings is that the group with ARFID was very small (7 participants), and thus these results should be confirmed in other studies.

Another Treatment Option for BED Patients

A pilot study helped patients deal with the negative

emotions underlying BED.

While cognitive behavioral therapy has been the treatment of choice for patients with binge eating disorder (BED), additional treatment choices are needed. One promising approach uses emotion-focused therapy (EFT), recently described in a pilot randomized wait-list control trial (*J Eat Disord.* 2021. 9:2).

As Dr. Kevin Glisenti and researchers at Queensland University of Technology, Brisbane, Queensland, Australia, explain, EFT addresses negative emotions that have been extensively linked to binge-eating episodes in BED. The researchers designed a study to test the feasibility of using EFT to treat patients with BED.

EFT: focusing on negative emotions

Thus far, only one prior study has examined using EFT specifically to treat BED (*Clin Psychol Psychother.* 2016. 11:24). EFT approaches are based on the premise that human emotions are connected to human needs. Therefore, emotions have an innately adaptive potential that, if activated and worked through, can help people change problematic emotional states and interpersonal relationships. The goal of EFT is to help clients identify and accept their primary emotions (their first emotional response to a stimulus), as opposed to secondary emotions (a response that obscures the primary response). By doing so, they can process primary maladaptive negative emotions by attending to and increasing awareness and expression of these primary maladaptive emotions. One treatment goal is to develop a successful therapeutic relationship where the patient or client feels understood, supported, and safe.

Study participants were recruited from local primary care practices. The participants were between 18 and 65 years of age, and all had a *DSM-5* diagnosis of BED. Twenty-one persons, 17 females and 4 males, participated in the study. The average age was 45 years, and the average age at the first binge-eating episode was 18 years (one 61-year-old client reported that her first binge-eating episode occurred when she was 8 years of age). Participants were first telephone-screened for BED based on *DSM-5* diagnostic criteria.

Those who qualified were randomly assigned to 12 weekly one-hour sessions of EFT for maladaptive emotions over 3 months or to a wait list control group (after which they, too, were offered EFT). Phase 1 of treatment focused on promoting awareness of emotions, welcoming and accepting emotions, putting these emotions into words, and identifying primary emotions. Phase 2 focused on evaluating whether the primary emotion was adaptive or maladaptive, identifying destructive emotions, accessing other adaptive emotions and needs, and transforming maladaptive emotions.

The authors reported that there was no significant difference between immediate post-therapy and 3-month follow-up scores, indicating that treatment gains were maintained. According to Dr. Glisenti and his colleagues, "...evidence is emerging for the benefits of EFT for BED..." which focuses on helping clients experience and process unpleasant emotions, while at the same time decreasing reliance on an eating disorder as an emotional coping mechanism. Future research, including longer follow-up periods and larger studies, is needed.

More Fallout from the COVID-19 Pandemic

In one study, medical admissions of teens with EDs were markedly increased.

Emerging data point to a pattern suggesting that the COVID-19 pandemic has increased calls to ED help lines, and to worsening ED symptoms among adults and adolescents alike. Early evidence has suggested this is leading to an increased need for ED treatment. When Alana K. Otto, MD, MPH, and fellow

researchers at the University of Michigan, Ann Arbor, reviewed records of patients 10 to 23 years of age who were admitted to their hospital from March 2017 through March 2021, they saw a significant rise in admissions during the COVID-19 pandemic (*Pediatrics*. 2021. 148:e2021052201, published online before print).

The authors completed a chart review of adolescents 10 to 23 years of age who were admitted to C.S. Mott Children's Hospital, Ann Arbor, from March 1, 2017 to March 31, 2021 for medical complications of restrictive EDs. The authors identified 297 ED-related admissions among 248 patients during the study. These included AN, atypical AN, and avoidant or restrictive food intake disorder (ARFID), as well as other specified feeding and EDs or unspecified feeding or eating disorders.

The key finding was that the number of admissions during the first 12 months of the pandemic was more than double the yearly mean for the previous 3 years. The greatest number of these admissions occurred near the end of the study period, 9 to 12 months after the pandemic began. Another trend they identified was that patients admitted during the pandemic were less likely than those admitted before the pandemic to have public insurance.

COVID-19 linked to worsening symptoms

The authors' findings suggest that COVID-19 pandemic and related precautions may be associated with worsening symptoms among teens with EDs or with the emergence of symptoms among teens at risk of EDs. Features of the pandemic may also contribute to the increased admissions, say the authors. Changes to adolescents' day-to-day lives, such as school closures and cancellation of organized sports, for example, may disrupt routines related to eating and exercise and may act as an impetus for development of ED behaviors among those at risk. Profound changes in daily lives related to the pandemic, such as social isolation, may also have contributed to the increase in admissions at their hospital.

The authors suggest that those who care for adolescents with EDs may need to be able to adapt rapidly in response to the increasing demands for care during the pandemic. Despite the advantages of telehealth, in-person evaluations to assess weight and nutritional status, vital signs and laboratory studies and evaluation of signs of medical complications that may require hospital admission are essential in the primary care setting. They advise that those who care for adolescents with EDs in inpatient settings be prepared to handle the challenges of the pandemic, particularly because demand for treatment as well as a lack of providers and facilities may only increase.

Earlier Signs of Risk for Eating Disorders

A study finds signs of risk in preadolescents.

Traditionally, anxiety and mood disorders are understood to be signs of risk for an eating disorder and can present in adolescents. However, telltale signs of risk of development of an eating disorder may also be present earlier, in preadolescent children, according to the results of a recent study. Welsh researchers recently underscored the association between disordered eating and anxiety and depression in a study of preadolescent children (*Brain and Behavior*. 2021. 11:e01904, published online before print).

The goal of Dr. Kai S. Thomas and colleagues at the School of Psychology, Cardiff University, Cardiff, Wales, was to examine the association of anxiety and depression among a demographically diverse sample of boys and girls. They hypothesized that preadolescent children who have higher levels of disordered eating behaviors will also have higher-than-normal levels of anxiety and depression. They also sought to examine the role gender may play in disordered eating symptoms in preadolescence.

Initially, they recruited 213 children 9 to 11 years of age (mean age: 10.3 years; 51% male) from 12 primary schools in south Wales. Then, disordered eating behaviors and attitudes were measured in the participating schools with the *Children's Eating Attitude Test* (ChEAT), a self-report version of the adult *Eating Attitudes Test* (EAT-26). The ChEAT includes 26 questions designed to measure disordered eating behaviors and attitudes among children 8 to 13 years of age. The researchers also used the *Revised Child Anxiety and Depression Scale* (RCADS-25; 25-item version). Head teachers gave consent for the study to take place at their schools, and all questionnaires were administered in the individual schools in a separate classroom during the school day. At the end of each session, children had a chance to ask questions, and a written debriefing was sent home with each child.

Positive correlations were found

The investigators found that there was a significant positive correlation between ChEAT scores and total RCADS scores. Consistent with the authors' hypothesis, the relationship between anxiety and disordered eating was statistically significant. In contrast, depression scores were not significant.

According to the authors, their findings underscore those of the few prior studies that have examined associations between disordered eating and anxiety in preadolescence (*Eating Behaviors*. 2014. 15:275; *Appetite*. 2014. 80:61). Both disordered eating and anxiety during this stage of development have the potential of increasing risk of developing EDs and anxiety disorders later in adolescence.

There were some limitations to the study, including the reliance on self-reports as well as the use of a cross-sectional design, so the authors were not able to study the trajectories of disordered eating, depression, and anxiety from preadolescence to adolescence. Dr. Thomas and his colleagues suggest that longitudinal studies that start in preadolescence and continue to follow-up in adolescence would be valuable to better examine co-occurrence of symptoms.

Despite its limitations, the study did underscore the association between disordered eating and anxiety for both girls and boys and that this relationship may present sooner than we generally think of it.

Two Common EDs Are Omitted from a Global Survey

Though far more common than AN and BN, OSFED and BED were left out.

Eating disorders have often been partially or fully excluded from prevalence of illness surveys. One example is the original US-based National Comorbidity Survey. Another more recent survey is the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD).

Damian Santomaura, PhD, of Western Sydney University, Penrith, New South Wales, and his colleagues noted that AN and BN were the only eating disorders included in the 2019 GBD Study, even though binge eating disorder (BED) and other specified feeding or eating disorders (OSFED) are more prevalent. Why is this important? Adding the two missing eating disorders would not only give a truer picture of the incidence and effects of these disorders but could also bring them to the attention of policy makers, who could help target the disorders for greater attention and funding (*the lancet.com/psychiatry*. 2021. 8: April). Dr. Santomaura and his fellow researchers conducted extensive analyses in hopes of achieving more accurate inclusion of ED prevalence and disease burden in future surveys.

What is the GBD?

The GBD is an epidemiologic study that evaluates mortality and disability from diseases, injuries, and risk factors globally, regionally, and nationally. The GBD uses the disability-adjusted life-year (DALY) as a measure of burden. It uses a formula to view AN and BN, for example, as one year of healthy life lost due

to mortality or disability. The authors included 54 studies, 36 from high-income countries, in their analysis.

The authors noted that the GBD 2019 report estimated AN and BN as affecting fewer than 0.2% of the global population. By including BED and OSFED, the prevalence of EDs would rise to 0.7%, similar to substance abuse disorders, and to a level higher than bipolar disorder, autism spectrum disorder, and conduct disorder.

The authors' analysis showed that the number of global ED cases underrepresented in the GBD 2019 included 41.9 million cases, including 17.3 million persons with BED and 24.6 million with OSFED. The GBD for 2019 listed 13.6 million persons with AN and BN. Thus, cases of BED and OSFED were easily the most common EDs reported.

Adding the missing EDs would promote inclusion of EDs in future nationally representative surveys and would improve data and understanding of the burden these EDs place upon patients and their families. The authors' goal is to have AN, BN, OSFED, and BED cases included in the next global survey.

Is Intensive Multi-Family Therapy Worthwhile?

One study is examining the possible benefits of shortened treatment.

A new feasibility trial will assess whether a 5-day course of intensive multi-family therapy (MFT) will produce better results for adolescents with anorexia nervosa than traditional single-family therapy. The concept involves adding 5-day MFT to the early stages of FT (*J Eat Disord.* 2021. 9:71).

As author Dr. Julian Baudinet and colleagues at Kings College and Maudsley Centre for Child and Adolescent Disorders, London, explain, the early stages of FT are very important: one principle is that weight gain within the first few weeks of treatment predicts improved outcome at the end of treatment. That is, as numerous studies have shown, 6 months of FT is just as effective as 12 months of treatment. And, family factors, such as increased emotion, including criticism, hostility and emotional over-involvement, for example, can reduce a patient's response to treatment.

MFT for adolescent AN is associated with a reduction in ED symptoms, and improved mood and self-esteem, quality of life, and outcomes. Despite the promising findings, there have been few controlled trials, and a great variety in the ways MFT is administered, according to the authors.

The study design

The primary objective of the study is assessing whether adding a 5-day MFT intensive week in the first 2 months of FT-AN will improve outcomes for adolescent AN patients. The researchers are recruiting 60 adolescents and their families for the trial. All participants will receive FT-AN, so that all will receive the best available care, say the authors. The control group will receive 6 months of FT-AN, and the experimental group will receive 6 months of FT-AN plus a 5-day intensive course of MFT delivered within the first 2 months of treatment. Those in the 5-day intensive multi-family therapy group will have an adaptation of the usual manualized 10-day approach. In contrast, the intensive MFT group will include up to 8 families working together with a clinical team over a week to build skills, promote engagement, and increase understanding about the illness and family dynamics. The brief intensive version also includes between 2 and 8 families per group and condenses the main treatment content into 5 consecutive days (10 am to 4 pm, Monday through Friday) over one week. The treatment content matches the phases of regular FT-AN, and focuses on empowering parents to support their child to manage eating disorder symptoms and to restore weight. Two clinicians will deliver the extensive treatment. General function,

reflexive functioning, emotion regulation by patients and their parents, parental mood and anxiety symptoms, expressed emotion, and therapeutic alliance will be measured with a number of questionnaires and other instruments.

Time will tell if it is feasible and acceptable to add 5-day intensive MFT to the critical early stages of FT for AN. The researchers point out two limitations to their study—one is the relatively small sample and the second is that MFT is added in the first 2 months of treatment rather than during the first month. (Increasing data are indicating that MFT may be more effective the earlier it is delivered.) However, in the authors' study, having MFT during the first month is not possible, due to study time constraints. (One wonders if similar time constraints might present in real-world implementation of such a combined approach. If so, using MFT in the first 2 months in this study might reflect how this would be implemented over time.)

Study strengths include the use of a randomized controlled design and the inclusion of data collection points during treatment as well as at the end of treatment.

QUESTIONS AND ANSWERS: Fasting

Q. Recently I have seen several college students who are regularly fasting. This seems risky. Do we have any information about the effects of fasting, especially among young adults with eating disorders?

A. Finding that young people are regularly fasting is not surprising. It is estimated that nearly 1 in 5 men and 1 in 4 women in college are regularly fasting, and these numbers are only increasing. Often this takes the form of a daily fast, where an individual eats one large meal per day and then fasts for the next 18 to 24 hours. Some do this to lose weight but others claim it improves their physical and mental functioning.

A recent article from the University of California, San Francisco, outlines some of the negative effects of this growing trend (*J Eat Disord.* 2021. 9:88). Data from the Healthy Minds Study, which surveyed 8255 college undergraduates and graduate school students, showed that the students who regularly fasted had high rates of depression, anxiety and, importantly, eating disorders, suicide ideation, and non-suicidal self-injury (cutting and burning themselves). Also increased were substance use disorders, including use of marijuana and illicit drugs such as ecstasy and cocaine.

Eating disorders were measured with the *SCOFF*, a 5-item questionnaire that asks such questions as "Do you ever make yourself sick because you feel uncomfortably full?" and "Do you worry that you have lost control over how much you eat?" Regular fasting during the past 4 weeks among men was significantly associated with positive depression, anxiety, and eating disorders screens. Among women, regular fasting during the past 4 weeks was significantly associated with greater odds of marijuana or illicit drug use in the past 30 days as well as positive results on depression, anxiety, and eating disorder screens.

Among college men and women, a higher body mass index was associated with any degree of fasting, which was no surprise because one of the primary reasons for fasting is weight loss. However, BMI was not associated with regular fasting. Among women who reported regular fasting, greater odds of cigarette smoking, marijuana use and use of other illicit drugs were reported.

In the popular press, fasting is presented as a health strategy. Sharing information about the risks associated with fasting with the students you are seeing may be helpful. Furthermore, the results from studies such as the one at the University of California-San Francisco may be helpful. Also, in studies such as this, it is not clear whether fasting causes eating, anxiety, mood and substance use symptoms or is promoted by them. But, either way, regular fasting is a reason for real concern.

Personality Factors Can Help Predict Symptom Changes After Residential Treatment

But observable symptoms might be misleading.

Treatment guidelines for AN and BN routinely state that evaluation of a person's characteristics should be used to predict responses to different treatment approaches. However, the best predictions remain unclear. For example, ED-specific characteristics, such as those given in the *DSM-5*, have not performed very well as outcome predictors.

Psychologists Dr. Laura Muzi and colleagues at Sapienza University of Rome, Italy, recently reported on the role of personality features in a group of 84 female patients with AN and BN treated in a residential program. They reported that personality factors had the potential to target relevant individual factors and to indicate effective treatment strategies (*Eat Weight Disord.* 2021. 26:1195). The work was based in part on the idea of pathoplasticity. That is, factors such as disordered eating or personality features (in this case) can influence the course of each other over time.

The participants and the program

Of the 84 participants, 38 were diagnosed with AN, restricting subtype, with an average body mass index, or BMI, of 15.16 kg/m², while 14 others diagnosed with AN, purging subtype, had an average baseline BMI of 16.82 kg/m². The remaining 32 had diagnoses of BN; this group had an average baseline BMI of 22.85 kg/m². The mean age of participants was 16 years.

Once admitted to the program, participants became involved in a full-time, non-hospital-based and multidisciplinary residential treatment program that used a predominantly psychodynamic approach. The average length of treatment was long relative to that provided in many settings, 5.5 months. All medical professionals, including psychiatrists, psychologists, social workers, nutritionists, and nurses, met weekly to discuss individual cases. Patients were offered 24-hr supervision so the therapists might interrupt any repetitive and pervasive ED behaviors. In addition, each patient had individual psychotherapy once or twice a week. Other activities included nutritional counseling and rehabilitation, meal support, interventions focused on affective and emotional experiences, skills training, recreational and art therapy, and social cooking classes.

The researchers used a number of questionnaires to test the patients, including the *Clinical Diagnostic Interview* (CDI), the *Shedler-Westen Assessment Procedure-200* (SWAP-200), the *Eating Disorder Inventory-3* (EDI-3), and the *Outcome Questionnaire-45.2* (OQ-45.2). The OQ-45.2 measures function and symptomatic impairment, such as interpersonal problems and social roles. The SWAP-200 is a clinician rating of observed personality features.

Higher EDI-3 symptoms could be linked to dietary restrictions

Higher EDI-3 symptom scores at discharge were positively linked to the number of restriction episodes per week and are negatively related to length of treatment. When Dr. Muzi and her colleagues analyzed the *SWAP-200 Personality Disorder (PD)* scales, they found positive associations between higher ED symptomatic impairment and avoidant PD scales. Associations with higher PD impairment were also noted for paranoid, schizoid, histrionic, avoidant, and other symptoms. Higher healthy personality function was related to lower ED symptom scores, as well as dysphoric and obsessive: depressive high-functioning Q-factors.

Nearly 40% of ED patients showed clinically significant improvement after the treatment, and an

additional 8.3% showed reliable symptomatic change even though they remained in the dysfunctional population. On the other hand, it is also worth noting that 46.4% of the women showed no significant improvement, and 6% had deteriorating symptoms.

To the best of the authors' knowledge, their study was the first to explore the relevance of a broad spectrum of personality traits and styles to determine therapeutic outcomes in people with AN and BN. Overall, the findings did support the authors' hypotheses. Elements of a person's personality disorder significantly helped predict therapy outcomes at both the group and individual levels.

The promise of future studies

Some clinical variables emerged as significant predictors. The authors suggest that future studies analyze the relationship between such variables and personality disorders in greater depth. For example, a larger number of dietary restriction episodes per week predicted a worse therapeutic outcome, as did higher rates of compensatory behaviors per week.

The authors also pointed out limitations of the study. First, the moderate sample size of exclusively white/Caucasian women limited the ability to generalize findings to males, minority populations, and other populations with EDs other than AN or BN. Data also came from a single treatment center and only included patients who were discharged after completing treatment.

Nonetheless, as the researchers write, "First and foremost our findings suggest that if clinicians want to understand and treat ED symptoms effectively, they have to know something about the person who hosts them." Concentrating on observable symptoms may lead clinicians to neglect less overt and less easily measured aspects of patients' other subjective experiences, such as loneliness and feelings of shame. Thus, applying the principal of pathoplasticity may help point the way to more effective treatment guidelines and strategies.

Substance Use Disorders and Eating Disorders

Dealing with increased risk when the two coexist.

Co-occurrence of eating disorders and substance use disorders is common, and also challenging for clinicians. Most treatment programs are very comfortable with the disorders they typically treat (ED or SUD) but view the co-occurrence of the two as risky. A new study underscores and supports that perception of increased risk.

In the study, Mellentin and colleagues used Danish data registers to examine mortality in patients with both ED and SUD (*Am J Psychiatry*. 2021; 1-11, doi: 10: 10-1176/appi.ajp.21030274). Data were included on 20,759 people with EDs; information was also available on abuse of alcohol, cannabis, or "hard drugs."

Results showed that having an SUD increased the risk of dying. For those with ED but not SUD, there was also a higher risk of death (Hazard Ratio (HR) 2.85). This fits with what we already knew: that those with EDs are at higher risk of death. In this study, having an SUD markedly increased risk. Substances that directly increased risk included alcohol (HR 11.84), cannabis (4.55), and "hard drugs" (14.16). For those with all three (HR 22.99), the risk was even higher.

These figures make clear the risk of co-occurring ED and SUD. They should be taken as a strong endorsement of the need for more combined ED-SUD treatment programs.

IN THE NEXT ISSUE

The Media's Role in the Development of Eating Disorders

PLUS

- From the Patient's Perspective: What it Feels Like to Have an Eating Disorder
- Feeding and Eating Disorders after Bariatric Surgery
- Voice Disorders
- The Pros and Cons of Creative Bibliotherapy
- Mortality of Eating Disorder in a Specialist Unit: A Follow-up from 1974 to 2000
- And much more...

Reprinted from: *Eating Disorders Review*

iaedp

www.EatingDisordersReview.com