Eating Disorders Review
March/April 2022
Volume 33, Issue 2
Scott Crow, MD, Editor-in-Chief

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Using the Internet to Reach Those at Risk of EDs

A new way to reach people?

More often than not, people with eating disorders do not seek treatment (*Clin Psychol Rev.* 2011. 31:727). Stigma and shame, lack of motivation to change, lack of support or encouragement from others, and practical barriers of cost and lack of transportation are just a few of the underlying reasons for hesitation to seek help.

Today, researchers are looking for ways to reach those with ED symptoms, including using the Internet. By doing so, it may be possible to avoid a number of the barriers that prevent people from seeking help thorough more traditional means. For all the effort aimed (appropriately) at strengthening our existing treatments, approaches that increase the actual usage of current treatments should have very large effects (*UED*. 2017. 50:1378). A recent study reported by Dr. Kathina Ali and researchers at Flinders University, Adelaide, Australia, highlights some of the promise and challenge of nontraditional approaches to treatment (*J Eat Disord*. 2022. 4:1).

The *Pro Youth* programs

The *ProYouth* program, first developed in Germany, was designed to promote mental health in young people aged 18 to 25, and is specifically related to healthy eating, body satisfaction, and eating disorders. The *ProYouth OZ* program in Australia offers various online information and support modules to young people without any face-to-face interaction.

The researchers devised an Internet-based eating disorders prevention program using three study conditions: (1) *ProYouth OZ*, without peer-to-peer support, (2) *ProYouth OZ Peers*, with peer-to-peer support, and (3) a waitlist group that acted as controls (*J Eat Disord*. 2021. 10:1). The outcome was then measured with the *Eating Disorder Examination Questionnaire*.

Young adults 18 to 25 years of age were recruited over a 12-month period beginning in October 2016, and the study was open to all Australian patients. The authors advertised the study at two major universities, using print fliers, and on social media and through various mental health organizations, including the National Eating Disorders Collaboration, the Butterfly Foundation, and Headspace, a mindfulness app that offers an interactive site for persons with alcohol- and drug-related problems. Only those at risk for developing an eating disorder were eligible, while those who had a current diagnosis of an eating disorder, a body mass index (BMI) less than 17 kg/m^2, or binge eating/vomiting/or use of a laxative more than once a week or once a week for longer than 3 months, or a current treatment for an eating disorder were excluded.

The *ProYouth OZ* program

Those randomly assigned to the *ProYouth OZ* group (no peer-to-peer contacts) had access to the internet—based prevention program for 6 weeks. The ads for this group targeted young adults at high risk for developing an eating disorder, such as those with greater than normal weight and shape concerns and early symptoms, but who did not meet the diagnostic criteria for a threshold ED.

> **“ *Challenges to using the Internet for contact included problems in recruitment, low rates of adherence, and high dropout rates.***

Participants had access to monitoring and feedback designed to assess eating disorder-related symptoms, enable early detection of increased symptoms, and to provide minimal intervention by using supportive feedback. Those who received monitoring and feedback also received 6 weekly invitations to complete 8 questions assessing cognitive and behavioral aspects of body dissatisfaction, overconcern about weight and shape, poor nutrition/dieting, and binge eating with compensatory behaviors. After participants responded through a 4-point Likert scale, they received automatically generated feedback messages. The messages were designed to motivate and encourage the participant to maintain positive eating attitudes and behaviors, to provide support and to reinforce positive change. One example is â€œThink about three positive qualities that you have that others value.â€

ProYouth OZ Peers

Young adults assigned to the *ProYouth OZ Peers* group also had 6-week access to the components of the *ProYouth OZ* program as well as online peer-to-peer support. They were encouraged to attend weekly 1-hour chat sessions led by a peer and a trained health professional with more than 5 years’ experience moderating online chat groups. In this group, the adults were led by a peer in recovery, who shared his or her experiences and learning opportunities. The trained professional’s job was to ensure a safe environment for the participants. Participants were given specific guidelines, such as not sharing weights, and unhealthy behaviors were not discussed. At the beginning of each session, participants were invited to watch a brief video of peers, which was designed to provide messages of hope, insight, and sense of belonging. The videos also may have helped reduce stigma by encouraging discussion of concerns about stigma and shame (*Internet Interv*. 2015. 2:351).

Participants could withdraw from the study without explanation by e-mailing the trial manager. After the two groups had completed the 6-week intervention and the 3-month follow-up, the same procedure as described for the non-peer *ProYouth OZ* condition was followed for those who had been randomized to the waitlist control group.

The participants were assessed with self-report online questionnaires at pre- and post-intervention and at follow-up contacts 3 months and 6 months after the intervention. Half of the total group reported that they would use the program again, and would probably recommend it to friends.

Challenges

The authors encountered a number of challenges, including problems in recruitment, low rates of adherence, and high dropout rates. The majority of young adults, 51%, who were initially interested, were excluded because of their severe eating disorder symptoms. Those who responded reported significantly higher weight and shape concerns than those recruited from offline strategies. It may have been that those who sought help through *ProYouth OZ* online were more actively seeking eating-disorder-related information and support.

Assessment completion was low: only 30% of participants completed post-intervention measures (24% from the intervention groups vs. 44% in the control group).

On the other hand, case-by-case examination of the limited outcome data suggests that there was often improvement in those receiving peer support (but not in the study group lacking peer support). The challenges may be a mix of research-specific issues (follow-up assessment non- completion) and issues relevant to treatment delivery or effect (dropout from treatment itself, and non-response). Further work is needed, as the potential of approaches that increase treatment reach is great.

UPDATE: Eating Disorders in Those Receiving Medicare

Healthcare spending for older adults is significant, including the cost of care for eating disorders, according to a recent study at Johns Hopkins School of Health and Columbia University School of Medicine. The study analyzed prevalence, sociodemographic and clinical characteristics, and healthcare spending among a large group of Medicare enrollees (*Int J Eat Disord.* 2022. Jan 13. doi:10.1002/eat.23676. Published online before print).

After analyzing data from nearly 12 million Medicare enrollees, the researchers found that 0.15% had EDs, compared to those without an ED diagnosis. In a 2016 analysis, a greater proportion of individuals with an ED were female than were male (73.8% vs. 54.3%, respectively), younger than 65 (41.6% vs. 15.5% respectively), and were dually eligible for Medicaid because of disability or low income (48.0% vs. 19.6%, respectively). In the more recent analysis, Dr. Rachel Presskreischer and colleagues reported that older Americans with EDs also had higher rates of comorbid conditions than those without EDs, especially cardiac arrhythmias (35.3% vs. 19.9%, respectively), arthritis (40.1% vs. 25.6%, respectively), and thyroid conditions (32.2% vs. 19.4%, respectively). Overall, spending was more than three times higher for Medicare enrollees with EDs compared to those without ED diagnoses: $29,456 as opposed to $7,418, respectively.

From Across the Desk: Some Benefits of Using the Internet for EDs, and a Challenging Patient

Some eating disorder programs have turned to technology to bring treatment to patients who would otherwise be out of reach. A few of the barriers that keep patients from seeking treatment include stigma, lack of transportation, cost, and geography.

Today researchers are looking for ways to reach those with ED symptoms, including using the Internet. By doing so, it may be possible to avoid a number of barriers that prevent people from seeking help thorough traditional means. Internet-based prevention programs for eating disorders are promising, according to a recent study reported by Dr. Kathina Ali and researchers.

Internet-based programs help clinicians like Dr. Ali and her colleagues breach such barriers. The COVID pandemic has only accelerated this effort. Stigma and shame, lack of motivation to change, lack of support or encouragement from others, and practical barriers of cost and lack of transportation are just a few of the underlying reasons for their hesitation to seek help. Dr. Ali and her colleagues (see “Using the Internet to Reach Persons at Risk of EDs” elsewhere in this issue) turned to the Internet to try to break down some of these barriers.

Another group has turned to the classroom in an effort to improve or reduce body image concerns among teens (see “The Effects of School-based Classes on Body Image”). Could community-based educational programs help improve risk factors? A British group reported positive effects of using a school-based program—improvement in girls and boys that lasts at least 6 months, a longer period than previously reported teacher-led body image intervention. They concluded that shifting interventions to community- and school-based programs such as theirs could help improve adolescents’ body image.

Finally, see a personal essay on addressing unexpected challenges in the midst of treating complex emotional issues. Dr. Roy Ehrlichman shares his experiences in an essay aptly named â€œFeeling Stuck,â€ where he describes how he dealt with complex issues that arose with one long-time patient.

—MKS

Toward a Better Definition of the Night Eating Syndrome

One study recommends studying night eating as an independent disorder.

Night eating syndrome, or NES, was first described by Mickey Stunkard in 1955 (prior even to the description of BED) and is still being defined and debated. The most recent definition was published in the *DSM-5* (American Psychiatric Association, 2013).

The best definitions of NES have been unclear, so to better define *DSM-5* proposes a number of criteria for NES. These are: (1) evening hyperphagia, or eating 25% or more of one’s total daily calories after the evening meal, and/or an average of two nocturnal ingestions, on average, per week; (2) awareness of one’s eating behaviors; and (3) at least 3 of the following criteria: (a) morning anorexia, (b) the desire to eat between dinner and sleep, (c) sleep-onset insomnia, (d) the belief that one needs to eat in order to fall asleep; (e) depressed mood or lowering of mood in the evening and nighttime; (f) distress or impaired functioning; (g) 3 months or more under these conditions; and (h) conditions not secondary to any medical condition.

To better define NES, Dr. Jasmine J. Kaur and colleagues at the University of Melbourne, Australia, recently designed a systematic literature review of patients with NES, obesity, and BED (*Front Psychol*. 2022. 12:766827.doi: 10.3389/fpsyg.2021.766827, published online before print).

NES and BED

Unlike some other EDs, NES is not dependent on body mass index (BMI, kg/m^2) and occurs across a wide variety of body weights. However, it is most often found in obese persons, and is a risk factor for earlier-onset obesity. NES is also related to higher rates of depression and lower self-esteem. NES appears to be pretty common. Rates range from 3% to 15% in most studies.

One issue in the literature centers around the classification of NES as an eating disorder or as a sleep disorder (*Expert Rev Endocrinol Metab.* 2019. 14: 351). This is especially controversial because of the overlap of NES symptoms with symptoms of Sleep-Related Eating Disorder (SRED). Patients with NES and SRED both present with nightly binge-eating, an increase in weight, and sleep disruptions. Moreover, both conditions are highly prevalent among women and are often comorbid with depression. Some argue that these similarities in symptoms may indicate that the two disorders are really one disorder previously studied through two different lenses in the literature.

The only key difference between SRED and NES the authors found in their literature search was the degree of awareness individuals had during night-eating episodes. While NES patients are fully conscious and aware of their night-binging episode(s), SRED patients have only partial or no awareness of their night-eating episodes. Supporting this claim, researchers such as Latzer and Tzischinsky (2012) believe that NES should be considered an ED because of the presence of psychopathological features related to disordered eating (such as binge eating and emotional eating). However, the authors point out that the differences between NES and SRED are still under-researched.

Night Eating and BED

Studies assessing NES and BED showed that the two disorders differed by the way patients engaged in emotional eating. BED patients tended to eat emotionally more often than did NES patients. This was a response to negative emotions, stressful situations, and loss of control over eating. Such findings provided support for the hypothesis that, although the observable behaviors between BED and NES may overlap, the two conditions are likely to have distinct underlying motivations for engaging in disordered eating. For BED patients, these motivations may differ because of higher levels of emotions and loss-of-control eating.

In comparison, NES patients tend to â€œsnackâ€ at abnormal times (i.e., after the evening meal); however, they demonstrate greater control over their abnormal eating behaviors than do BED patients. Perhaps the reason why night eaters indulge in snacking at night lies in their shame over giving in to the temptation of binge-eating and the fear of being caught binge-eating during the day. However, there are few studies exploring the motivations behind night-eating behaviors in NES patients, a key question to be explored in future studies. Another key difference between the two disorders has also been demonstrated (*Surg Obes Relat Dis*. 2019. 15:1374). The authors found that depressive symptoms fully mediated the relationship between BED and food insecurity, but only partially mediated the relationship between NES and food insecurity.

Dr. Kaur and her colleagues have found support for the notion that NES is highly prevalent in those suffering from obesity and BED, and among those undergoing bariatric surgery. However, in most instances, individuals with NES are unaware of their condition, and healthcare professionals are distracted by comorbid conditions. Thus, individuals with NES often do not receive appropriate mental health care, which is further worsened by the dearth of research on treatment modalities for NES. Therefore, health professionals should be made aware of NES and its high prevalence in the relevant populations. Further, according to the authors, healthcare professionals should be trained to screen patients for NES by using validated screening tools such as the Night Eating Questionnaire (*Eat Behav*. 2008. 9:62).

To guide clinical decision-making, the authors recommend that researchers consider a wider range of symptoms for patients with NES. Further, they suggest that NES and BED be considered as two distinctive EDs despite the high rate of comorbidity. Therefore, mental health professionals should include the underlying characteristics of both NES and BED patients into treatment, to provide the most individualized and appropriate care for these patients.

The authors reached three overall conclusions.

The authors reached several conclusions, and pointed out several weaknesses of their study. First, they write, “Given that the DSM-5 is governed by Western thinking and most studies included were conducted in Western countries, the results may not be generalizable to non-Western countries.” Social and cultural backgrounds are considered significant contributing factors in the development of EDs. Given this, such factors would significantly differ in non-Western countries, and future research should focus on identifying the clinical presentation of NES among individuals from a range of different cultural and ethnic backgrounds.

Second, the authors did not focus on finding evidence to resolve the debate around how NES should be classified in the DSM--as a sleep disorder-- or whether it should be classified as an independent ED. According to the authors, future studies would benefit from finding answers to these crucial issues. Furthermore, all studies included in this review were cross-sectional; thus, causality and direction of the relationship of the symptoms and comorbidities assessed could not be determined. Therefore, the conduction of replication studies using different data collection methods, including longitudinal and more rigorous experimental designs, is deemed to be necessary.

Third, most studies included in the review examined mainly female NES patients (ranging from 65% to 100% of the samples). However, given that NES is equally common in males and females, and that differences in clinical presentation between these two genders have been suggested, future research using a gender-diverse sample is needed to reach generalizable findings.

Unlike most studies that compare NES with BED, these authors found that BED can be differentiated from NES by the greater occurrence of emotional eating, body-related concerns, and abnormal eating episodes among those with BED.

It seems reasonable to conclude that more work is needed to better define these questions. However, one is struck by how frequently NES symptoms are reported.

Compulsive Exercise and Muscle Dysmorphia

An ongoing study hopes to point to better guidelines for treatment.

In the past, many people with EDs were advised to avoid exercise. This abstinence approach could be viewed as analogous to the common approach used in substance use disorder treatment. Recently there seems to be more interest in including physical activity and healthy exercise as a normal part of ED treatment.

Dr. Jordan Andre Martenstyn, of the University of Sydney and his colleagues are conducting a systematic review of this. Compulsive exercise generally refers to a highly driven, rigid urge to exercise, combined with a perception that one is unable to stop exercising despite knowing its risks. Among ED patients, the risk of compulsive exercise ranges anywhere from 17% to 85% in teens and 32% to 80% in adults (*Comp Psychiatry*. 2008. 49:346). Unhealthy exercise is also a core feature of muscle dysmorphia, a condition where a person has an intense fear that he or she is not big enough or is not more muscular than the average person. Body builders call this *bigorexia.*

For people with EDs, unhealthy exercise can lead to a poorer prognosis, lower quality of life, longer hospitalizations, greater risk of suicidal behavior, and increased risk of relapse (*Psychol Med*. 2004. 34:671). Despite the poor prognosis, the authors note, there is no clear definition of "excessive exercise" paired with an ED.

Guidelines for safe exercise are needed.

Information is sorely needed on many questions. Current practice advocates introducing safe exercise into an ED treatment program where appropriate (*J Eat Disord*.2018. 6:34). Although many studies have outlined treatment interventions for compulsive exercise among ED patients, the authors note that no systematic review has yet summarized this, and thus guidelines are urgently needed. The authors' review includes studies that sample teens, defined as older than 10 years of age and/or adult participants of both sexes diagnosed with either an ED or muscle dysmorphia.

Another study goal is to note changes in compulsive exercise from pre- to post-intervention. The authors included only studies that measure compulsive exercise using standardized tests, such as the *Compulsive Exercise Test* (*Eur Eat Disor Rev*. 2011. 19:256), the *Exercise Addiction Inventory* (*Br J Sports Med*. 2005. 39:e30). or the *Obligatory Exercise Questionnaire* (*Eat Disord.* 1999. 7:219). Moreover, even the best definitions of unhealthy exercise, as well as the relationship between compulsive exercise and body dysmorphia, remain unclear.

The authors hope that the review will shed light on these questions regarding compulsive exercise in EDs and muscle dysmorphia.

In this article, Dr. Ehrlichman explores some of the challenges encountered while treating patients with eating disorders. The article also appeared in the January-February 2022 Spanish edition of Eating Disorders Review.

On Not Knowing

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To be stuck is not to know. It may be synonymous with not understanding or perhaps a defense against such feelings as helplessness, failure, confusion, or inadequacy. It may be momentary or long lasting. In my experience, feeling stuck is implicit in the process of treating complex emotional issues and is important in helping clinicians better understand our patients and ourselves.

In fact, feeling stuck is but one of many countertransference responses that arise in the practice of psychotherapy, including therapy for eating disorders patients. For me, feeling stuck, much different from being stuck, is inevitable and confirms the realistic limitations on what I can know or accomplish in my work. This may leave me with thoughts and feelings that may differ dramatically from what a patient expects, fantasizes or demands of me or that I expect of myself. In the treatment of eating disorders, there is little that restores health promptly and little that consistently eases or resolves moments of stuck-ness, both for patient and clinician. Healing demands time; and as another aside, do we yet have a clear, universal definition of healing or cure?

Sarah

And then there is Sarah. In her early 40s, Sarah presented with a fascinating history. Well-educated, she had served in the US government for years, and was married to an accomplished man. She had no siblings and both parents had passed away. When I asked how I could be helpful, Sarah clearly told me she wanted to be rid of her anxiety, her intractable depression, and what she referred to as â€˜unusual thoughtsâ€™ that intruded in her life. I did not know what they were nor, in the early sessions, did I ask. To do so then felt premature. I could wait.

In the first months of our work, Sarah was cooperative. She came to her sessions on time, spoke openly and paid her bills reliably. One day, for reasons I did not understand, I felt a nagging, uneasy feeling and decided to explore with Sarah how our sessions were going. Actually, I asked her, “How am I doing?” I did not direct my question to her as a command or personal criticism, but instead invited her to speak about me and how I was doing as her therapist. In other words, if she chose to, she could speak critically or positively without

> ***“ The sense of interpersonal acceptance may have little to do with the issues at hand, but far more to do with feeling valued or devalued by another.***

recrimination. That was my hope.

Sarah said that our work was going well, but the positive feelings she verbalized did not match the feelings I experienced. Telling me all was going well was simply not the case. Something was wrong, but I did not know what. When feelings and thoughts do not match, I wonder why.

I wonder when patients are too kind, too effusive in praising a therapist's work — or too critical. Are we hearing what is true or what is self-protective and therefore safe? Does the patient fear retaliation, rejection, or abandonment? Likewise, I question when patients displace rage on me undeservedly for behaviors, thoughts or comments that I neither had nor engaged in, but the patient had attributed them to me anyway. What if I think I am being helpful, but in the mind of the patient I may feel or be of little value? How to respond? Experience and theory have taught me that the prudent thing is to accept and say little or nothing.

From time to time such questions arose when Sarah would ask for exercises or techniques to help ease the stressors she felt. If I were being as helpful as she said, I wondered why the need for more tools and techniques? What was I missing? What was I failing to do? At first these requests felt reasonable. Technically, they were. We discussed breathing exercises, pausing exercises, yoga, meditation, books to read, visualization — but to no avail. Nothing helped.

What did become clear was that Sarah had no interest at all in exercises or techniques—and, in fact, the case was to the contrary. What I realized later was that Sarah was determined that somehow she would compel me to understand and feel the intensity of the emotional pain she experienced every day-and for which she had no words, because there were no words. These were preverbal memories. As time passed, she would use colors to describe early childhood experiences — for example, that the pain of her anxiety was fiery red or that her depression was cold gray. She required that I feel these feelings and somehow save her from them.

She never said this because she had no words. I simply intuited her message.

Through many sessions, I felt I had become an amalgam of the mother and father who are supposed to 'simply know' what their child needs. Magically, these parents turn on the light when it is dark, change diapers when they are wet, and feed and love their child naturally and easily. While the infant does not yet have a verbal language, she does know the sounds and feelings of such love and in time, and grows to accept it with trust and confidence. Sarah never knew this experience.

For a long time, I continued not knowing what to say to Sarah. Clearly, my presence was more important than my words and, like Sarah, I had no words. As I was asking Sarah to walk across her own 'bridge over troubled waters' and put her thoughts and feelings into language, I had to do the same. What I knew was what I felt — an empty, sad, raw state that often left me frustrated and uncertain and frequently ashamed and embarrassed. I was supposed to be an agent of hope in Sarah's life, but, in truth, I felt myself a failure. Yet we persisted.

Then, an epiphany

And then came that special moment, the epiphany in which the elements of our work gradually were seamed together. What appeared to have happened is that my inner world had evolved into a narcissistic mirror of Sarah's. The insecurity that I felt as a therapist mirrored the insecurity she felt as both child and patient. The rage she displaced onto me was the rage that her parents displaced onto her. Feeling like a failure as a therapist was the feeling she felt as a child. Blaming me for failing her in our work was the blame she experienced for not satisfying her parents' endless demands for achievements, too lofty for the most gifted of us. What was imposed on her was imposed on me. There was no love in their messages, and Sarah felt this. Nor would I get any love or appreciation. I would suffer, too, until I understood.

> **_Feeling stuck is but one of many countertransference responses that arise in psychotherapy, including therapy for eating disorders patients._**

More months passed. Sarah persistently railed on about my lack of understanding and what she labeled ‘my lack of proper compassion.’ It was ‘just like my parents,’ she said. Repeatedly, she reminded me that I was a failure as a therapist, and wondered why she ever came to see me. But interestingly—and I grew increasingly curious about this—no matter how fiercely she complained, she continued to come to our sessions and invariably was on time. She paid her bills as we had agreed, and responsibly handled the details of appointment changes. She now periodically requested more sessions, not fewer. This seemed contradictory. If she so loathed and criticized me, why continue treatment? Certainly she could find another therapist more effective than I. In truth, I hoped there was one. I was tired.

As Sarah spoke more openly, we studied together how I had become so disappointing to her, and what I had done to warrant her rage. Had anyone ever listened to her, accepted her dark feelings and her ‘unusual thoughts?’ Was there a safe way to talk about the real relationship she had with her parents and others whose lives had touched hers? Were her parents the good people she described or were they as detached, punitive and toxic as they seemed to me? I continued to ask questions, to study Sarah’s replies with her and, to the best of my ability, rendered neither judgments nor interpretations. It was better, it seemed to me, for her to arrive at her own conclusions independently, without criticism, pressure or editorializing on my part.

Sarah’s voice grew clearer, louder, and braver. In one tender conversation, she confirmed tearfully that she was indeed a brutalized child who had never been allowed to feel or speak. As she felt increasingly safe displacing hateful feelings onto me—as a substitute in the transference for her parents—she talked more freely about her memories, feelings, perceptions, and dreams. At times, this process felt interminable, and yet it grew increasingly informative and relieving to us both. As the rage lessened, her brighter self gradually emerged. Through many agonizing sessions, what became true was that Sarah had grown up with parents who were diametrically different from the parents she had first described. They had nearly destroyed her mind and her soul.

As an infant, Sarah learned that her obligation was to do her parents’ bidding without question. To do otherwise was to manifest disloyalty for which she would be punished. To be silent was to be safe and loyal—the good child. Later in treatment, when speaking no longer terrified her, she needed to confirm with certainty—know—that I would tolerate her rageful feelings and behaviors. If I could do that and remain non-punitive, that would confirm that I could be believed and trusted. Her perceptions, memories and feelings were to be valued, not scorned.

Doing nothing or little, waiting for Sarah to guide me— in her own language and at her own pace—was to do more. Slower was indeed faster.

Sarah and I worked together for several years. Feeling stuck, uncertain and unknowing colored the course of our relationship. Curiously, I do not recall ever feeling hopeless. I have often wondered why. In retrospect it seems to me that Sarah’s determination to have the life she rightfully deserved gave me both hope and courage.

Sarah did prosper in our work, although I frequently wondered if I could. As treatment advanced, she reported significant improvements in her relationships with others. Her career blossomed. She no longer spoke of her depression, anxiety, or unusual thoughts. Her marriage became a source of confident, loving mutuality. After treatment ended, Sarah periodically would call me or send a card to let me know that she was doing well in her new world. She invariably asked how I was, an important step for someone who for years barely acknowledged my existence.

The case of Sarah was one that went well. Not all do. I have had others that have disappointed me, even caused despair. But knowing that feeling stuck can be both meaningful and useful encouraged me to stay the course.

Hearing disguised cries for help

Helping Sarah to restore her ‘wounded self’ required that I hear her ‘disguised cries for help,’ her perceptions and feelings about life and reality, whether real or imagined. When I accepted her perceptions, which frequently defied reason or my own perspective, I believed—actually felt—that this gave her a sense of unqualified acceptance, of feeling understood, and emotion—I believed—which she may have never experienced before.

In other words, the sense of interpersonal acceptance may have little to do with the issues at hand, but far more to do with feeling valued or devalued by another. Whether correct or incorrect, logical or not, I find that a patient’s words are the offspring of their mind, a verbal representation of the self. To have them accepted and valued is to be valued. For me to argue with these perceptions may be experienced as rejection, possibly a replication of her traumatic experiences as a child. Here again, I was one more adult, her doctor now, who may listen but not hear. Clearly relational trust is not legislated in therapy, but cultivated, earned over time, just as the infant internalizes over time that their parents will be reliable, present, loving objects. For me personally, it was a privilege to share Sarah’s journey. Often, I wish I could know more, do more and feel less ignorant and uncertain. However, to borrow from Donald Winnicott (the well-known English pediatrician, psychiatrist, and psychoanalyst who developed the theory of the false self), like parents we can only be ‘good enough.’ It is easier, though, to be good enough when we accept that feeling stuck and not knowing are rightful elements of what we do and who we are.

The Author

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has had an extensive career in eating disorders treatment. He is a Certified Eating Disorders Specialist and Fellow of the International Association of Eating Disorders Professionals (iaedp) and has served as President of the iaedp Board of Directors. In 2019, he received the Whoâ€™s Who in America Lifetime Achievement Award for clinical contributions, and in 2016 was awarded the iaedp Lifetime Achievement Award for service. Dr. Erlichman has written numerous articles, presented at conferences throughout the country, and is an Associate Editor of *Perspectives* magazine.

Sex Differences in Eating Disorder Treatment

A recommendation for establishing individualized guidelines for male patients

Males are receiving treatment for EDs more frequently than in the past. How (if at all) should treatment approaches differ for males and females? Dr. Jason M. Nagata of the University of California, San Francisco, and colleagues concluded that some differences do (and likely should) exist (*Int J Eat Disord.* 2021. doi: 10.1002/eat.23660. Published online ahead of print.).

In this study, records for 601 people 9 to 25 years of age who were receiving inpatient treatment for eating disorders were reviewed. The authors sought to determine sex differences in refeeding (i.e., shortterm nutritional rehabilitation) outcomes among hospitalized adolescents and young adults with eating disorders. The focus was on nutritional and weight-gain-related factors.

A final group of 588 adolescents and young adults (19% male) were included in the study.

Higher energy needs, longer hospital stays

> **_Males had higher estimated energy requirements than females._**

Not surprisingly, the results showed that males had higher estimated energy requirements than females (3694 vs. 2925 kcal, respectively). Males and females were prescribed similar amounts of food at admittance (around 2000 kcal), but by discharge males were prescribed about 800 kcal more than females. The length of hospital stay was also longer for males than females (11 days vs. 9.4 days, respectively), which one might view as relatively short, but it is important to recall that this was inpatient treatment focusing on medical management and refeeding. In unadjusted comparisons, there were no significant sex differences in prescribed kcal per day at admission between males and females (2013 kcal vs. 1980 kcal, respectively; $p = .188$). However, males also had higher estimated energy requirements (EER, kcal) than females: (3694 kcal vs. 2925 kcal, respectively; $p < .001$). In linear regression models adjusting for potential confounders, male sex was associated with higher prescribed kcal at discharge (B = 835 kcal; $p < .001$), greater weight change (B = 0.47 kg; $p = .021$), and longer length of stay (B = 1.94 days; $p = .001$) than females. Older age, lower weight on admission, lower prescribed kcal at admission, higher EER, and lower heart rate at admission were all factors associated with longer stays when reviewed in a linear regression model.

These are valuable results. The authors recommend taking an individualized approach to male eating disorder patients. The authors correctly note that existing guidelines are generally not sex-specific, but the results from this study suggest that, at least in regard to refeeding, they should be.

The Effects of School-based Classes on Body Image

A community-based program delivered good results.

Body dissatisfaction affects from 25% to 61% of teens, and can lead to poor physical and mental health, including, of course, disordered eating. Body dissatisfaction is a clearly identifiable risk factor for EDs and prospectively predicts depression, low self-esteem, unhealthy weight control practices, self-harm, smoking, and high-risk drinking (*Int J Eat Disord*. 2018.5:1168). Could community-based educational programs help improve risk factors?

Yes, according to results from a recent randomized control study by Phillippa C. Diedrichs, PhD, from the University of the West of England, Bristol, UK, and her colleagues. The researchers showed a number of positive benefits from using a school-based intervention program to improve body image among adolescents (*J Adolesc Health*. 2021. 68:331). The authors' 36-month randomized controlled study was based on the model of the Dove Confident Me 5-Workshop Series for Body Confidence program. The authors' 45-minute interactive sessions were also based on an existing program, “Happy Being Me” (*Body Image*. 2013. 19:126). Importantly, the intervention was provided in the classroom by classroom teachers, which presumably greatly increases the real-world practicality of the intervention.

The authors' program included an intervention group of 848 boys and girls and a control group of 647 students who received class lessons as usual. The students in the study were from 11 to 13 years of age and attended 6 secondary schools in southern England. Students in the intervention group had a total of

225 minutes of class time, where they viewed videos, participated in exercises, and viewed creation of social media images and messages aimed at body image. The ratio of teacher to students was usually 1:20. The fifth and final lesson involved a group "take-action" project to champion body confidence in their schools and communities. Follow-ups were done at 7 points: at baseline, post-intervention, and at 2, 6, 12, 24, and 36 months.

The primary outcome was improvement in body image (body esteem). Secondarily, investigators looked at risks for body image (internalization of appearance ideals, sociocultural pressure, and appearance-related teasing and conversations). Tertiary outcomes included psychosocial well-being, including negative affect, self-esteem, dietary restraint, and life engagement. The authors pointed out that teachers only received 2 hours of training (nonetheless, fidelity to the intervention was strong at around 75%) and students were generally younger at baseline than those in comparable school-based interventions.

Improvements in the intervention group

Compared with control group members, students in the intervention group showed improvement in body esteem and appearance-related teasing at the 6- and 12-month follow-ups. The primary outcome of body image and secondary outcomes of self-esteem and teasing (among girls) were promising, and students reported being happy with the program. At two schools, retention levels fell at the 24- and 36-month follow-up: those schools chose not to give up school time for research purposes and dropped out of the program. Another reason given for leaving the program was conflict with other school activities. There seem likely to be challenges facing any sort of in-school intervention, though, and they highlight challenges in follow-up after research rather than the impact of the program.

The authors note that the intervention showed improvement in girls' and boys' body image that lasted for as long as 6 months, the longest of any prior teacher-led body image interventions. They concluded that shifting interventions to community- and school-based programs such as theirs could help improve adolescents' body image. Clear practical strengths of this approach are the modest dose of intervention and the fact that it was helpful when delivered in a real-world setting by people with limited specific training.

QUESTIONS AND ANSWERS: Evaluating Rapid Symptom Changes after CBT

Q. I hope you can help us. A 30-year-old patient with bulimia responded very quickly to cognitive behavioral therapy (CBT), but then over time we began to notice increases in his symptoms. I have always considered a good early response as a predictor of good long-term outcome, so this caught me off guard. What could have caused this? (*L.G., Dayton, Ohio*)

A. There may be more complexities to consider with early response during treatment. While CBT for BN can be a very effective tool for persons with very irregular eating when they are first seen, it might lead to poorer long-term outcomes for those not using significant dietary restraint between binge eating/compensatory episodes, according to a study from Drexel University, Philadelphia (*Eat Weight Disord*. 2022. doi: 10.1007/s40519-021-0138-5. Published online before print). This study analyzed response patterns in 56 people with BN in more sophisticated detail—not merely a yes-or-no early treatment strong response. In particular, binge eating, compensatory behaviors, and regular eating were all considered.

The Philadelphia authors found that more nuanced classification of outcome response patterns provided better prediction. Six-month follow-up remission was significantly less common among patients with the medium-level binge eating decrease class compared to other classes.

They concluded that identifying a patient’s trajectory of change might help develop personalized interventions to improve long-term outcomes. And, although it is tempting to predict that rapid and seemingly positive changes in ED behaviors is a sign that treatment will always lead to long-term improvement of individuals with BN who are being treated with CBT, this early improvement may subside.

The study findings suggest the need for more individualized approaches based on more fine-grained consideration of treatment response. Will personalized treatment improve long-term outcomes? Time will tell, but this case is a reminder that personalized treatment approaches should be evaluated among individuals at risk of poorer long-term outcomes.

—SC

IN THE NEXT ISSUE

Internet-based Cognitive Behavior Therapy

By Nilma Hamid, MPsc

COVID-19 has accelerated the use of telemedicine and Zoom programs. Cognitive behavior therapy (CBT) is the primary therapy for EDs in adults, but patients may face barriers such as geography, cost, and availability of treatment. Internet-based CBT, or ICBT, offers a number of advantages for clinicians and patients, including an alternative to delayed intervention.

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