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Transitioning to Adult AN Services

Three studies identify barriers to AN patients, healthcare professionals, and parents.

At some point during treatment, sometimes at a pre-specified age, a patient with anorexia nervosa becomes eligible to transfer to adult services. Care handoffs of this sort are problematic in many areas of medicine, and this has led to recommendations intended to improve the process (including one from Britain's Royal College of Psychiatrists on this very topic). The transition can be smooth, but at times is not, according to Dr. Anthony P. Winston and his colleagues at Aspen Centre and Coventry and Warwickshire Trust, Warwick, UK.

Dr. Winston and his team note that problematic transitions can result in dropout from treatment, interrupted treatment, and avoidable re-admissions to the hospital. The British group also found that only a few services are available that refer child and adolescent patients in mental health services (CAMHS) to specialist adult services. They theorize this may be due to the relatively small investment in adult services in Great Britain (*BJ Psych Bulletin*. 2022 doi:10.1192/bjb.2021.109).

Dr. Winston and his team distributed a self-report questionnaire designed to establish how many child and adolescent teams actually met the Royal College of Psychiatrists' recommendations for managing transition between the youthful treatment centers and adult services for eating disorders. The authors distributed the Royal College recommendations to 70 teams in England that provide eating disorders treatment. Thirty-eight services agreed to participate in the current study.

Age at transition

Among the participating centers, 97% had a fixed age limit for treatment transition ranging from 16 to 25 years of age, with 18 being the most common age. Most CAMHS centers set their transition boundary to match that of the anticipated adult service. Slightly more than half of the young patients went to specialist ED services, and the remainder were transferred to community health care teams. Slightly more than half of the CAMHS centers had a transition protocol specifically designed for young people with EDs, and 68% had a generic protocol for all young people being transferred to adult services. Twenty-eight services reported having active discussions with the adult service, beginning at least 6 months before the planned transition.

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How services blended

The authors also found a wide variety of therapeutic interventions between the CAMHS and adult treatment centers: 97% of the CAMHS participants reported differences in therapeutic models/orientation

between their protocols and the adult services. Half of the CAMHS services had a family-focused approach, whereas the adult services focused more on the individual patient. Most of the CAMHS centers (71%) reported having a good understanding of the adult services. (However, the authors noted that many centers did not answer this question.)

Timing the transition

Thirty-one (88%) of the services reported that the timing of the transfer depended on the young person's needs. Twenty-nine CAMHS centers reported they could delay the transition, and half reported that the transition time could be moved forward when the young patient was in crisis. Slightly more than half of the centers had a written protocol for this.

Gaps in service

The authors found that the CAMHS services did reasonably well in terms of identifying the young patients' individual needs in advance. Many reported that the transition included working with adult services to manage the transfer prior to the actual move. However, the authors also found that 22% of the services did not use individualized transition forms, and 26% failed to provide transitional support for the family and caregivers. Most did offer the services of a transition coordinator to help the young person during the change to the adult center. Because coordinated care is very difficult to maintain with an interruption in services, the authors were concerned to find that nearly 24% of services reported a discrepancy between the time at which CAMHS services ended and adult services began. This only increased the chances that young people would lose contact with ED treatment services.

The authors noted that this fragmentation also made it impossible to start interventions such as the Episodic Rapid Early Intervention for Eating Disorders, or the FREED program [see "A Promising Program for Emerging Adults with EDs," in the May-June issue of EDR].

One important thing to note was that only a few services reported that their young clients are always transferred to a specialist adult ED service. Instead, patients were referred to a generic service, presumably based on the perceived severity of the ED.

Some of the limitations of the study were that it surveyed only services in Great Britain, and the overall response rate was only 58%, which might be a source of bias, say the authors. It also might have been helpful to have data from a wider viewpoint, from adult ED services and from the viewpoints of parents and patients.

Two Norwegian studies echo barriers to the transition process

Two studies from Dr. Veronica Lockertsen and colleagues in Oslo, Norway, analyzed the experiences of mental health professionals and parents of patients with AN who moved from CAMH services to adult services (*BMC Health Services Research*. 2020. 20:890; *J Eat Disord*. 2021. 9:45). Many of the problems came from less-than-ideal communication between healthcare professionals at CAMH centers and those at adult treatment services.

In recorded interviews and through focus groups, mental health professionals reported four main barriers to the transition process: (1) parents were included to differing degrees at different centers; (2) mistrust between CAMHS and adults services created a lack of collaboration and predictability for the transfer; (3) clinicians reported a lack of self-confidence among professionals, which affected continuity of care; and, finally, (4) there was a lack of trust between services and/or not enough focus on building a new alliance, leading to a negative effect on patients with AN.

Parental barriers

One problem in the transfer involved parents, who are recognized as an important part of CAMH programs and theoretically should be involved from the first meeting on. Some of the adult treatment

services had few resources and thus less time to include parents. Also, some centers found it hard to prioritize collaboration with parents and also felt insecure about how to use information provided by parents. And, after age 18, patients frequently choose not to include their parents in their treatment. This put professionals in a difficult position and, as one noted, “when parents aren’t included, they don’t manage and back off.” One answer to this was to emphasize the importance of the patient’s level of maturity and his or her readiness for treatment in an adult center. However, when so much responsibility was given to the patient too rapidly, relapse often followed. When too much emphasis was placed upon autonomy and voluntary treatment, some patients reported just “wanting to be alone with my symptoms.”

Professionals also reported feeling a lack of trust between their patients and themselves. Even though both professionals and patients work closely and collaborate during transition, CAMH professionals felt uneasy about transferring a patient after working so long with him or her. To make the transition easier for professionals and patients, the authors suggest that professionals at CAMH centers and adult treatment centers develop a written list of procedures.

What parents needed

In their second study, Dr. Lockertsen’s team found several challenging areas reported by parents. Parents have an important caregiving role, which changes when their children enter adult services. For example, in the CAMH programs, parents are responsible for meals and weight restoration; however, in adult treatment, the patient has responsibility for these areas. Often, both patients and parents are not prepared for these changes in responsibilities.

The parents listed several areas they would like to see improved during and after the transfer to adult services. First, the discharge from CAMHS to adult services often seemed extremely abrupt for parents. Second, parents reported that the lack of continuity was often followed by deterioration of and relapses in their child. The lack of involvement and information was distressing to the parents. In addition, parents needed more knowledge about the ED and the transition to adult care, and felt this was important for developing a trusting relationship between them and the clinicians at adult care facilities. Finally, the parents felt overwhelming, multifaceted responsibilities and felt they needed professional support. Strong emotions, fear, and frustration were common among the parents.

Just as in the earlier study of healthcare professionals, knowledge was a very important part of the transition process. The authors note that clinicians treating AN patients in transition need to balance the patients’ needs for independence with the degree of parental involvement in treatment. Somehow, while parents need to be informed and to have professional support, young AN patients need to continue developing autonomy and independence in adult treatment.

Dr. Lockertsen and her team recommend that the clinicians involved with the transition consider the important role parents have as a secure center for adolescents at this turbulent period in their lives. “Establishing family support within healthcare services could decrease the negative aspects of caregiving during the transition period,” they write.

What do we take from this work?

Several themes emerge from these studies. First, the UK study suggests that it is possible to create a thoughtful program. In reality, actual use of the program varies. Second, team communication seems paramount, but can be difficult to do well. Third, the change to a new treatment team often occurs around a time where patients with AN experience new autonomy. The involvement (and decision-making ability) of the family can drop significantly. These studies plus clinical experience shows this brings many challenges and frustrations.

From Across the Desk

From Transition to Adult Care to Treating the Vegan Patient

Transition is often hard, particularly moving from adolescence to adulthood. This can be especially difficult for older teens with AN who are receiving inpatient care and must move to adult care facilities. Moving to a new facility is a problem encountered throughout health care, and eating disorders treatment is no exception. In this issue, "Transitioning to Adult Services," highlights guidelines from British and Norwegian authors to make the move easier for patients, healthcare professionals, and parents alike. One area for improvement is recognizing the changing role of parents in the transition.

In another study, even with all the tools and tests available, researchers discovered there was no rapid screening method for uncovering EDs in pregnant patients. See "A New Screening Tool Identifies EDs in Pregnant Patients." The study shows how a rapid test using only 12 questions can be easily added to the patient's workup.

One common question is the long-term impact AN can have on the heart, such as loss of heart muscle thickness, changes in how the heart contracts, and altered electrical conduction. A Question and Answer item in this issue addresses just this. Look for "Long-Term Effects of Anorexia Nervosa on the Heart."

Finally, some clinicians treating patients with restrictive eating disorders may encounter unsuspected problems with patients who identify themselves as "vegans." See "Vegan Patients and Restrictive Eating." This article offers helpful hints on how these individuals can become more involved in their own treatment.

— MKS

Update: Seeking the Brain's Role in Binge Eating

The brain's prefrontal cortex is the site for many executive decisions, such as focusing attention, predicting the consequences of an action, controlling impulses, managing emotional reactions, and coordinating complex behaviors. A team at the Icahn School of Medicine at Mount Sinai, New York City, is investigating the role the prefrontal cortex plays in women with BN and severe loss-of-control (LOC) binge-eating. Their goal is to better understand the neural mechanisms that might explain why some individuals cannot stop taking one more bite or sip during binge-eating episodes.

Dr. Barbara A. Berner and her colleagues used a new portable brain imaging technique, functional near-infrared spectroscopy (fNIRS), to measure activity in the prefrontal cortices of 23 women with BN and 23 healthy controls. The measurements were made during two tasks, a go-no-go task requiring inhibition of eating responses and a standard go-no-go task requiring inhibition of button-pressing responses.

Women diagnosed with BN made more errors on both tasks. BN subgroups with the most severe degree of LOC eating (n=12) and those who felt most strongly that they binge ate during the task (n=12) had abnormally reduced bilateral ventromedial prefrontal cortex and right ventrolateral prefrontal cortex activation associated with inhibition of eating responses. Reduced prefrontal cortex activation may directly contribute to more severe eating-specific control deficient in BN. For the first time, according to Dr. Berner, "this method has allowed us to measure what is happening in the brains of people with BN when they are trying to inhibit their eating responses but cannot." The authors believe their findings point to the areas in the prefrontal cortex that might be useful targets for treatment in LOC binge eating.

A New Screening Tool Identifies EDs in Pregnant Patients

The goal was developing a rapid, nonthreatening test.

Despite the many screening tools available for pregnant patients and for people with eating disorders, one has been overlooked. Until now, a method for rapidly screening pregnant patients for an underlying eating disorder has been lacking. Eating disorders are common during pregnancy. Existing screens are either undesirably long (in the case of the SCOFF test) or may yield false-positives among those who are pregnant. Now, a rapid screen for detecting EDs has been developed by University of West Virginia researchers. Using only 12 questions, the test can reliably and sensitively identify EDs across all trimesters.

As described in a recent article by Dr. Elizabeth A. Claydon and researchers at the West Virginia School of Public Health, Morgantown, WV, the Prenatal Eating Behaviors Screening, or PEBS, tool provides a sensitive, quick, and specific test clinicians can use to identify possible EDs in pregnant patients (*Arch Womens Mental Health*. 2022 . doi.org/10.1007/s00737-0022-1230-y) .

A shorter, language-appropriate test

The authors developed a series of questions taken from existing sources, such as the EDE-Q and SCOFF questionnaires, as well as from their own prior work, and designed the test to include appropriate language for women throughout their pregnancy. Content expert review ensured that the questions addressed AN, BN, BED, BN, and eating disorders not otherwise specified, or EDNOS. As part of the survey, participants were asked if they had ever been diagnosed with an ED.

Keeping the test brief and to the point

One of the challenges for all screening tools is brevity, and to that end the authors shortened their original 25-item questionnaire to 12 questions. In the developmental sample, 190 women were identified, most of whom were 25 to 34 years of age, married (n=164), white, 140; 74.4%), and had private insurance (n=129, or 68%). The mean week of pregnancy among the women was 19.26 weeks, reported by the individual patient (first trimester, weeks 4-13; second trimester, weeks 14-27; and third trimester, weeks 28-40).

Mothers with Active AN: Risk of Complications Can Be Reduced

It is commonly believed that women with active AN are less likely to become pregnant. A team from Townsville Hospital and Health Service, Townsville, Australia, performed a systematic review showing that women with active AN are just as likely to become pregnant as those without an ED. Women with active AN have a different profile of complications during pregnancy compared to malnourished women and women in various stages of starvation (*J Eat Disord*. 2022 10:25).

Dr. Jeremy Ryan Pan and colleagues recommend that clinicians have an early discussion with patients with AN about fertility and complications that can occur during pregnancy. This may help improve physical and psychological symptoms of AN as well as nutritional deficiency during pregnancy, and to ensure adequate caloric intake and the well-being and general health of the mother and infant. They also recommend a psychiatric follow-up after birth for mothers with AN because AN symptoms can also appear during the perinatal period.

Women who scored at least 39 points on the shortened screening tool were nearly 16 times more likely

to have a diagnosis of an undetected ED than were women with lower scores. The American College of Obstetricians and Gynecologists states that their healthcare providers “should be comfortable screening and recognizing patients with EDs.” The authors suggest that a “professional expert” make the final diagnosis (ACOG 2018). The goal of the authors’ study was just that, to help primary care clinicians detect EDs and to refer the pregnant patient to an ED expert for further care.

The authors noted that their study was limited because their sample included only English-speaking participants, and convenience samplings were used. The data collected for the development and validation sample was conducted at slightly different time points, but within a few months of each other (and a notable strength is the provision of extensive psychometric data).

Future research

This is a valuable new screening tool. The next steps identified by the authors are to distribute informational booklets on how to use the PEBS tool and to develop PEBS translations so it can be used in more diverse populations.

Night Eating Syndrome Combined with BN and BED

One study searched for connections to personality profiles.

The DSM-5 outlined a specific group of symptoms of the night eating syndrome, or NES, and assigned it to the category of other specified feeding or eating disorders, or OSFED (*DSM 5*. 2013. American Psychiatric Publishing, Washington, DC). This pattern can cause significant distress and or can affect general functioning (*Ann NY Acad Sci*. 2018. 1411:96). NES has been found to be a risk factor for earlier onset of obesity and is related to higher-than-usual rates of depression and lower self-esteem (*Int J Eat Disord*. 2009. 42:720).

We still know relatively little about night eating syndrome, at least compared to what we know about BED or BN. This is striking, in that Albert Stunkard actually described night eating a few years before he first described binge eating (and of course, both were described 20 or more years before BN). Two recent studies help to further explain and illuminate NES.

Searching for personality traits in women with NES, BN, and BED

A team headed by Natasha D. Melunsky at University College, London, and her colleagues in Christchurch, New Zealand, analyzed an outpatient psychotherapy trial of 111 women with BN or BED to see if personality disorders were associated with NES symptoms (*Eat Weight Disord*. 2022. 27:803). The authors noted that little research is available that has measured any associations between personality traits and NES. Pre-treatment measures of personality traits were measured with the Temperament and Character Inventory-Revised and night eating symptoms were recorded with the Night Eating Diagnostic Questionnaire (www.researchgate.net/publication/319186992). Regression analysis was used to test for associations between the two variables of night eating and BN or BED, and adjusted for age, ethnicity, and other variables.

The authors reported finding associations between high harm avoidance, low self-directedness, and increased NES symptoms. The authors feel that there is a need for greater knowledge of the influence of personality traits in NES in persons with EDs. Future studies and longitudinal research may help clarify which personality traits are associated with NES and also to validate low cooperativeness in those with and without comorbid EDs.

Night eating, obesity, and BED

In a second study, Dr. Jasmine Kaur and colleagues at the University of Melbourne performed a systematic review of studies of people with NES, including only studies that were published since 2013 (after the DSM-5 categorized NES) (*Front Psychol.* 2022. 12:766827). No sociodemographic correlates associated with NES could be shown. However, those with NES had elevated ED pathology, including emotional eating, loss of control eating, and a higher occurrence of depressive symptoms compared to controls.

The review suggested that the presence of body concerns and binge-eating episodes were hallmarks distinguishing BED from NES. As a result of their findings, Dr. Kaur and colleagues recommend studying NES as an independent entity, to further establish its diagnostic criteria and treatment options.

How Has the Pandemic Impacted ED Symptoms?

A mixed but worrying picture emerges.

The COVID-19 pandemic has posed a number of risks for those with EDs. The risks include limited access to support networks during the lockdown, which might lead to reduced motivation to recover and worsening symptoms. Also, increased use of social media can lead to greater exposure to unhealthy body images, negative stories, and stressful local and national news. During the quarantine, a team in Australia sought to define how the COVID lockdown affected ED patients. As the authors pointed out, patients were exposed to increased anxiety, isolation, and depression. Increased access to food and irregular food patterns also increased the risks of an ED.

This has been the subject of a remarkable amount of study. Dr. Yunqi Gao and researchers at the Centre for Research on Ageing, Health & Wellbeing in Acton, Australia, analyzed epidemiologic studies before and after the main epidemic to learn how the COVID-19 epidemic was affecting ED patients (*J Public Health.* 2022.<https://doi.org/10.1007/s10389-022-01704-4>).

The inclusion criteria included epidemiologic studies of patients with diagnosed EDs and reported changes in ED symptom severity (either self-reported or through medical records) before and after the lockdown. Studies were excluded that featured populations without a primary diagnosis of EDs or those that did not include a comparison of ED symptoms before and during the lockdown. From an initial group of 132 articles, 21 potentially relevant studies were reviewed in full, and 11 studies were considered eligible. This is an impressive number of papers to be conceived of, written, and published in a 2.25-year period.

First results

Dr. Gao and colleagues found that during the lockdown women and younger patients were most concerned about their body image and appearance, had more difficulties regulating their eating, and overall were at greater risk of worsening ED symptoms. All the studies concluded that the pandemic lockdown was associated with a worsening of EDs, and led to higher levels of anxiety and depressive symptoms.

The severity of ED symptoms fell back to normal levels during the transition from lockdown to re-opening. However, some study participants reported relief of some symptoms during the confinement period; this was especially true among patients with AN. The possible explanation was that these patients continued to receive internet-directed therapy during the lockdown. The restrictions may also have led to more stable family relationships and fewer social stressors, reducing symptoms of AN.

Social isolation

The stay-at-home orders worsened social isolation and loneliness. Most study participants, except for essential workers, had to work from home or were unemployed. Numerous authors, including Branley-

Bell and Talbot (J Eat Disord. 2020. 8:44), have written that spending time with friends and relatives can be an important source of motivation in the recovery of patients with EDs.

Another major problem for ED patients during lockdown was reduced access to in-person face-to-face treatment (*Eur Eat Disord Rev.* 2020. 28:86). Although some patients received online treatment (with teletherapy and videoconferencing) during the confinement period, they stated that online support could not replace the traditional support mechanisms of face-to-face treatment. During the COVID-19 pandemic peak, some psychiatric wards were downsized, closed, or converted into wards for coronavirus patients. ED patients experienced treatment suspension, cancellation of non-essential treatment, and reduced availability of hospital beds when needed.

Dietary restrictions

The lockdown measures placed restrictions on normal movement, and thus influenced the access to food. Robertson et al. reported that such a lockdown can affect people's eating patterns and body image (*Appetite.* 2021. 159:105062). Most participants had irregular eating patterns and experienced worsened ED symptoms during the COVID-19 outbreak (*Psychol Health Med.* 2020. 1-8. <https://doi.org/10.1080/13548506.2021.1883687>).

These authors' findings align with those from a previous study demonstrating the association between dietary changes and increasing ED symptoms (*Psychol Bull.* 2004. 130(1). <https://doi.org/10.1037/0033-2909.130.1.19>). Lockdown might lead to food restrictions, unhealthy eating habits, depression, and anxiety symptoms, and might result in increasingly disordered eating symptoms.

Therefore, the combination of a health crisis (COVID-19 pandemic), social isolation (enforced lockdown), and negative emotions could lead to worsening ED symptoms and general psychopathology (anxiety and depression).

On the other hand, some positive results occurred as restrictions were lifted.

Some improvements may be seen as the pandemic's grip loosens. For example, Fernández-Aranda et al. (*Eur Eat Disord Rev.* 2020.28:239) saw a significant lessening of ED symptoms among AN patients after restrictions were lifted. A possible explanation for this phenomenon is that patients were able to access support from internet-delivered therapy or could follow their pre-COVID treatment plan. Living with their parents may have increased social support and improved and strengthened personal relationships (*Int J Eat Disord.* 2020. 53:1780). In addition, during the period of isolation parents might have had a better opportunity to supervise their children and teens' diets.

Further study is needed over the continued evolution of the pandemic and post-pandemic period to learn more about the risks and course for those whose EDs worsened during the pandemic (or did not worsen, which might be informative in different ways). We also need to understand what to expect for those who had the onset of an ED during the pandemic.

QUESTIONS AND ANSWERS: Long-Term Effects of Anorexia Nervosa on the Heart

Q. We don't hear much about the long-term effects of AN on the heart. Is there any new information? (C.B., Sacramento, CA)

A. We know that medical problems and high risk of death are important parts of AN, and a substantial part of those risks seem to be related to heart problems. Short-term studies in adolescents with AN have shown numerous cardiac changes. In the short run, some of those problems seem to diminish with treatment. What happens over longer periods?

A recent study that followed AN patients first diagnosed as adolescents and then revisited them 20 years later gives us some answers. Flamarique and colleagues (J Eat Disord. 2022. 10:22) reported on a small sample of people who had AN as adolescents. The study included 29 people who had had AN and 30 matched healthy comparison participants, and follow-up occurred an average of 22 years after entering treatment. The mean age when the patients were first seen was 13.58 years, and the mean BMI at that time was 15.9 mg/kg².

Low weight and cardiac structural abnormalities were important clues to underlying cardiac problems. The main measures used were an electrocardiogram and an echocardiogram to assess the electrical function and structure of the heart. At follow-up, 18 of the 29 AN patients were in full recovery. However, 4 patients had AN; 2 had atypical AN; 2 were diagnosed with partially remitted AN; and 2 had atypical BN. Patients with AN diagnoses had decreased dimensions and mass of the left ventricle and left atrium.

The results showed that the hearts of those who had fully recovered were indistinguishable from the controls, who had never had an ED. In those who remained at low weights, some structural changes persisted, but ECG abnormalities were not noted.

This study is small, and in that sense, conclusions should be preliminary. But it is clinically useful (and reassuring), in that it provides evidence that recovery reverses physical complications of AN and (one would presume diminishes risk over the long term).

— SC

Vegan Patients and Restrictive Eating

Nutrients of concern include vitamins B12 and D, iodine, selenium, and omega-3 fatty acids.

It is of course common to encounter people with EDs who restrict certain foods from their diets, such as dairy products or meats. ED screening tools may not be able to differentiate between dietary restraint due to veganism or vegetarianism and restraint due to an ED. Thus, clinicians treating people with restrictive eating disorders may encounter unsuspected problems among vegans who identify themselves as vegans or vegetarians.

There is a well-known link between vegetarianism and eating disorders (*Appetite*. 2012. 58:982). To learn how common veganism is among ED patients, Dr. Sarah J. Fuller and her colleagues at the East London NHS Foundation Trust, Schoen Clinic, Birmingham, UK, performed a “flash survey” to learn how many patients receiving specialist treatment self-identified as vegans on admission to adolescent or adult care centers (*BrPsych Bulletin*, doi.org/10.1192/bjb.2021.37). Sixty-five specialist services, representing 1008 ED patients, responded to the survey. In the adult services, 11% of patients and 6.4% in day hospitals identified themselves as vegans.

Two key questions clinicians should ask when trying to distinguish if an individual is following a vegan or a vegetarian diet are, first, Are ethical choices being reported in non-food aspects of life, such as in clothing, toiletries, and use of free time? Second, has the dietary restriction increased, for example, did it start with healthy eating habits, then evolved into vegetarianism, and finally to veganism?

Refeeding and veganism

A vegan diet becomes an increasing concern when refeeding is needed. While a vegan diet is not a risk factor for developing the refeeding syndrome, vegans may have to consume a larger amount of food to

maintain healthy vitamin levels, and delayed gastric emptying may lead to bloating and abdominal pain. The authors note that many vegans will accept some foods that contain a minimal amount of animal products, such as a soya-based enteral feed in which the only non-vegan ingredient may be a vitamin such as vitamin D. Currently key nutrients of concern with these restrictive diets are vitamin B12, vitamin D, iodine, selenium, and omega-3 fatty acids. Close monitoring is advised because people with a restrictive eating disorder may not consume enough quantity and variety of foods, and as a result may become nutrient deficient.

Respecting legal rights

In Great Britain, veganism is classified as a nonreligious belief protected under Article 9 of the European Convention on Human Rights (the right to freedom of thought, conscience, and religion). According to the authors, treating someone with AN involves balancing respect for the person's religion or beliefs while at the same time making sure they aren't discriminated against in treatment. For example, in most treatment centers there is an overall lack of vegan sip feeds and enteral feeds. In some lifesaving cases, the person may accept non-vegan treatment options. If the patient refuses or is incapable of accepting enteral feeding, legal advice should be sought.

According to the British Dietetic Association's Mental Health Specialist Group, in some cases veganism can actually help patients recover from an ED by helping them discover new foods and new ways of cooking. This may even change the way they perceive the culture of veganism. In contrast, it may also be an opportunity for a person with a restrictive eating disorder to maintain that very disorder (Appetite. 2012. 58:982).

Dr. Fuller and her team note that, wherever possible, treatments for people with EDs should be person-centered, and dealing with a vegan patient offers a chance to adapt meal plans, offer appropriate dietary supplements, and help such people become more involved in their own treatment. The authors predict there will be far more research into this growing trend of "healthy eating" and concerns about animal welfare and the environment.

When Virtual Care Is Necessary

A Canadian Consensus Panel issues guidelines for virtual treatment of children, teens, and emerging adults.

A Canadian Consensus Panel has developed information and guidelines for using virtual treatment for children, teens, and emerging adults with eating disorders (*J Eat Disord.* 2021. 9:46). The context was that during pandemic care, but of course, virtual treatments have the potential to address longer-term access care issues as well.

Dr. Jennifer Couturier and colleagues at MacMaster University, Hamilton, Ontario, Canada, first used scoping review techniques to examine databases from 2000 to 2020, and then evaluated information from a panel of individuals across Canada to develop their guidelines focused on virtual interventions for children, adolescents and emerging adults with eating disorders and their caregivers.

Telehealth is a promising alternative for delivering outpatient care, but the review panel identified some of the challenges of virtual treatment of those with eating disorders. One of the strongest recommendations was that in-person medical evaluation for children, teens, and emerging adults with eating disorders continue.

The panel reviewed the existing evidence based for other interventions. Based on that, Internet CBT-based guided self-help resonated best among emerging adults with AN, BN, BED, and EDNOS received

strong recommendation; so, too, was Guided Parental Self-Help CBT. Weak recommendations, based on the evidence base, were made for a number of other interventions including MANTRA, telehealth FBT, use of apps for support, caregiver interventions, and moderated forums.

Some reports have shown that adults with AN, BN, and BED in the US and Netherlands are concerned about the quality of virtual ED treatment during the pandemic, feeling that this is “somewhat” or “much” worse than usual care (*Int J Eat Disord.* 2020. 53:1780). There also is a reported ambivalence among ED patients about video calls. They can experience heightened self-criticism, and awareness of bodily appearance, leading to a negative experience during virtual calls (*Eur Eat Disord Rev.* 2020. 28:239).

Those with EDs and their caregivers have been concerned about the lack of face-to-face accountability with virtual weigh-ins, for example, as well as worry about long-term social isolation. There also is the negative effect of social media posts and ads about inevitable weight gain related to isolation and staying at home, increasing weight concerns. For example, during the pandemic, households often had a week’s supply of groceries, which could trigger binge-eating episodes.

Countering negative views of virtual sessions

For clinicians treating individuals with EDs of any age, one suggestion was to stress that the virtual session was “business as usual,” especially for ED patients who might view the virtual sessions as second best to in-person treatment. Another suggestion was to use video call platforms instead of audio calls, underscoring the challenges associated with COVID-19 to those with EDs. Another helpful approach was using COVID-19-specific psychoeducation for CBT or enhanced CBT sessions. Another suggestion was to use a person-centered and harm-reduction approach. For those with avoidant/restrictive food intake disorders (ARFID), one suggested approach involves carefully listening to individuals, family members, and partners of those affected by COVID-19.

This review panel’s work is valuable. It provides an overview of what is known—and with how much certainty—in this area.

In The Next Issue

Highlights of the June 9-10 ICED Meeting, "Embracing Change and Extending Reach in a Transformed World."

Taking full advantage of the virtual meeting format, the meeting included workshops, guest speakers, discussions on "fatophobia," EDs at midlife, EDs among middle-aged and older patients, the status of eating disorders among men, substance abuse and anorexia nervosa, and so much more.

PLUS

- A Web-based Program for Patients with Bulimia Nervosa
- A New Look At Ketamine for Serious Eating Disorders
- Nonsuicidal injuries
- Body Image and the ‘Disappearing Body’ in Anorexia Nervosa
- And much more...

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