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Update: A Grant Will Help Promote Awareness and Detection of EDs

The movement to promote early detection and prevention of eating disorders among adolescent girls got a boost in September with a $1 million grant from the US Department of Health and Human Services (HHS) Office on Women's Health. The grant is part of HHS's effort to expand prevention and awareness of eating disorders, and thus to improve care and reduce stigma, according to Dr. Dorothy Fink, Deputy Assistant Secretary for Women's Health and Director of the Office on Women's Health.

The awards are going to programs at Washington University, St. Louis, MO, and George Mason University, Fairfax, VA. Spurred by the adverse effects of the COVID-19 pandemic, which increased barriers to care for eating disorders, the grants will address gaps in care by developing partnerships among primary care clinicians, nutritionists, and community organizations, according to Dr. Fink.

From Across the Desk

This issue is all about research and variety, ranging from dealing with long-term and complex eating disorders, which affect a fifth of persons with eating disorders, to eating disorders among men (see “More Data on Eating Disorders and Gender,” elsewhere in this issue). Another article examines new research on the effects of loneliness on intimate partner violence. We learn that the effects of the COVID pandemic continue, even as the numbers of people affected by COVID-19 seem to fall. For example, in Canada, COVID-19-linked hospitalizations and cases of anorexia nervosa (AN) have risen for Canadian children and teens.

Another article turns the spotlight on bone health among persons with eating disorders, particularly those with AN. Abnormally low body weight from malnutrition or an eating disorder affects a number of organ systems, including the musculoskeletal system, and the cardiovascular and central nervous systems. AN leads to lower bone mass in both the spine and the hip, increased cortical porosity, and reduced bone strength; the same pattern is much less marked among patients with bulimia nervosa (BN).

In an article aimed at clinicians rather than at patient care, Dr. Sandra Wartski, a frequent contributor to *Eating Disorders Review*, reminds readers to think about their own well-being in her article, “The ABCs of SOS, or Strategies of Self-Care.”

There is good news, too, as in the latest Health and Human Services awards to two universities. These awards are aimed at improving early detection and prevention of eating disorders among teenage girls. In addition, it is interesting to note that since 2013, the National Eating Disorders Association's (NEDA) Feeding Hope Fund has awarded $2 million in research grants to 20 researchers.

—MKS

Eating Disorders and Increased Risk of Fractures

Those with AN were at greater risk, regardless of age or gender.

More than 800,000 persons in the US each year are hospitalized due to falls, most often because of a head injury or hip fracture (Centers for Disease Control and Prevention; National Center for Injury Prevention and Control; https://www.ncoa.org/article/get-the-facts-on-falls-prevention). While attention is primarily directed at older Americans, a recent study showed that patients of all ages with eating disorders (EDs) are also at risk for bone-related injuries.

A number of systems are affected

Abnormally low body weight from malnutrition or an eating disorder affects a number of organ systems, including the cardiovascular and central nervous systems, and the musculoskeletal system as well. AN leads to lower body mass index (BMI, or Kg/M^2) of both the spine and the hip, increased cortical porosity, and reduced bone strength. Persons with BN and AN have less severe bone effects and lower spinal bone mineral density (BMD), but normal hip BMD. In AN, the risk is related to lower-than-normal levels of estradiol and testosterone and relative hypercortisolemia, resistance to growth hormones, and effects on other parts of the hormonal system. Women with AN also have lower muscle strength than do age-matched controls, which could also increase their risk of falls.

Swedish study casts a new light on fracture risk with EDs

A large national retrospective cohort study in Sweden revealed that men and women with EDs (total number of participants=8867; 9.4% were males) had a significantly higher risk of injury from falls and hip fractures than did age-, gender-, and county-matched controls (n=88,670). The study is by far the largest to date in terms of the number of patients, the attention to those with EDs, and the length of follow-up. It is also the first to examine fracture risk among men and women with EDs, and the first to show a statistically significant increase in risk of hip fractures among men with eating disorders, according to Dr. K. F. Axelsson and researchers in Sweden and Australia. The median age of patients and controls was 41.6 years, and subjects and controls were followed for up to 10 years (*Osteoporosis Int*. 2022.33:1347).

The researchers used national medical registers in Sweden to identify non-obese patients with eating disorders diagnosed between January 1, 1998 and December 31, 2017. The control group was assigned the same starting date as their corresponding cases, and only those without a previous diagnosis of an eating disorder were included.

Greater risk among patients with eating disorders

Major osteoporotic fractures were significantly greater in patients with EDs than in the population-based control subjects (EDs, 17.9% vs. controls, 9.7%). This was also true for major osteoporotic fractures (7.3% for ED patients vs. 3.7% for controls). Hip fractures continued the trend, showing a significant increase in such fractures among the subjects versus the controls (1.6% among the subjects vs. 0.7% among the controls). Currently there are few studies of increased risk of fractures and falls, and little data exists for men.

Patients with an ED had 1531 non-skeletal fall injuries, including 434 head injuries. The injuries occurred among both men and women of all ages. The increased risk of falling could also have been due to hypotension, arrhythmias, hypoglycemia, peripheral neuropathy, and conditions related to AN, according to the authors. To a lesser degree, the same trend was found among patients with BN. Medications such

as antidepressants antipsychotics, sedatives, and hypnotics, were also tied to falls. Curiously, the authors did not consider the possibility that being placed on medications could be a marker of greater severity of illness. In addition, there is evidence that depression is linked to osteoporosis; this, too, could partially explain the increased risk of fracture. Investigation into fall risk for higher-weight patients with eating disorders is needed for a more complete review.

A major worry

These results are a cause for major, perhaps increasing, worry. The study included those diagnosed up to 25 years ago—so, for the most part, falls affected people up to their 40s or early 50s (remember, the mean age in Axelsson and colleagues' study was 41.7 years). However, it appears that the prevalence of AN increased in the 1970s; thus, someone who developed AN at 16 years of age in 1972 is now 66 years old. The concern is that the study's results suggest that many people who have had AN and may have developed osteopenia or osteoporosis in earlier life are now reaching an age when osteoporosis is a common and important problem.

Long-Term, Complex Eating Disorders

A pathway is proposed for the 20% of patients with complicated disorders.

Many people with EDs recover, but some go on to develop what are sometimes called severe and enduring eating disorders, or SEED. While recent work has called into question assumptions about the “untreatability” of longstanding EDs, a fuller understanding of best approaches to helping those who have had their EDs for a long time is needed. A team at the Oxford Health NHS Foundation Trust, Oxford, UK, devised a program involving a literature review, in-person interviews, and focus groups with staff members to help patients find a care “pathway” to recovery and weight restoration (*J Eat Disord.* 2022. 10:128).

Dr. Megan Reay and her colleagues sought to define, describe, and support patients with long-term complex eating disorders, and to identify ways to best support them. Their three-stage approach involved 12 patients who agreed to be interviewed, and 28 staff members, from varied specialties, who participated in one of three focus groups. The interviews and focus group sessions took place in person, by telephone, or via video calls.

What the researchers found

The mean length of eating disorders among the patients was more than 19 years. Five participants (42%) were inpatients, and seven (58%) were outpatients at the time they took part in the study.

Most of the patient participants preferred the term “long-term eating disorder” rather than SEED or chronic eating disorder, and did not like the use of arbitrary cutoffs, such as using body mass index (BMI), as one criterion for recovery. Many described feeling that their eating disorder had turned into a lifelong illness that had become more complex and more complicated with time. Many also felt they had no control over their eating disorder. They wished for personalized support and age-appropriate treatment. Many reported that the disease had a large impact on their day-to-day functioning; many also had a sense, as one patient expressed, that their “life has been lost.” Many of the participants also proposed having greater access to peer support groups, and using video access when needed.

Twenty-eight staff members took part in the focus groups; most were female, and they represented a wide range of professions. Many staff members wanted more flexibility, while others preferred the current structured approach. Some recommended promoting a more hopeful message to patients. Other

recommendations included taking an individualized approach to treatment, with more patient choices in care, so that patients were not just passively receiving care without any controls. The staff members worked to prepare patients for their life after recovery and weight restoration. Other recommendations were helping patients learn to manage and maintain their weight and to improve their quality of life, as opposed to simply focusing on BMI. The need to build helpful connections outside mental health services was very clear to the patients and staff members.

A suggested pathway

The patients and ED staff participants offered a number of suggestions to improve long-term care. The authors propose that some patients with long-term illness who are not yet ready to work toward recovery might benefit from an alternate pathway that focuses on quality of life through individually centered support. The results also underscore the importance of promoting hope among patients.

Neuropsychiatric Disorders among Children of Mothers with EDs

Having an ED during pregnancy increased the risk.

Are children of mothers with eating disorders at greater-than-normal risk of neuropsychiatric diseases? According to the results of a study of Swedish mothers, the answer is Yes.

Angla Mantel, MD, PhD, and her colleagues used the Swedish Medical Birth Registry to study singleton births recorded between January 1, 1990 and December 31, 2012 (*JAMA Netw Open.* 2022. 5:e2143947). The final population-based study group included 52,878 children, 8813 born to women with eating disorders, and 44,065 matched children born to women without an eating disorder. In addition, to adjusting for shared familial factors, a cluster of exposed children with full maternal cousin comparators was identified.

The authors studied records from 1 year of age on for autism spectrum disorder (ASD) and from 3 years of age on for attention-deficit/hyperactivity disorder (ADHD). The relative risks of ASD and ADHD were assessed among exposed children, then stratified by subtype of ED and ongoing versus previous disease. ASD was defined as at least two registered diagnoses in the patient register during the follow-up period, and ADHD was defined as at least two registered diagnoses in the patient register during the follow-up period and/or dispensed prescription of ADHD-specific drugs in the Prescribed Drug Register. Follow-up started at the index age and ended at the point of outcome, for example, December 31, 2017, or death, or upon migration from Sweden.

The authors found roughly 1.5- to 2-fold increased risks in the children that could not be entirely explained by parental comorbidities or familial confounding. The risk of neuropsychiatric diseases was greatest (roughly two- to fourfold) among children whose mothers had ongoing eating disorders during pregnancy. The results underscore the importance of clinical awareness and increased support for women with eating disorders and their children, as well as the need for future research in this area.

Intimate Partner Violence

Fear of being alone and social isolation were connected to intimate violence.

Between early and late adolescence, emerging adults face important physical, psychological, and neural changes, as well as negative impacts on social function. Eating disorders can increase a perception of

loneliness, defined as a feeling of rejection or isolation by others or the lack of a social partner to lean on and with whom to share activities.

Psychologist Janire Momeñe and researchers in Bilbao, Spain, recently examined the relationship between eating disorder symptoms, fear of loneliness, and intimate partner violence (IPV) among 683 participants (mean age: 21.14 years). According to the journal *Partner Abuse* (https://www.springerpub.com/partner-abuse.html) and the Association of Domestic Violence Intervention Providers (ADVIP) (https://domesticviolenceintervention.net/), 40% of women and 32% of men report excessive abuse from a partner; 41% of women and 43% of men report coercive abuse. And, according to national samples, 0.2% of men and 4.5% of women have been forced to have sexual intercourse by a partner; 4.1% to 8% of women and 0.5% to 2% of men report at least one instance of being stalked by a partner during their lifetime.

Similarly, according to the ADVIP, psychological victimization among women is significantly associated with poorer occupational and social functioning. Psychological victimization is strongly associated with symptoms of depression and suicidal ideation, anxiety, self-reported fear, and increased perceived stress, insomnia, and poor self-esteem. Psychological victimization is at least as strongly related as is physical victimization to depression, posttraumatic stress disorder (PTSD), and alcohol use as is physical victimization. The effects of psychological victimization remain even after accounting for the effects of physical victimization.

A study examining IVP and EDs

Dr. MomeÃ±e and colleagues proposed that items on the *EDI-2* would be linked to IPV, and that this relationship would be at least partly explained by social withdrawal and fear of loneliness.

The cross-sectional survey included 683 emerging Spanish adults. Participants were mostly students (80%), with an average age of 21 years (78% female, 22% male). Nineteen percent were workers; the remaining participants (0.6%) were unemployed.

The participants completed a number of questionnaires, including the *Eating Disorders Inventory-2* (EDI-2). Fear of loneliness was assessed with the *Fear of Loneliness* scale from the *Emotional Dependency Questionnaire* (EDQ). Social avoidance was registered with the *Coping Strategies Inventory* (*Cog Ther Res*. 1989. 13:343). Received violence was measured with the *Violence Received, Exercised and Perceived in Youth and Adolescent Dating Relationships* scale. This questionnaire includes 28 items, including five violence subscales and three aspects of violence--received, exerted, and perceived.

A relationship between EDs and IPV

Fear of loneliness and social withdrawal significantly correlated with all test variables. The study's results underscored the relationships between eating disorders and IPV, and suggest that we should be examining loneliness and social withdrawal as potentially important causative factors in IPV. The authors noted that childhood abuse is also highly related to both EDs and future IPV, offering one more explanation for the connection.

The ABCs of SOS (Strategies of Self-Care): Self-Reflection for the ED Clinician

By Sandra Wartski, PsyD, CEDS
Silber Psychological Services, Raleigh, North Carolina

Clinician self-care is critical. We know this to be true, yet making time to mindfully attend to this practice

amidst a busy practice week is often put last on the commotion list. Clinicians working in the field of eating disorders in particular face a number of complex challenges and varied comorbid conditions. The work is invigorating and stimulating yet can be overwhelming and deceivingly difficult. Putting off, ignoring or resisting self-care can result in blind spots, distraction, mistakes, compassion fatigue, and even burnout. We want to avoid an emergency situation, where we are sending an emergency SOS (believed to have originated with sailors signaling for help from a vessel in distress to mean "Save Our Ship"), and instead to more regularly apply a therapeutic type of SOS ("Strategies of Self-Care").

Research into the science of self-care supports a multitude of its benefits: sustaining stamina, increasing flexibility, improving creativity, maintaining optimism, and enriching therapy. By reflecting on our own professional process with a focus on proactive application, we can begin to apply the ABCs of SOS. Let's briefly examine each of the ABC steps (Assess, Build, Continue).

A Stands for Assess

In order to take care of the caretakers, we need to assess our own status on a regular basis. Being aware of the subtle but significant changes occurring in our brain, body, and behaviors is key. Some individuals notice sleeping difficulties, concentration lapses, more irritability, increased avoidance of social activities, or changes in substance use. Assessment also can apply to increasing awareness of the barriers that stand in the way of engaging in necessary self-care behaviors. Here are a few questions to ponder:

- Are you aware of your signals of vulnerability or your "red flags" when overload is looming?
- What are your top two sources of stress?
- What most often gets in the way of actively engaging in self-care?
- Are you conscious of any conflicted feelings, greatest challenge, or most common "excuse" about self-care?
- Is there a way to make a more conscious decision to regularly tune in and assess your centered-self status?

Your self-care requires tuning in intellectually, psychologically, biologically, and somatically. Knowing when external and internal events are disrupting your sense of well-being is the first step in being able to make some changes, but such shifts are not possible if you aren't paying attention. The distinct occupational hazards that accompany work with ED clients, especially in our current pandemic world, only make this more essential.

B stands for Build

Every individual needs to explore realistic options for their SOS and to develop personalized plans for application that can be incorporated regularly, including developing practices of mindful attention to active rejuvenation and resilience routines. There are certain universal foundational factors (such as attending to regular eating, sleeping, and play), known professional elements (such as regularly engaging in peer consultation, utilizing mindful attention to optimism, and focusing on the rewarding process of recovery). Add to this dialectical dynamics to maintain (such as by taking decisive action while also being patient, stepping forward to take action but also stepping back to rest, accomplishing small steps but remembering the bigger picture). However, each clinician must also develop his or her own personalized plans for maintaining mindful self-repair. Each of us has different ways of minding the body and mending the mind, and clinicians have a varied set of diversions that can allow healthy escapes.

We alone can tell ourselves what should be in our personal care plan. A few questions can help put this in clearer focus:

- What specifically do you do to take care of yourself (what, when, where, and how)?

- What deepens and strengthens your sense of personal well-being?
- What are you doing to prevent low-grade fatigue or burnout? What are you *not* doing?
- What makes for a good workday or week? When do you feel most in flow with your work?
- What recharges your battery in terms of therapeutic work? How do you enhance your “bounce-back” capability?

Building in regular routines assures that we are more likely to do this more consistently. Just as we work hard to assist our clients in creating new and improved routines around eating and body appreciation, we, too, need to patiently do the work to add in routines on which we can more easily rely. With more mindful attention to regular self-care implementation and personalized professional adjustments, therapists and therapy are enriched.

C Stands for Continue

Just as maintaining recovery from an ED requires a set of skills that must be maintained over a lifetime in order to sustain recovery, clinicians must continue applying proactive SOS skills across their personal and professional lives. Contrary to what many experienced clinicians may believe, this is not limited to beginners who are new to the field and potentially more overwhelmed at the start. In fact, those who have been in the field longer are at greater risk for fatigue from the cumulative effects of the enormity of the work over the years. Reflecting on the changes needed over time and looking forward to the future can be helpful to consider. A few questions can be helpful:

- How has your own self-care changed over time?
- What is better in how you approach self-care, and what is more lacking?
- What are resources (internal or external) that you didn't have earlier in your career but now have in order to meet upcoming challenges?
- What do you want to do more of and less of in the coming years?
- What helps you to feel hopeful about the future?

What was rejuvenating for us earlier in our careers may need transformation. There is actually benefit to periodically diversifying our SOS portfolio because novel activities can provide freshness, energy, and new neural networking opportunities. And, by being attentive to resources we may need for the future, we are planting the seeds for continued maintenance of self-care and building in self-accountability.

Summing Up

While most of us know that self-care is a responsibility that benefits ourselves and our clients, application and systematic execution are often inconsistent. We all want to prevent burnout but don't always fully accept and commit to this goal. Given that our profession is unique in that one of the most essential “instruments” of our work is ourselves, keeping fine-tuned through ongoing self-awareness and regular bouts of mindful personal-battery-recharging across our personal and professional lifespans is imperative. And, just as importantly, taking care of ourselves is not just a good idea, it is an ethical responsibility.

Resources

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More Data on Eating Disorders and Gender

Eating disorders are a health risk for men, too.

An estimated10 million men and boys will have an eating disorder during their lifetime, according to the June 2019 issue of *the American Journal of Men's Health.* Males are largely underrepresented in ED studies, but EDs are increasingly emerging as a health risk to men. Current global statistics estimate that from 0.7% to 2.2% of men will have anorexia nervosa, bulimia nervosa, binge eating disorder or OSFED (Other Specified Eating Disorder) during their lifetimes.

Men who do seek treatment for a suspected ED often report encountering barriers to treatment for an ED. When they finally seek help for a suspected ED, they may feel marginalized, may struggle to be understood by therapists in otherwise women-dominated facilities with women-oriented treatment, and emerge feeling their specific concerns are not being adequately addressed.

A German study examines the effect of gender during treatment

To compare outcomes of eating disorder treatment among men and women, German researchers led by Georg Halbeisen, Ruhr-University Bochum, Luebbecke, Germany, designed a case-matched retrospective pre-post comparison of EDs among 200 men and 200 women with AN, BN, BED, or other specified feeding or eating disorders (OSFED) treated at their clinic.

The men and women were treated in the same setting during the same period, using the same outcome

measurements (*Nutrients*. 2022. 14: 2240). Among the men, 47 had AN, 18 had BN, and 10 with OSFED were admitted and treated more than once between January 2018 and December 2021. The final group of 200 women was drawn from a large sample of women treated at the clinic during the same time, who were then matched to male subjects by diagnosis, age, and duration of treatment. On admission, age, gender, and height were measured. Patients' body perceptions and body images were measured with the *Body Experience Questionnaire*, or FBek, widely used in Germany. Four subscales include physical attractiveness, self-confidence, accentuation of physical appearance, and physical/sexual discomfort, and insecurities and concerns about body processes.

All subjects completed the *Symptom Checklist SLC-27-plus* and the *Eating Disorders Examination Questionnaire*, and the *Beck Depression Inventory II*. Body mass index and eight weight trajectories were recorded during the study.

For two eating disorders, faster weight gains and losses were reported by men

Patients with AN were younger compared to patients with BN and BED; among all other groups, the ages were comparable. As in earlier studies of adolescents and adult males, men with AN had better weight gains compared to women throughout treatment. More improvement in ED cognitions was also seen in men with AN as compared to women.

Men with BED had greater overall weight loss compared with women throughout the treatment period. Men also had less severe ED-related cognitions and more positive body images than did women. The authors reported that the causes for this difference were also elusive, and that more and larger studies are needed. For those with BN and OSFED, the authors could find no gender differences. However, they also pointed to the relatively small number of ED patients in this group.

Should assessments and treatment apply to men and women alike?

Should men and women receive different assessment or treatment for eating disorders? According to Dr. Halbeisen and colleagues, current diagnostic methods are adequate for assessing eating disorders for men and women, and no changes are needed. However, they also point out that current assessment tools may not tap into issues of importance to men, such as muscularity concerns. They add that additional, larger-scale, and controlled studies are needed to produce more specific recommendations about treatment outcomes based on gender. However, the authors also suggest that therapists use different criteria when evaluating treatment outcomes for men and women. They add that further, larger-scale and controlled studies are needed to produce more specific recommendations about treatment outcomes based on gender.

BOOK REVIEW

Temperament Based Therapy with Support for Anorexia Nervosa
By Laura L. Hill, Stephanie Knatz Peck, and Christina E. Wierenga
(Cambridge University Press, 2022).

Numerous treatments have been shown to be helpful for people with anorexia nervosa, but more—and more effective—treatments are needed. Existing treatments have generally had good research support, but to date they have not really grown out of our knowledge base about the neuroscience underpinnings of ED symptoms. This new and highly valuable book describes a new approach based on this kind of newly evolving knowledge.

Drs. Hill, Peck, and Wierenga lay out a new approach that they have developed and tested. This will be a valuable resource for clinicians.

The Introduction provides an accessible and clear view of the concepts of temperament, personality, and character. Next, the basic neurobiological ideas underlying the treatment are described. The authors note that there is a growing evidence base for temperament-based therapy with support (TBT-S), but controlled trials are not yet available. The treatment is presented in two forms: one for “You adults” 17 to 27 years of age, and one for those with severe and enduring AN. This seems a real strength; many treatments are presented in a single form for all cases, but clinicians are well aware of the varying presentations seen in practice.

The treatment itself is described in the chapters that follow. Neurobiological psychoeducation modules are provided. Skills training and dietary approaches are laid out. The manual for TBT-S addresses a variety of “situational” factors: multifamily groups, use in different levels of care, incorporation into existing programs, approaches for those with severe and enduring AN, and so on.

Valuable appendices are also provided. These are a particular strength and constitute nearly half of the volume.

This is a valuable addition to the literature, and one that is highly readable. A particularly nice feature is that key points are summarized in a clearly marked fashion. We have learned a great deal to date about the neurobiological underpinnings of ED, and this wonderful volume provides a method to harness those findings in treatment.

Reviewed by Scott Crow, MD

COVID-linked Hospitalizations Rise for Canadian Children and Teens

The number of AN cases also rose with the pandemic.

In Canada, the COVID-19 epidemic has been linked to a spike in cases of AN among children and adolescents. As reported in other areas, there have been increases in both ER visits (Toulany A, et al. *J Adolesc Health*. 2022. 70:42) and hospitalizations (Vyer E et al. *J Adolesc Health.* 2022. S: 1054-139X). These increases were also reported in an ongoing study by Debra Katzman, MD, professor of pediatrics at the Hospital for Sick Children in Toronto and the University of Toronto. From September 1 to December 31, 2021, Dr. Katzman and colleagues saw 118 first-time hospitalizations for persons with AN. Among these patients, more than 90% were female, and 66% of cases occurred among teens 14 to 17 years of age. The remainder occurred in teens aged 11 to 13. In 49% of the cases, the reporting physicians identified the pandemic as a precipitating factor in AN onset, and in more than one third of the AN-related hospitalizations (*Medscape*. September 28, 2022).

The authors reported familiar reasons for the spike in cases: disruptions in daily routines, closure of schools and cancellation of recreational activities, loss of regular connections with friends, and loss of extracurricular and social activities. All these factors led to increased anxiety and depression and a feeling of lack of control. Compounding this were closure of outpatient facilities, long waiting lists to get into facilities that were open, and fear of the virus when going to medical offices and to emergency departments.

Anxiety and depression were present for older teens, adolescents, and preteens alike. The average age for these diagnoses among pediatric patients in Canada fell from 16 to 15 years, and the youngest age at diagnosis declined from 12 to 11 years.

QUESTIONS AND ANSWERS: Veganism's Challenge to Treatment

Q. One of my patients, a 22-year-old woman who has declared that she is a vegan, was recently admitted for treatment of AN. She has lost 15.5 lb over the past 5 weeks, and has a 2-year history of amenorrhea. Our local treatment center cannot provide a full vegan diet, and as a result she refuses to eat. Often she will only drink water. What do you suggest? (*P.L., Seattle*)

A. This can be a serious challenge. Researchers at the East London NHS Foundation Trust, UK School Schoen Clinic, in York, UK, reported a similar case. They point out that some patients with restrictive eating disorders such as AN can limit their diets in various ways, ranging from total restriction of calories to self-diagnosed dietary allergies (*BJPsych Bulletin*. 2022. 46:116). These authors provide a very useful and practical review of this topic.

(The Vegan Society defines veganism as "a philosophy and way of living which seeks to exclude—as far as is possible and practicable—all forms of exploitation of, and cruelty to, animals for food, clothing or any other purpose; and by extension, promotes the development and use of animal-free alternatives for the benefit of animals, humans and the environment.") In dietary terms this denotes the practice of doing away with all products derived wholly or partly from animals.

According to Dr. Sarah J. Fuller and her colleagues, with the right planning and consideration, a vegan diet can be well balanced and will be able to meet the nutritional needs of any vegan patient, such as yours. The key is to make certain that vegan patients eat a wide variety of foods, and to find plant-based alternatives for meat and dairy products. Some specific needs should be met and, for example, vegan patients with eating disorders should have blood tests every 3 months to measure their vitamin and mineral levels, and to make sure they are receiving adequate nutrition. The key nutrients to be aware of are vitamin B12, vitamin D, iodine, selenium, and omega-3 fatty acids.

The authors also note that it is possible to refeed a patient who is strictly observing a vegan diet. It is important to be aware that in some cases, adapting vegan diets to catering menus may result in vegans having to eat a larger volume of food, perhaps increasing psychological distress as they compare their portions with those of their non-vegan peers. It can also cause problems for patients who have delayed gastric emptying that causes uncomfortable bloating and pain.

At this time, Dr. Fuller and her colleagues point out that in Great Britain there is only one prescription supplement drink that is vegan-friendly(AYMES ActaSolve Smoothie®), but it is not nutritionally complete, and not suitable for enteral feeding. Many vegans will often accept foods that contain slight amounts of animal products. In cases where patients will not accept such an option, and if they are deemed unable to make such a decision, you should seek legal advice.

Taken in sum, it seems clear that adherence to a vegan diet introduces some challenges but does not in any way preclude successful ED treatment. It is a relatively common situation that clinicians and treatment programs should be prepared to address.

—SC

In the Next Issue

Anorexia nervosa: A 30-year outcome

A long-term study shows that the time when the disorder was diagnosed and premorbid perfectionism

played roles in outcome.

Plus

- Rethinking Anorexia Nervosa
  The identification of underlying biological mechanisms may provide both insight into extreme weight dysregulation and new possible points of entry for AN treatment.
- Managing EDS for Higher-Weight Patients
- Preadolescent Eating Disorders in the US
- And much more...

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