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Eating Disorders Later in Life

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Eating disorders are usually diagnosed during adolescence and young adulthood, but the truth is that eating disorders do not discriminate on the basis of age, sex, or race. Eating disorders may present at any age in women and men. Unfortunately, social stigma may get in the way of older adults getting the help they need.

Betsy Brenner, author of *The Longest Match: Rallying to Defeat an Eating Disorder in Midlife* (Stillwater Publications, 2021), describes her own struggle in midlife when she began to battle eating disorder thoughts and behaviors. She reports that as an adolescent and young adult she had occasional negative thoughts about her weight or food. The overwhelming amount of her midlife stressors seemed to spark the eating disorder.

There are unique issues to consider when treating a patient who is in mid- to later life. For example, older women may need help coming to terms with perimenopause and normal life cycle changes. Midlife and later life is full of transitions. Just like adolescence and young adulthood, each stage of life holds many new challenges, as an individual works to get to the next stage of life.

Women in mid- to later life may be single, divorced, unemployed, in an unhappy marriage, or be living with very few healthy support systems in place. In midlife, women seem to be constantly multitasking, and taking care of their children and families even while supporting ill or aging parents. They may work outside the home or multitask at home, all the while trying to somehow take care of themselves as an individual.

Patient Vignette: A Battle with Stress

Elizabeth, a 48-year-old female, never had any weight issues or struggles with food, diet, exercise, or disordered eating in the past. She has always coped with her anxiety by running. Within the past year, she had gotten divorced, her elderly father was diagnosed with colon cancer, and her 14-year-old son began struggling in school. Elizabeth began to increase her running distances and the frequency of her workouts. Soon she was working out nearly 2.5 hr. daily.

She was so stressed that she had little time or energy to eat, and she frequently would grab protein bars or shakes. It was not until Elizabeth passed out on a long run that she realized she really was struggling not only with stress but might have a life-threatening eating disorder.

At work, she did not have any more paid time off; she was the only one able to care for her father, and her ex-husband had moved out of state. She used all these reasons to explain why she was not able to see an outpatient therapist or dietitian. After continuing to put her work and family before her own health, her eating disorder and the stress made it difficult to function. After discussion with a new therapist, she *decided she had to make some changes in her life to survive.*

The challenge of accepting help in midlife

It is more difficult as a middle-aged individual to accept needing help. Just as with Elizabeth in the patient vignette, work, children, parents, and the daily stressors of life often get in the way. When such individuals feel life is out of balance, he or she may try to regain control through food and body issues. Many times the question remains: Do the symptoms and presentation represent a continuation of a lifelong disorder or a late-onset disease?

According to midlife eating disorder specialist Dr. Holly Grishkat, most women who struggle with later-life eating disorders may actually have had an eating disorder all their lives, even dating back to when they were young. Others might have developed an eating disorder for the first time in midlife. A history of struggling with an eating disorder in the past may predispose an individual to relapse later in life. Midlife or later-life eating disorders can cause the same emotional and physical havoc seen in younger patients. Unfortunately, the eating disorder is just as deadly for the older adult, but with it comes more embarrassment and shame, which have become the main barriers for older adults who avoid getting help (Rowel, 2020).

Triggers

Stressful life events and depression seem to be the most common precipitating events in late-onset eating disorders. According to a study by Lapid and colleagues (*Int Psychogeriatr*. 2010. 22:523), 54% of patients report that a stressful event occurred before the development of the eating disorder.

Triggers such as divorce, the death of a parent or spouse, finances, “the empty-nest syndrome,” and a visibly aging body, along with societal pressure to stay thin and youthful, contribute greatly to the stress. Due to the pressures of career, finances, and family commitments, older women find it difficult to make time for treatment. Also, later in life, women can be more set in their ways and may lack insight into the fact that their disordered eating is a problem.

Often, for both the young and older populations, disordered eating behavior becomes a top coping skill. Many older adults may isolate themselves and start using eating disorder behaviors after they have reduced social interaction with others. This behavior may also act as a way to regain power they feel they have lost due to aging. Sadly, the eating disorder may even be a slow form of suicide.

Body Dissatisfaction

One of the main risk factors for middle-aged and later-life eating disorders is body dissatisfaction. Women appear to be more critical of their bodies and compare it to their â€œthinner, more youthful, and desirableâ€ physiques. Many women in midlife and beyond may struggle to accept the varying normal body changes that occur throughout mid- and later life. The signs of aging (wrinkles, hair loss, changes in the body) begin in the mid- to late stages of life. At the same time, women live in a society that prizes thinness. Thus, the older woman may constantly compare herself not only to her more youthful self, but to many other younger women.

The fear of aging is definitely related to disordered eating, and the drive for thinness is increased in middle-age and older women. Some argue that women in their middle age to later life begin to feel more devalued by society as time goes by. This manifests as feelings of shame, grief and loss, and greater preoccupation with body image. Other women may even seek more control and attention through disordered eating.

Comorbidities

Depression and anxiety are prevalent in women with eating disorders occurring later in life. Some studies show that women with eating disorders in mid- to later life are less likely to have a problem with substance use, self-harming behaviors, and suicide attempts, but have more problems with anxiety, depression, and other mood disorders (**https://www.verywellmind.com/midlife-eating-disorders-4177137**). In addition, even if the medical complications of late-life eating disorders are the same ones underlined for early-onset eating disorders, the risk of death due to cardiovascular, metabolic, gastric and bone disorders is considerably higher among older patients.

The Impact of Hormones

Hormonal fluctuations that occur during the perimenopause can also be a risk factor for the development or maintenance of eating disorders in midlife. It is well known that sex hormones exert a fundamental role in the control of eating behaviors. Estrogens in particular reduce food intake, whereas progesterone and testosterone increase it, promoting bulimia and abdominal obesity (*Aging Dis*. 2014. 6:48).

Stigma

Unfortunately, middle-aged and older patients struggling with an eating disorder face double stigmatization. First, the eating disorder itself is highly stigmatized. Also, because it is considered a disorder of the younger population, there is further stigmatization due to the patient's advanced age. Shame may then paralyze older adults, isolating them further and preventing them from seeking help.

Patients report that when they disclose their eating disorder to their clinicians, many are in disbelief, confused, and skeptical. Also, website and treatment facilities are seen as unhelpful, as they are solely focused on younger patients. It is difficult and uncomfortable to go to a treatment center where most patients are younger than 35. Many adults in mid- or later life feel uncomfortable participating in such group sessions. Thus, many older adults are not well suited for treatments geared specifically to teens and younger adults.

Researching for help online may not be helpful, since most of the articles and research are, once again, geared to the adolescent and younger adult population. On the other hand, many of the adolescents and college-aged women cannot relate to the challenges faced by those in midlife or older. Ultimately, many women in midlife and later may feel ashamed to reveal that they are struggling with an eating disorder.

Older Men with Eating Disorders

Older men are also affected by eating disorders. Approximately 1 in 3 persons experiencing an eating disorder is male, according to the National Eating Disorders Association (NEDA; **https://www.healthline.com/health/eating-disorders/eating-disorders-in-men#Why-are-body-concerns-among-men-on-the-rise**). Men frequently present with binge eating disorder (BED) and anorexia. Older men may also have different motivations to restrict. For example, anger may be an underlying issue, possibly due to unrealized goals and expectations.

Men are typically defined by their occupations, and retirement can leave a man with a feeling of loss of purpose, which may then lead to overeating or restricting food intake. Also, due to the stigma and shame around having an eating disorder, many men will not seek help.

Sadly, some individuals may have fewer future goals for recovery because they see themselves in an end-of-life phase, and already anticipating future poor health or death. Recovering from an eating disorder can be much more hopeful for young adults, as there is a whole life ahead. These young adults have a more optimistic view

WEBSITES FOR OLDER ADULTS

- **www.aarp.org/…/midlife-eating-disorders.html**
- **www.emilyprogram.com**
- **www.ncoa.org/article/eating-disorders-dont-discriminate-on-the-basis-of-age-or-gender**
- **www.montenido.com/how-eating-disorders-affect-elderly/**

of a brighter future ahead (if they choose recovery).

Early recognition and proper treatment of eating disorders in middle- to later-age patients are essential to reduce the psychosocial and medical impact of the disorder and to improve the patient's quality of life. It is essential for them to find a treatment program or therapist they feel they can trust.

Eating disorder recovery is always possible, especially in a treatment program that addresses the specific needs and challenges uniquely faced by older women and men. Many think that they can magically grow out of eating disorders when they leave adolescence. Nothing could be further from the truth.

Suggested Reading

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The Author

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Kirsten Book is a dual board-certified family nurse practitioner and psychiatric nurse practitioner who specializes in treating adolescents and adults struggling with eating disorders, substance use, and co-occurring disorders. She has an outpatient private practice in Chicago and is the Medical Liaison for iaedp. She often speaks at local schools to help educate adolescents and staff about eating disorders prevention and treatment.

Update

The recently released new eating disorders treatment guideline issued by the American Psychiatric Association (APA) provides suggested approaches to treating patients with eating disorders.

The American Psychiatric Association Practice Guideline for the Treatment of Patients With Eating Disorders (**https://psychiatryonline.org/doi/10.1176/appi.books.9780890424865**), 4th edition, replaces guidelines not revised for some time, and the new edition is welcome. These can impact coverage decisions by payors and, presumably, treatment decisions by treatment providers, so they are of importance to the field. The guideline writing group was headed by chairman Catherine Crone, MD, and colleagues (*Am J Psychiatry*. 2023. 180:167).

The new recommendations begin with the suggestions for the physical examination, including assessing vital signs, including temperature, blood pressure, orthostatic pulse, and orthostatic blood pressure.

The APA breaks down the approach for anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED), noting that the many studies of eating disorders they evaluated neither examined data separately for subgroups nor excluded patients with comorbidities. The new guideline emphasizes culturally appropriate and person-centered treatment plans, including medical, psychiatric, psychological, and nutritional expertise, ideally using a multidisciplinary team.

For AN:

Adults: the guideline recommends eating disorder-focused psychotherapy aimed at normalizing eating and weight maintenance, restoring weight, and addressing psychological factors such as fear of gaining weight and body dysmorphia. For adolescents and emerging adults, the APA recommended family-based approach and caregiver education focused on normalizing eating and weight maintenance eating and weight maintenance as well as weight restoration.

For BN:

Adults: the APA recommends starting treatment with eating-disorder-focused cognitive behavioral therapy, or CBT. In addition, the APA recommends prescribing a serotonin reuptake inhibitor, such as fluoxetine, 60 mg daily, if the patient prefers medication, or when there is little to no response to psychotherapy alone by 6 weeks. For adolescents and emerging adults: eating disorders-focused family-based treatment is recommended for those who have an involved caregiver.

For BED:

For adults and adolescents with BED, the guideline points to individual or group-based eating disorder-focused cognitive behavioral therapy, or CBT, or interpersonal therapy. Antidepressant medication, or lisdexamfetamine, is suggested for adult patients with BED who either prefer medication or who have not responded to psychotherapy alone.

The guidelines also include ethical issues in the treatment of eating disorders, as well as a listing of Internet resources, and suggested books for patients and their families. These guidelines will likely influence several aspects of eating disorder treatment in the coming years.

From Across the Desk

In each issue, we report on articles we think you will enjoy and that offer new approaches and/or techniques for treating patients with eating disorders. Some studies produce controversial results, but we try instead to find studies that produce helpful information that will aid readers in their practices. The original article can then supply more in-depth details. We also like to include links to net information and websites that might also be helpful.

In this issue, look for an original article addressing the ongoing challenge of identifying and treating middle-aged women and men at risk of an eating disorder, by Kirsten Book (see "Eating Disorders Later in Life"). Some of the barriers for older patients include shame and embarrassment, comparison with younger patients, or believing that only teens and young adults develop eating disorders. For men, reactions to signs of an eating disorder during retirement or body changes natural with aging may include restricting food intake, and overexercising. Shame may keep them from seeking help for disordered eating. Another barrier may be underlying anger.

Two bills in Colorado are nearing approval in the Colorado Senate. State Senate bills 14 and 176 are aimed at improving care, advancing prevention by establish new facilities, improving education and treatment, improving access to treatment, and restricting harmful drugs, such as diet pills. Colorado eating disorders experts reported that monthly sign-ups for support groups have increased by 1,000%, largely due to the COVID epidemic.

Finally, a newer study looks at genetic factors in those with avoidant resistant food intake disorder, or ARFID. The authors of the Swedish study state that their results show that ARFID is "among the most heritable of psychiatric disorders."

—MKS

Weight-Neutral Treatment for BED

Weight stigma also occurred in healthcare settings

Many studies and news stories have described the harm caused by teasing and bullying those with binge-eating disorder (BED) about being overweight. In a sad but and surprising twist, some patients report experiencing the same type of weight stigma from medical professionals in healthcare settings.

Dr. Meg G. Salvia from the Harvard T. H. Chan School of Public Health, Boston, and colleagues have described the results of their study of 21 women with BED (*Lancet*. 2023. 56). Their goal was to examine whether weight-neutral care might improve psychological and behavioral outcomes among women with BED.

All participants had been patients at a single specialty center that offered an intensive outpatient BED treatment program. Ninety percent of the women were non-Hispanic whites (mean age: 49 years) who had type 2 diabetes or prediabetes. The mean BMI ranged from 30.2 to 63.9 kg/m^2. The women had completed at least 2 weeks of a specialized BED treatment program, participated in an English-spoken interview, and did not have cognitive impairment or severe psychopathology that would interfere in the interview. The main outcome was the patients' real-life experiences in general healthcare settings and in a weight-neutral eating disorders treatment program.

Perceived quality of care

The reports from the women were revealing. Many of the participants believed the weight stigma they experienced in healthcare settings lessened the quality of care they received. Even as they tried to lose weight, they felt embarrassment and a sense of failure, and felt blamed for their current weight and health. In contrast, in a weight-neutral treatment setting, they named helpful elements, including consistency in eating patterns, programs that emphasized varied, adequate, and nourishing foods, specific and sufficient education about BED, and comprehensive support by healthcare professionals. As a result, they had fewer binge-eating episodes, experienced less shame, and reported having increased resiliency after treatment.

The authors were particularly concerned about the extent to which weight stigma was found in healthcare settings. They noted that research points to evidence that such negative reactions by professionals adversely affect medical care and increase medical risk.

A misleading emphasis on weight loss

Nearly all the women reported that their healthcare providers emphasized the benefits of weight loss during visits and gave overly simplistic suggestions that did not take into account the underlying factors that had led to overweight. For example, the women reported that their doctors either discounted or did not acknowledge their past attempts to lose weight. Thus, the standard advice they received included statements such as 'Well, you just need to lose weight,' 'cut the calories,' or 'exercise more.' Others felt blamed or shamed in response to such comments and interactions where lack of weight loss was often interpreted as noncompliance.

Patients felt doctors were sternly telling them they must get in control and somehow have greater willpower to lose weight. Other healthcare professionals told patients that they were at fault for their BED and were "walking strokes" or "walking heart attacks." One study participant reported that all was fine while she was doing well, but her doctor became very condescending when she slipped and regained weight—at this point the doctor told her she was wasting his time.

Having a high body weight also acted as a barrier to accessing care, according to some patients. Some described being turned away at the first examination with comments about their weight. The healthcare professional added that did not want to deal with any more overweight patients. Another physician told the patient that he couldn't help her because she was too attached to food. Some patients did not help their case by avoiding mentioning that they had BED, fearing they couldn't acknowledge to themselves that they had BED and that they couldn't get help if they mentioned having BED episodes.

In the weight-neutral care setting, what skills helped physical and mental health?

Among the helpful experiences in the weight-neutral treatment setting, the women reported having improved physical health, such as reduced binge-eating, self-control around food choices, and less shame. One of the program components that participants enjoyed most was more about the consistency of their behavior than a need to change everything about their lifestyle. It wasn't about counting calories but instead having balanced, healthy meals. Some participants were surprised but pleased that the program wasn't about "losing weight." The weight-neutral treatment approach gave them enhanced self-sufficiency, greater flexibility, and more freedom around food and decisions about eating.

Many participants reported that weight-neutral treatment helped them reduce their binge-eating behaviors during and after the treatment program. But, according to the authors, for longstanding BED, when the onset occurred in adolescence or young adulthood, it was unrealistic to expect that one treatment episode would extinguish binge-eating behavior. Some patients felt they had to return to or at least consider returning to the pursuit of losing weight. In their group of type 2 diabetics, the authors believed that a weight-centric approach can backfire, leading to decreased diabetic self-management and self-care, weight-cycling, weight regain, and worsening of physical and mental health.

This is valuable work. It emphasizes the risk of bad experiences in the medical system related to weight stigma. At the same time, it also describes that positive experiences can occur, perhaps particularly with a weight-neutral approach.

Genetic Risks and ARFID

Heritability was high among 17,000 Swedish twin pairs

The evidence for a genetic link to an eating disorder is broad and deep, but it has focused largely on AN and BN. A recent study has begun to shed light on genetic factors in those with avoidant resistant food intake disorder, or ARFID (*JAMA Psychiatry*. 2022. doi:10:1001/jamapsychiatry. 2022.4612). Children with ARFID, who are often labeled as picky eaters, are disinterested in food and have certain sensory aversions or fears about choking or vomiting. ARFID is the most common eating disorder treated in children: between 5% and 14% of children in inpatient programs, and nearly 25% of those in outpatient programs have now been diagnosed with ARFID.

The Swedish study included nearly 17,000 twin pairs. Data were collected between the ages of 6 and 12 and showed that 2% of the participants had a presentation consistent with ARFID. The extent of the risk of ARFID attributable to genetic factors vs shared and nonshared environmental factors was then calculated.

Strong heritability found

The heritability of ARFID was quite high: 0.79. The authors note that this makes ARFID "among the most heritable of psychiatric disorders." They also remarked that the use of a group of markers rather than using a more typical diagnostic method is a limitation, but the method used does seem strong, so this is likely a minor limitation at most.

These interesting results tell us more about ARFID and seem to underscore its distinction from other eating disorders. More research on risk factors for ARFID is needed and may help lead to development of further treatment.

Helping Parents Who Are Caregivers for AN Patients

The burden was hardest for mothers of patients with AN

Parents are the most frequent long-term caregivers for patients with AN, yet few studies have examined the burden of emotional distress parents may have, along with underlying and unaddressed grief. To learn more about parental stress and grief, Dr. Jeanne Duclos of the Department of Psychiatry at the University of Lille, France, and a team of French researchers studied the role of burden among parents of AN patients (*Eat Weight Disord—Studies on Anorexia, Bulimia and Obesity*. 2023. 28:16),

In their recent study of 80 mothers, 55 fathers, and their adolescent children with AN (n=84), the authors sought to explore parents' and adolescents' characteristics that may be related to parental burden and grief in AN, and to identify links between the two. Before inclusion in the Evaluation of Hospitalization for Anorexia Nervosa (EVHAN) study, all participants had been hospitalized for an acute AN episode in a specialized French treatment center for life-threatening physical and/or mental conditions related to AN. Inclusion criteria included patients aged between 13 and 21 years who were living with their parents before they were admitted for treatment. Those who had a potentially serious underlying disease, such as diabetes, Crohn's disease or other metabolic diseases, were excluded.

Along with sociodemographic and clinical data, parental grief was assessed with the Mental Illness Version of The Texas Revised Inventory of Grief (MIV-TIG) (39). This inventory is ordinarily used to assess grief at the death of a loved one. In this case, it was modified to assess grief because of a relative's mental illness, instead of death, and the loss of that person as she/he was before developing mental illness.

Burden and emotional drama

Most of the patients (94%) were girls, and the mean age was 16 years. One-fourth of the sample was enrolled in primary school; 36% were in secondary school, 7% in higher education, and data were missing for 31. A few were adopted and nearly 29% had parents who were separated. Nearly half had one sibling, 31% had 2, and 13% were only children. The mean sample had had AN for nearly 2 years, a body mass index, or BMI (mg/kg^2) of 14.3 on admission and a minimum lifetime BMI of 13.61.

More than half of the adolescents met the criteria for restrictive AN; the rest met criteria for purging-type AN. According to the results of the French study, parents can suffer from feelings of burden with emotional distress, along with high levels of depression and anxiety. Parents caring for a patient with AN may describe a sense of â€œliving lossâ€ and grief. Some may feel that they have lost their childâ€™s former self, along with their relationship with him or her, and their hopes for the future are disrupted. These feelings are particularly strong in the case of AN, where this life-threatening disease may make it difficult to be supportive to their child or to fully engage with normal life. Caregiver burden has two parts: the first is disruption of family/household life due to the patientâ€™s illness; subjective burden is subjective distress among family members.

Helpful steps that can be taken

The grief process in adolescent AN is particularly challenging and complex. The first step involves letting go of the adolescent as she/he was before the illness and of one's relationship with the "old" person of one's former dreams and expectations. Next, the caregiver or caregivers have to find a way to live with and accept the person as he or she is now. The authors found that one particularly painful task for parents of adolescents with long and enduring AN is accepting the irreversible loss of their child's normal adolescence. And, they must also work on who their child may be in the future. Parents need to know that 50% to 60% of adolescents with AN will eventually improve or fully recover. Addressing parents' intolerance of uncertainly may be very helpful at this stage of loss and grief work. "Negative uncertainty" can contribute to feelings of distress and uncertainty and undermines self-confidence and self-efficacy.

It is essential to help parents with their emotional distress. While fathers need specific help in decreasing their levels of anxiety, mothers need to be given priority, paying attention to interrelated parental experiences. Fathers’ attendance in family-oriented treatment is generally poor and tends to decrease over time (*J Clin Child & Adolesc Psychol.* 2018. 47: S56). The authors point out that society and therapists often tend to accept the fact that fathers will be absent from family therapy over time and thus reinforce their absence, conveying to mothers that they are the main agent for change and perhaps the guilty one to start with. This merely increases the mothers’ burden. It is possible to work on such cycles without blaming one or the other parent. Fathers do play an important role in their adolescent’s recovery, including ways in which their attendance in therapy is associated with improved treatment outcomes (*Clin Soc Work J.* 48:389). Both parents expressed more grief when their child's clinical state was more severe. The fathers' grief was related to their own levels of depression and anxiety, while mothers' grief was associated with their own levels of depression and alexithymia. The authors' results: mothers might be more affected by their child's clinical condition than by their own psychological condition, whereas fathers feel a higher burden related to their own anxiety. The burden was explained by grief in both parents, by anxiety in the fathers and by the child's worsening clinical state in the mother's grief.

The authors did point to several limitations of the study. One was that the study was conducted purely in an inpatient setting, which may have biased the sample toward a more severe eating disorder population. Parents of hospitalized adolescents, who could not be managed on an outpatient basis or managed it at home with little or no additional professional help, may have felt a more acute sense of distress and failure than parents who were outpatient caregivers.

They also call for larger samples of patients with both restrictive and purging AN. Larger samples are needed and may promote development and use of specific loss and grief programs for this clinical population. As a result of their study, the authors themselves were encouraged to include some components or parts of the non-death loss and grief-oriented theories in their multifamily therapy and parent group programs for adolescent AN.

Insurance Type: One Barrier to Care for Minority and Low-Income Patients

Insurance is just one of many hurdles

Diversity and equitable healthcare receive a lot of attention, and for good reasons. While access to early mental health treatment is a necessary first step toward health equity, results of a recent study showed that race/ethnicity and type of insurance were significantly associated with failure to receive care for eating disorders.

When pediatrician Ruby Moreno and her colleagues at the University of California, San Francisco, did a retrospective chart review of 1060 patients 11 to 25 years of age of diverse backgrounds, who presented to an urban adolescent medicine specialty program, they discovered that the type of insurance, public or private, strongly influenced the patient's access to further care (*J Eat Disord*. 2023. 11:10).

The study population included patients with a mean age of 16; 86% were girls or women, 55% were White, 17.7% were Latinx, and 22.2% had a prior hospitalization. The most common diagnosis was AN (38.4%), followed by unspecified feeding or eating disorder (27.6%), atypical AN (13.3%), avoidant restrictive food intake disorder (6.1%), bulimia nervosa (BN) (6.1%), other specified eating disorders (5.5%), and BED (1.6%).

The charts revealed that the assessing clinicians, all specialists in mental health or in adolescent medicine, recommended further treatment. Patients diagnosed with restrictive eating disorders nearly always were referred for family-based treatment (FBT), except when this was contraindicated by a family history of abuse or borderline personality disorder. For the young adults, cognitive behavioral therapy (CBT) was often the first recommendation, except when the patient was living at home and preferred FBT, or when a higher degree of care was needed.

Compared with patients who had public insurance, such as Medicaid, those with private insurance were 3 times more likely to receive recommended treatment than were those with public insurance. Compared with White youth, racial and minority youth were about half as likely to receive the recommended treatment.

Patients with a history of hospitalization were nearly twice as likely to receive recommended treatment as those without. In contrast, patients with a diagnosis of "other eating disorders" were half as likely to receive recommended treatment as those with AN. Remarkably, those with a diagnosis of AN were *14 times* more likely to receive recommended treatment than those with atypical AN (AAN); this is a striking finding, given that in many settings AAN appears to be the most commonly encountered eating disorder.

Other obstacles to treatment

What barriers other than insurance interfered with treatment? The authors reported that many publicly insured patients in their program were not able to access FBT at their institution or in the community; instead, these patients relied on therapists with limited experience with eating disorders and on nonspecialized individual therapy.

Minority youth often live in communities with fewer specialized medical mental health providers. The authors call for more research to identity the factors that may interfere with access to appropriate care for these youths with eating disorders. Thus, according to the authors' results, minority patients are less likely to be screened for or to receive recommended treatment for eating disorders. Insurance coverage alone cannot guarantee equity to treatment of eating disorders.

Stigma and cultural beliefs about mental health care may act as additional barriers. The possible stigma of "mental disorders" may also be at work. Data are lacking due to the historic under-recognition of eating disorders in the population of people of color. Among Latinx patients with public insurance, for example, those with AAN were significantly less likely to receive recommended treatment than patients with AN.

Provider bias may be another barrier, according to the authors. Although eating disorders occur in people of color, males and non-binary individuals are also affected, and this is being more increasingly recognized. For many years eating disorders were believed to occur predominately in White females; this, of course, has changed with time. This study also indicates that youth of color are less likely to receive recommended treatment. These findings reflect the need to examine the role of structural racism in treatment of eating disorders.

QUESTIONS AND ANSWERS

Can a Leptin Regimen Help a Teen with AN?

Q. Can you tell us more about the effects of leptin on anorexic patients? An older teen patient skips meals, picks at her food, and exercises excessively. As a result, she has a daily caloric intake of less than 450 kcal. We have tried many approaches, but none seem to make a difference. I've heard that human recombinant leptin (metreleptin) treatment might help. Can you comment on this? (*A. H., Oklahoma City*)

A. Leptin has been known to impact eating and weight for some time. Recently, results of an off-label trial showed that metreleptin (Myalept®) had helpful effects in a case of a teen with AN. German and Swiss researchers led by Dr. Gertraud Gradl-Dietsch had very promising results when they treated the 15-year-old patient with an off-label test of metreleptin. The girl, who had a number of complaints and had been hospitalized at various times, had restrictive-type AN and a body mass index (BMI) of 16.3 kg/m^2 when first seen. At home she skipped meals and picked at her food and had a self-reported caloric intake of less than 500 kcal per day. She was amenorrheic, exercised excessively, and had nighttime bradycardia (38-44 beats/minute). She reported feeling cold, tired, weak, irritable, and was depressed and had suicidal ideation (*Obes Facts*. 2023. 16:99).

She and her parents agreed to try off-label treatment with metreleptin for 9 days. The dosage on the first day of treatment was determined by measuring the patient's serum leptin level (1:16 ng/ml). Daily dosages were 3.0-5.8 mg/day, given subcutaneously at 9 am. The patient self-assessed depressive and eating-disorder symptoms using the German version of the *Beck Depression Inventory* and the *Eating Disorders Inventory*. She was asked to choose the symptom that bothered her the most, and she decided at the end of the dosing period to work to increase the number of foods she was eating. Weekly phone calls also let her name the new food she was adding to her diet. A follow-up was done 175 days after completion of the 9-day dosing period.

Results of treatment with metreleptin were quickly seen. Within 2 days of starting treatment, the patient's self-reported inner tension and depressed mood decreased. By the fourth day, the patient's BDI-II score was cut in in half; her sleep improved, and her social interactions increased. She reported having many fewer mood swings and was less likely to harm herself. Her appetite varied widely during the dosing period. Her hunger, which had been rated as between 1.5 and 4.5 before dosing, now reached a peak value of 9 on dosing days 6 and 9, then fell to 1 on three days of the post-dosing period. Her urge to vomit was markedly reduced during dosing and increased afterward; binge eating was infrequent. She stopped cutting her food into tiny pieces and ate bread again for the first time in a year. She was also able "to imagine eating once-forbidden foods."

At the final follow-up, the patient had gained almost 20 kg. She reported having a stable mood and her menses returned 3 months after treatment stopped. Her leptin levels were in a low-normal range. After 6 months, the teen had gained 15 kg.

The authors hypothesized that metreleptin impacts hunger and appetite. The case report suggests that mood was improved as well. Perhaps most interesting Ed thoughts diminished rapidly after starting metreleptin.

Metreleptin is a drug with significant side effects that have led to a specific side effect monitoring regime (Risk Evaluation and Mitigation Strategy, or REMS), and its use is still experimental for people with AN. The authors also correctly note that that randomized controlled studies are needed to better define the role of leptin and metreleptin in hunger and appetite.

—SC

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- Disgust and Self-Disgust in Treatment
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