
Eating Disorders Review

May/June 2023

Volume 34, Issue 3

Scott Crow, MD, Editor-in-Chief

Changing Body Weight Bias: Things That Hurt and Help

Sandra Wartski, PsyD, CEDS

The severe stigma and bias associated with larger bodies is well established in eating disorders literature,^{1, 2} and we are aware that the many negative consequences of such attitudes are far reaching. Eating disorder professionals are especially aware of this prejudice, for it is interwoven in our work with recovering individuals of any size. We can often feel we are waging an uphill battle with our clients as we attempt to shift attitudes about body acceptance. However, we also know this bias goes far beyond our clients—this rampant societal movement affects everyone negatively.

We may be saddened but also not completely shocked when we hear about a study of children who say they would rather lose an arm than be fat or hear of a news headline recounting a tragic ending for someone bullied due to their weight.³ Clinicians know firsthand how stigmatization and shame lead to greater - not fewer - difficulties with eating, self-esteem, mood, and overall mental health.^{4,5} Recently I was further discouraged when I heard about a new report on the Implicit Association Test results reviewing positive changes in sexuality and racial biases. Unfortunately, there were no changes in body weight bias.

New Findings on Body Bias

The Implicit Association Test (IAT) is described as a way to measure “attitudes and beliefs that people may be unwilling or unable to report.” Many individuals consider themselves unbiased and non-prejudiced, but all of us are believed to have underlying implicit attitudes about which we are unaware. Project Implicit® was founded in 1998 by three scientists, Dr. Tony Greenwald, Dr. Mahzarin Banaji, and Dr. Brian Nosek. Project Implicit Health (formerly Project Implicit Mental Health) was launched in 2011 and is led by Drs. Bethany Teachman and Matt Nock. The mission of Project Implicit is to educate the public about bias, and to provide a “virtual laboratory” for collecting data on the internet. Project Implicit is a way for scientists to “produce high-impact research that forms the basis of our scientific knowledge about bias and disparities.”⁶ The data collection has gone on continuously on the internet since 2007; since that time, more than 40 million tests have been taken, creating a much more expanded set of data than the researchers had ever expected.

One of the scientists who founded Project Implicit is Mahzarin Banaji, PhD, professor of social ethics in the Department of Psychology at Harvard University, and a pioneer in the study of implicit bias. She is the author, with Anthony Greenwald, PhD, of the 2013 book *Blindspot: Hidden Biases of Good People*.⁷

Dr. Banaji was recently interviewed on the podcast of the American Psychological Association, “Speaking of Psychology.” Episode 199 is entitled “Can we unlearn implicit biases?” and covers a wide range of interesting findings, but her briefly mentioned reference to larger body bias felt especially relevant to eating disorder professionals.⁸

Dr. Banaji shared results of the analysis of six groups, looking at anti-gay bias, racial bias, skin tone bias, age bias, disability, and body weight bias (bias against people who are overweight). Various interesting and surprising findings were revealed, and researchers are studying why some beliefs change quicker than others. The biggest shift was in the finding that anti-gay bias has dropped off by 64% between 2007 and 2020, a huge decrease. Race and skin tone have been reduced by about 25% during that same period.

Three biases that have not shifted much at all are: anti-elderly bias is slightly but not significantly lower, while disability and body weight bias remain completely unchanged. Dr. Banaji noted that body weight bias seems so stable that “We think these biases are going to be around. If they move at this rate, we're not going to see change for 200 years. That's our prediction.” As exciting as it is that some important biases have decreased, and are starting to shift in important ways, especially as implicit biases have often been considered to be less moveable, the continued bias against larger bodies is discouraging.

Things That Can Further Hurt

A number of factors make this process of shifting attitudes about body weight difficult, and most of us recognize that the impact of sociocultural factors is huge. News about a “great new diet” or public commentary about someone’s body (most commonly highlighting weight loss or criticizing weight gain) reinforces the notion of things being wrong or bad among people of certain body sizes or shapes. We all know there are certainly no shortages of this sort of over-focus, and with summertime being strategically timed to have diet-body-loathing-change-focus, the over-focus will basically be maintained all year long, especially with the extensively increased exposure now available with the internet and social media. Diet culture exalts thinness, vilifies bigger bodies, and normalizes many disordered eating behaviors. We know that even if someone does not progress to a diagnosis of an eating disorder, our fat-phobic society continues to show significant oppression, prejudice, and discrimination.

In January 2023, the American Academy of Pediatrics (AAP) published “Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescent Obesity.” It is an example of a factor that has the potential to negatively impact any small steps of changes that have begun to happen with more of the HAES (Health at Every Size®) and weight-neutral movement. The *Guideline* urges pediatricians to speak with children and their families about dieting, medications and even weight loss surgery. First and foremost, the HAES principles promote safe and equitable access to healthcare for people regardless of size, health status, and healthy goals. Fortunately, various groups have expressed serious concern about the current recommendations. Petitions are being signed in opposition to the guidelines, and EDC meetings with the AAP have begun to lead to positive changes.

Things That Can Help

Attitudes can change, and beliefs can shift. Indeed, it would be hard to maintain hopefulness and optimism about eating disorders treatment if we did not ultimately consider change to be viable. However, unlearning bias is more difficult than we often think. Clinicians are actually in this wide dialectical gap: we know that humans often resist and are uncomfortable with change, yet our life’s work is basically focused, at least in part, on helping individuals change.

Taking Small Steps

Although we sometimes believe people have to shift their beliefs before they can shift their behaviors, science actually supports the notion that taking small behavioral steps can precede a belief change. Arguing oneself or others out of a bias tends not to work, and most people actually end up holding on even more stubbornly to some of those beliefs - as many clinicians well know. We also know there is so much psychoeducation to cover in eating disorders work, but education alone has rarely allowed someone to make sustainable changes. So, those mini-strides of behavioral change, such as leaving the house even if someone doesn't feel presentable or engaging in compassionate self-talk even without believing

it, can actually be important starts.

Tiny steps count. The focus on tiny steps of change cannot be oversold. Many clients will say, "There is no way I could love my body," but sometimes they can buy into a smaller intention, such as attempting to focus more on honoring or trusting a body signal (for thirst, urination, or sleep, for example). Similarly, we cannot expect that society will be able to make immediate leaps to more of a weight-inclusive culture, but society might begin to consider how health is more accurately measured in behaviors than by a specific weight or size. Even one degree of change shifts the trajectory significantly.

Cognitive Dissonance

Finding ways to create cognitive dissonance can also be helpful. Leon Festinger, credited with developing the theory of cognitive dissonance in the 1950s and 1960s, noted that when we are confronted with two seemingly dissimilar ideas, we must change one or the other.⁹ This discomfort in inconsistent cognitions turns out to actually be motivating. Going back to some of the IAT results, in attempting to uncover why some biases change faster (such as the rapidly decreasing anti-gay bias), scientists have proposed that when sexuality became more personal and more people began "coming out" to loved ones, the sexuality bias was able to be shifted more quickly. As people "came out," families and friends were forced to confront their own cognitive dissonance. Similarly, we can find more ways for people of all sizes to be revered for who they are and for what they do (as scientists, teachers, healthcare professionals, good parents, helpful colleagues, and kind human beings), in order to expand the currently more limited notion based only on weight.

Hollywood is also credited with assisting in shifting the anti-gay bias revealed in the IAT results much more quickly than any of the other unchanging biases. As Dr. Banaji explained, "They made movies and they made TV shows, not just ordinary ones, but ones in which the gay character would be cooler and smarter and nicer than the straight people on the show. People watched those and came to see that this was being normalized." Having more body types on TV and in movies would appear an important and worthwhile goal that might indeed begin to slowly but steadily shift the fat phobic mindset. Humans are adaptable, and revered role models can help in this evolution.

We also can come back to recognizing that bias is learned. Babies are not born with prejudices, but eventually are molded by families and societies in both explicit and implicit ways. While we want to assist in some unlearning of harmful notions for current citizens, we can also impact caregivers of the new generations to be more thoughtful about how body weight biases are passed along from the very start. Pushing past assumptions, making new norms, and challenging the status quo will be part of creating a more just and non-discriminatory world in many domains.

Looking to the Future

It may be a long time before we can really expect that weight-inclusive care and weight-neutral conversations will become the norm, but fortunately there are some small behavioral steps we can take to increase awareness and support slow shifts. We may still be at a more rudimentary point of attempting to prevent harm in medical treatment guidelines or reduce negative impact from some toxic social media trend, but hopefulness about reduction in other biases does provide some optimism about eventual positive prognosis in body weight bias as well.

As Lindo Bacon, of HAES (Health at Every Size), an activist and author, has so wisely noted, "The only way to solve the weight problem is to stop making weight a problem - to stop judging ourselves and others by our size. Weight is not an effective measure of attractiveness, moral character or health."¹⁰

References

1. Fruh SM, Nadglowski J, Hall HR, et al. 2016. Obesity stigma and bias. *J Nurse Pract.* 12:425.

2. Puhl RM, Heuer CA. (2009). The stigma of obesity: a review and update. *Obesity*. 17:941.
3. Solovay S. 2000. *Tipping the scales of justice: Fighting weight based discrimination*. Prometheus. SoundCloud.
4. Flament MF, Henderson K, Buchholz A, et al. 2015. Weight status and DSM-5 diagnoses of eating disorders in adolescents from the community. *J Am Acad Child Adolesc Psychiatry*. 54:403.
5. Puhl RM, Lessard LM. 2020. Weight stigma in youth: prevalence, consequences, and considerations for clinical practice. *Curr Obes Rep*. 9:402.
6. Project Implicit website: <https://implicit.harvard.edu/implicit/aboutus.html>
7. Banaji M, Greenwald A. 2001. *Blindspot: Hidden Biases of Good People*. Delacorte Press, New York, NY.
8. Banaji M. 2022. Speaking of psychology. Can we unlearn implicit biases? podcast on implicit bias: <https://www.apa.org/news/podcasts/speaking-of-psychology/implicit-biases>
9. Festinger L. 1962. *A Theory of Cognitive Dissonance*. Stanford University Press, Stanford, CA.
10. Bacon L. 2010. *Health At Every Size: The Surprising Truth About Your Weight*. BenBella Books, Dallas, TX.



The Author

Sandra Wartski, PsyD, Ceds

Sandra Wartski has been working with eating disorders over the past 25 years. She is a licensed psychologist who works as an outpatient therapist at Silber Psychological Services in Raleigh, NC. She enjoys providing presentations and writing articles on a variety of mental health topics, particularly eating disorders-related topics.

From Across the Desk

Relaxing the rules for lockdown as the COVID epidemic has wound down has been very helpful to end the isolation of so many, particularly people with eating disorders. Isolation was one large negative result of the epidemic and is often credited in the sharp upswing in eating disorders cases. One positive result of this has been the emergence of nationwide efforts to develop programs to identify eating disorders earlier (see "Update").

One issue that is unchanged is body weight bias, as author Sandra Wartsky points out (see "Changing Body Weight Bias: Things That Hurt and Help," elsewhere in this issue). She points to three biases that have not shifted much at all: anti-elderly bias is slightly but not significantly lower, and biases about disability and body weight are unchanged. She notes that our diet-centered culture exalts thinness, vilifies bigger bodies, and normalizes many disordered eating behaviors, she notes. Thus, even if someone does not progress to a diagnosis of an eating disorder, "our fat-phobic society continues to show significant oppression, prejudice, and discrimination," she writes.

While much of the current fat-phobic news may seem gloomy, there have been some positive steps: for example, researchers in Tennessee and Pennsylvania have developed new ways to reach out to those afraid of weight gain (see "Dealing with Fear of Weight Gain," elsewhere in this issue).

—MKS

Update

A number of states, including California, Texas, and Colorado, are sponsoring bills to help increase awareness and research into eating disorders. In California, for example, Assembly Bill 10 would require school districts, county education offices, and charter schools to develop and adopt policies and resources about body shaming before the 2025-2026 school year.

In Colorado, a bill to create a state Office of Disordered Eating Prevention is working its way through the legislature. This program is aimed at closing gaps in treatment, offering research grants, and working to educate students, teachers, and parents about eating disorders, including early warning signs of anorexia nervosa, bulimia nervosa, and binge eating disorder. Another goal in Colorado is prohibiting the use of body mass index (BMI) by insurers to determine medical necessity for eating disorders treatment. Opponents of using BMI in this way point out that persons who fall outside of BMI guidelines are often denied care or pushed out of treatment programs prematurely.

Other proposals nationwide include prohibiting social media algorithms from promoting products with potentially harmful content, prohibiting sales of weight loss pills to minors, and adding programs on eating disorders prevention to middle school students and high school curriculums. One of the factors credited to the increased interest in designing and starting such programs was the surge in eating disorders reported during the COVID-19 lockdown.

Dealing with Fear of Weight Gain

Future interventions should consider patients' views

Fear of gaining weight is one of the crucial factors that maintain some eating disorders, according to Dr. Rachael M. Butler and colleagues at the University of Louisville, KY, and Drexel University, Philadelphia (*Eat Weight Disord.* 2023. 28:29). While there is little research on the role of fear of weight gain during cognitive behavioral therapy (CBT-E), these researchers' study provides some new data about dealing with this stubborn symptom.

Fear of weight gain may originate from an overvaluation of shape and weight—a core symptom across binge-spectrum eating disorders, according to the authors. They add that fear of weight gain may also underlie disordered eating behaviors through a cycle of avoidance, as is seen in anxiety disorders. Those with a fear of gaining weight tend to avoid those foods they think will lead to weight gain. Then, ritualized eating behaviors and body-checking follow.

The study group

Dr. Butler's group recruited 63 adults with clinically significant binge-spectrum eating disorders. The participants (56 females, 7 males), were between 18 and 55 years of age, and had averaged one objective binge-eating episode per week over the past 12 weeks. Participants were excluded when 80% or more of the binge episodes included raw fruits and vegetables.

All participants received modified 12-session CBT-E sessions, and completed a 120-minute intake session; all other sessions were 60 minutes long. The participants were given homework involving self-monitoring, regular eating goals, and reducing shape-checking between sessions. They were also randomized to two groups, the first to complete a 10-minute computerized inhibitory control training and the second to a sham training daily for the first four weeks, then once weekly for the duration of treatment. Inhibitory control training aimed to increase inhibitory control toward food, using a "Go/No Go" task during which the participant viewed visual food or non-food cues and were instructed to reply as

quickly as possible, except when a “No Go” signal (a blue circle) appeared, always paired with stimuli representing the participant’s self-reported binge foods. The sham condition contained the same stimuli and instructions, without “No Go” signals. This was meant to act as an attention control.

The *Eating Disorders Examination* was used to assess disordered eating over the past 3 months, and all tests were completed online on the participants’ home computers. Participants also completed the *Goldfarb Fear of Fat Scale* (GFFS), a 10-item measure used to measure fear of weight gain or “fatness” measured pre-treatment, mid-treatment, and post-treatment. Before each session, participants were asked to list how often they had binged or had LOC episodes over the past week. Body mass index (BMI, mg/kg²) was calculated using participants’ self-reported height (reported at baseline). Weight was recorded during in-person sessions.

GFFS scores decreased with treatment

There were several notable findings. Over the course of treatment, from session 1 to session 12, fear of weight gain decreased significantly. Participants with BN-spectrum illness started with higher GFFS scores and larger decreases in fear of weight gain. The diagnosis did not affect the change in GFFS scores over time, according to the authors. BMI and fear of weight gain were not associated during treatment, suggesting that changes in an individual’s weight do not correlate with fear of weight gain. Importantly, while fear of weight gain was reduced during treatment, it was still elevated at the end of treatment. One wonders if this might be an important warning of relapse.

The authors noted that to their knowledge this was the first study to examine fear of weight gain during CBT-E treatment for binge-eating spectrum disorders. They also reported that fear of weight gain is not directly targeted in CBT-E. Future studies exploring which components of CBT-E contribute to decreases in fear of weight gain could allow clinicians to emphasize certain parts of treatment for persons with strong fears of weight gain.

Helping Prevent Eating Disorders Among Young Women with Type 1 Diabetes Mellitus

A pilot study emphasizes the importance of meeting peers with shared life experiences

Young women with type 1 diabetes mellitus (Type 1 DM) have two to three times the risk of developing an eating disorder than women without diabetes. It has long been thought that some of the risk relates to changes in weight or eating behaviors around the time of diabetes onset. Two important additional risk factors are pursuit of “the thin body ideal” and body dissatisfaction.

One prevention/treatment intervention that has had a positive effect is “The Body Project,” a targeted, manual-based eating disorder prevention program using cognitive dissonance theory. Cognitive dissonance occurs when there is a discrepancy between one’s beliefs and actions. This project has been shown to be one of the most effective interventions thus far to reduce eating disorder risk factors, and to prevent future eating disorders in the general population (*Clin Psychol Rev.* 2017.53:46). The Body Project encourages participants to criticize the thin body ideal by using a series of verbal, written, and behavioral exercises, and includes homework assignments.

Using the Body Project principles with women with Type 1 DM

Dr. Trine Wilge Hage and researchers at Oslo University Hospital and the Diabetes Center, Oslo, Norway, recently designed a study to explore the feasibility of using eating disorder prevention groups for people with Type 1 DM (*J Eat Disord.* 2023.11:42). Seventeen young women participated in focus groups and

interviews after completing an intervention; the results from five focus groups were then analyzed. The participants and researchers noted the benefits of meeting peers with a lived experience of Type 1 DM and body image concerns.

Study results and participants' reactions

Thirty-five females participated in the Diabetes Body Project feasibility study, where they were assigned to five diabetes body project groups. Twenty-five completed all six meetings, including pre- and post-tests (delivered online). Among this group, the mean age of onset of Type 1 DM was 9.34 years. At the study time, the mean age was 26.

The study developed an overarching theme, according to the authors: the benefit of meeting peers with a lived experience of Type 1 DM and body image concerns. In the first four sessions, participants were asked to define, discuss, and then to challenge current appearance ideals, as well as to include body activism ideals, and to discuss the advantages and disadvantages of using social media to combat body image concerns. Homework exercises included the "mirror exercise," where participants stand before a mirror and attempt to find positive attributes about themselves, including two positive reactions based on appearance.

Four main themes emerged from the focus groups: (1) the need for an integrated focus on diabetes, personal relevance, providing enough balance between structure and flexibility, and establishing a different perspective about having the disease. (2) The participants all expressed that meeting peers with Type 1 DM was highly valuable, and a much-appreciated experience. (3) The group setting also gave them a temporary "safe space" within a community of peers. (4) Many participants expressed that in their daily lives they had a limited network of other female friends and acquaintances with Type 1 DM. This was as true for participants recently diagnosed as for those who had lived with Type 1 DM most of their lives.

Participants also expressed a need for more integrated focus on Type 1 DM throughout the Diabetes Body Project. Most participants called for greater emphasis on the disease than on exercises or addressing the thin body ideal. The intervention was valuable to the participants, who reported both enhanced self-awareness and reflexivity. They felt that the most valuable exercises were letter-writing, role-playing, and mirror exercises.

The authors did point out several limitations of their study. Only about half (49%) of the women who originally enrolled as participants in the Diabetes Body Project also participated in the focus sessions, possibly affecting the information gained in the interviews. This was a small pilot study, and a further randomized controlled trial will be needed to further examine their findings.

These are positive findings. At this point, the Body Project Intervention has a large amount of research support across various settings, so it is not surprising that it showed promise here. But the risk for disordered eating among those with Type 1 DM has long been known, and this represents a great opportunity for targeted intervention.

Exercise Addiction: What Is It, and Does It Lead to Eating Disorders?

Many questions remain

Exercise addiction (EA) is marked by exaggerated training and loss of control over exercising. Many studies now describe issues related to the concept of EA, but EA is still not included in the current edition

of the *DSM*. A recent study attempted to evaluate reasons why relatively little information has emerged to pinpoint diagnostic signs of EA, and to review its connection with other psychopathology, particularly eating disorders.

A team headed by Dr. Aviv Weinstein from the University of Ariel, Israel, and a team from ELTE Eötvös Loránd University, Budapest, Hungary, reviewed 1000 studies of EA published over the past 12 years (*Dialogues Clin Neurosci.* 2023. <https://doi.org/10.1080/19585969>). They carefully searched for differences between overexercising and exercise addiction. In addition, their study included possible links between EA and eating disorders.

Physiologic signs

The group first evaluated the physiologic signs of EA. In one study, 50 professional football players were followed during seasonal training and then during 7 days of exercise deprivation. During the deprivation phase, athletes with high scores on EA measures had lower brain bioelectric activity, increased muscular tension, augmented sympathetic activity, and increased anxiety and depression (*Human Physiol.* 2011. 37:509). In another study of 53 male athletes, EA scores correlated with eating disorder symptoms, negative energy balance, and higher cortisol levels (*Open Sport Exer Med.* 2019. 5: e000439). However, a study of 176 people who performed aerobic and anaerobic exercises at least 3 times per week reported no differences in EA scores or other symptoms between those who were aerobic and anaerobic exercisers (*Addict Behav Rep.* 2021. 14:100369).

Gender differences

The researchers found differences in dysfunctional symptoms, quality of life, mood, and sleep among both females and males who regularly participated in exercise programs. Males showed greater dedication to training and gaining strength and vigor compared with females. Women in the anaerobic group reported more disorderly eating patterns and had higher levels of depression than men. However, as far as the time of exercise training, such as 3 hours a week, no gender differences were seen.

Treatment

The primary treatment that has been suggested for dysfunctional exercise is cognitive behavioral therapy, but the researchers found little evidence that it was effective. Hallward and colleagues have argued that treating EA is essential to treating eating disorders (*Eat Disord.* 2022.30:411).

Dr. Weinstein and his team noted that a central question remains: Is EA a behavioral addiction or a common symptom of various underlying psychiatric morbidities? Another problem involves the multiple questionnaires used to assess EA, which may inflate and “over-pathologize” EA. Appropriate assessment methods do not seem to be fully established. The authors believe that the varying tools used to assess EA and different structures of studies have led to confusing results. Weinstein and colleagues’ review includes topic-by-topic identification of research needs and suggested action steps, so the concept of EA can be fully understood.

Improving the EDE-Q for Men

Two important areas for men may be missing in its current form

Two areas on the *Eating Disorder Examination-Questionnaire* (EDE-Q) are body concerns and body dissatisfaction. Both need improvement to better detect eating disorders among men, according to a recent German study.

Dr. Nora M. Laskowski and her colleagues recently described the use of the validated German version of

the EDE-Q in adult inpatient men with eating disorders as an improvement to the current widely used screening questionnaire (*J Eat Disord.* 2023. 11:34). They report that the current version of the EDE-Q could be improved by including two areas specific to men. The authors note that gender differences may play a large role in overlooked and underrepresentation of men in eating disorders research largely because standard assessments were developed based on eating disorder symptoms in adolescents and young women.

One area that has led to continual discussion and debate is the structure of the EDE-Q, where the four subscales, Restraint, Eating Concern, Shape Concern, and Weight Concern, do not include men's concerns about musculature and concerns of males in special cohorts, such as gay men, bisexual men, or non-heterosexual men.

The German group studied 188 adult men diagnosed with eating disorders who had been admitted for inpatient treatment between January 2018 and December 2021. The mean age was 33 years, and the mean body mass index was 37.8 mg/kg². Their results suggested a five-factor solution, with a slightly shorter version of the EDE-Q (17 items). The proposed new questionnaire included the following factors, "Restraint," "Body Dissatisfaction," "Weight Concerns," "Preoccupation," and "Importance."

Is a five-factor model of the EDE-Q justified?

The authors believe that maintaining a distinction between Weight Concern, Body Dissatisfaction, and Importance is justified in men with eating disorders. While the EDE-Q includes items that assess general discomfort, for example, discomfort in seeing one's body and thinness-related discomfort, this might be too limiting to include eating disordered psychopathology in men. They add that men are just as concerned about their body mass and musculature, pointing to the need to consider a broad range of body images in ED assessments.

The authors noted one of the study's limitations was that their findings involved German men and might not be generalized to other locations. Still, they concluded that adding the five subscales—Restraint, Body Dissatisfaction, Weight Concern, and Preoccupation, and Importance—to the EDE-Q may help.

QUESTIONS AND ANSWERS

'New' Eating Disorders

Q. I have been hearing about "new eating disorders." Can you explain? (*J.B., Philadelphia*)

A. After the COVID pandemic, we have seen an increase in the incidence of eating disorders, along with a generally lower age of onset. Two disorders are being discussed more commonly after the pandemic. A recent editorial by a group of Italian pediatricians and child neuropsychiatrists has specifically referred to two of these "new" disorders, atypical anorexia nervosa (AAN) and avoidant/restrictive food intake disorder, or ARFID (*Nutrients.* 2023. 15:1307). Both disorders are listed in the *DSM-5* and typically affect children and young adolescents.

Both disorders involve prominent restrictive eating patterns, and both significantly impair physical health or psychosocial functioning among children and young adolescents, according to Dr. Alessia Salatto and colleagues in Naples, Italy.

While AAN and ARFID are important and common, neither is a "new" eating disorder. Those with ARFID often were not previously seen in the eating disorders setting, but rather more often in pediatric gastrointestinal or developmental settings. In that sense, ARFID might better be thought of as "new" in

many eating disorders clinics. And, AAN has actually been known and studied for some time, but often is termed “subthreshold AN.” While technically true (because people with AAN “fall short of” full AN criteria), the subthreshold designation was problematic. Most importantly, it suggested that these cases were less severe, posed lower risk, and/or less need for treatment. None of this is true.

ARFID, predominantly found in children, involves low body weight and a state of malnutrition and dysfunction, and is considered a psychiatric disorder even though it is not associated with body shape. AAN has been newly included in the *DSM*; it is characterized by normal weight, which often leads to a delay in treatment. Helpful clues in the diagnosis of AAN include a history of previous obesity or overweight and results of assessing the patient’s body mass index.

The authors note that eating disorders may affect as many as 25% of children with normal psychophysical development and as many as 80% of those with developmental delays (*Psychiatr Clin North Am.* 2019. 42:57). This may appear as an inability to feed properly, resulting in problems gaining weight or in significant growth retardation. Young patients may refuse food, throw food away, or show a general lack of interest in food. According to the authors, individuals with AN and AAN share similar degrees of caloric restriction and malnutrition and have very similar symptoms.

Why is this important? Most nutritional disorders are transient, but in 3% to 10% of children they are linked to a risk of malnutrition. In addition to the problems of growth impairment, patients may have later problems traced back to pubertal retardation due to malnutrition. The rise in eating disorders, especially in more subtle forms, has also been seen in recurrence of diseases “of the past,” such as beriberi or scurvy, now uncommon and more difficult to recognize and treat, according to Dr. Salatto and colleagues. One of the main problems with diagnosing an eating disorder is an inadequate dietary history. Especially in the case of adolescents, considering the age of onset of eating disorders and performing more accurate interviews about eating can be crucial to identifying the risk of eating disorders.

The authors also provided a table of red flags for eating disorders among young patients.

Warning Signs for Future Eating Disorders

- A child only eats his favorite foods.
- Most of the calories consumed are from liquids.
- The child seems distracted while eating.
- The child eats food hidden in other foods or liquids.
- Meals last longer than 30 minutes.
- The young person has excessive concern about his or her body weight and shape.
- Certain foods are restricted, particularly fatty foods or those linked to concerns about gaining weight.
- The child or teen compulsively exercises and is increasingly anxious about established goals.
- The young person acts guilty or shows shame when eating with others.

In sum, these “new” eating disorders have been with us for a long time. They are being seen regularly and are an important part of eating disorders treatment.

—SC

In the Next Issue

- The Benefits of Early Intervention for Eating Disorders
- Comparison of the *Eating Disorders Examination* and the *Eating Disorders Examination-Questionnaire* in Adolescents
- How Effective Is Internet-Based CBT For Bulimic Eating Disorders?
- Anger and Aggression Among Bulimic Teens
- Disparities In Access to Treatment for Publicly Insured Youth and Youth of Color
- And much more...

Reprinted from: ***Eating Disorders Review***

iaedp

www.EatingDisordersReview.com