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# Eating Disorders Review

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#### Scott Crow, MD, Editor-in-Chief

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## From Across the Desk

Fall is here, and it arrives with some new changes for Eating Disorders Review. For example, your article ideas, articles for consideration, suggestions and comments will reach us far more rapidly than before, thanks to several additions to the website.

Beginning with the November-December issue, *Eating Disorders Review* will have a number of new features we think you will enjoy. We have three new co-editors, and are adding links for your comments and a direct link for prospective authors.

And, we sadly bid farewell to **Dr. Scott Crow**, whom we will miss very much. He can't leave us easily because we intend to keep in touch with him, and have enjoyed all the 10-plus years he has so skillfully guided *EDR*.



### Dr. Scott Crow

Dr. Scott Crow, our Medical Editor for the past 10 years, has seen *EDR* transition to an online publication and made many contributions to the publication. He is currently Adjunct Professor of Psychiatry at the University of Minnesota, and Vice President for Psychiatry for Accanto Health. He is stepping down as Medical Editor of *EDR* this fall.

Also, meet our three new co-editors, **Anne Marie O'Melia, MS, MD, CEDS-S** (medicine), **Leah Graves, RDN, LDN, CEDS-S, FAED** (nutrition), and **John Levitt PhD, CEDS-S, FAED** (psychotherapy). See the article, "Co-editors Join the EDR Staff," elsewhere in this issue. The three bring special expertise and experience to our pages.

In this issue also note articles on treatment for terminal AN patients, anger and aggression in teens with bulimia, taking weight stigma out of AN treatment, and a report on increases in restrictive eating disorders among adolescents, among others.

—MKS

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## Co-editors Join the EDR Staff



### Anne O'Melia

**Anne Marie O'Melia, MS, MD, CEDS-S**, joined the medical staff at Eating Recovery Center, Denver, in 2014. She is a triple board-certified physician in Pediatrics and General Psychiatry. She also holds subspecialty board certifications in Child and Adolescent Psychiatry and in Psychosomatic Medicine. Prior to attending medical school, she earned her master's degree in counseling psychology from the University of Kentucky College of Education and then practiced as a psychologist in rural regions

of Kentucky. She earned her MD with Distinction from the University of Kentucky College of Medicine, and completed her residency training at the University of Utah Triple Board Program. Dr. O'Melia has co-authored multiple articles and book chapters on eating disorders, and served as a co-investigator for various clinical trials related to psychopharmacology in the treatment of eating disorders and mood disorders. Dr. O'Melia has been named one of the "Best Doctors in America" every year since 2007.



### **John Levitt**

**John Levitt PhD, CEDS-S, FAED** has more than 40 years of experience working with eating disorders, self-injury, trauma, and complex patients. He has been an active participant in the field of eating disorders and trauma as a clinician, program developer, supervisor/trainer, and presenter. He has taught widely, co-authored one book, co-edited three other books, and numerous publications as well. Dr. Levitt has presented nationally and internationally on the topics of eating disorders, trauma, self-injury, complex symptomatology, assessment, and intervention. Dr. Levitt specializes in working with individuals who struggle with trauma-related issues,

eating disorders and/or self-harm, and provides a safe, respectful, supportive environment where clients can learn to manage for themselves and enhance the quality of their lives



### **Leah Graves**

**Leah Graves, RDN, LDN, CEDS-S, FAED**, is currently Vice President of Nutrition and Culinary Services at Accanto Health, the Emily Program, and Veritas Health, Saint Paul, MN. A founding member of the Academy for Eating Disorders, Leah has treated patients with eating disorders for more than 30 years. Previously, she was Manager of Eating Disorders Nutrition Therapy for the Laureate Eating Disorders Program, Tulsa, OK. She graduated with the highest distinction from the University of Oklahoma

Health Sciences Center in 1985, and then began her work with individuals with eating disorders. She has written several publications pertaining to nutrition and eating disorders, and has special expertise in medical nutrition therapy, nutrition counseling, clinical supervision, and research. Throughout Leah's career, her motivation for working with individuals with eating disorders has centered around a mission to help clients and their supporters learn to eat in a manner that supports their ability to engage in life - work, love, and play.

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## **Update: Smartphone Addiction**

While it may sometimes seem that we are all addicted to our mobile phones, a recent Chinese study has linked side effects from true smartphone addiction to eating disorders (*Front. Public Health* 11:1111477. doi: 10.3389). In a cross-sectional study of 1112 college students aged 17 to 29, from several universities in Chengdu, China, nearly 23% of students were identified as addicted to their smartphones, and 10% of these students were at risk of developing an eating disorder. The researchers used the Chinese version of the *Mobile Phone Addiction Index* (MPAI) and the *Eating Attitudes Test-26* (EAT-26) (*Front Public Health*. 2023. 11:1111477. doi: 10.3389).

The total EAT-26 scores of students with smartphone addiction were higher than those of other students without the addiction. Students with smartphone addiction skipped breakfast significantly more often than normal subjects, and the frequency of drinking carbonated soft drinks was higher in the students with smartphone addiction than among those without the addiction. Time spent on the Internet, time used on a smartphone on weekends, and time using a smartphone on weekdays (hours per day) were

significantly higher in the students with smartphone addiction. Those with smartphone addiction used their phones for an average of 5 hours a day and 6 hours on weekend days. When asked about the purpose for using the phone, the students reported using their phones to view music/video/social networks for 292 minutes a day; for gaming, 270 minutes per day; for shopping, 185 minutes per day, and for studying, 243 minutes per day.

Most students are aware of their overdependence on smartphones; however, the study participants reported that it is difficult to control this behavior by themselves. In addition, it has been pointed out that students with higher depression and anxiety levels are more likely to use smartphones as a compensatory attachment target (*Modern Prev Med.* 2021. 48:491). Moreover, several studies found that using a smartphone during normal sleeping hours alters the circadian system and cerebral blood flow, and even leads to changes in cardiac rhythm and negative sleep patterns. (Current recommendations suggest that smartphones should be kept at least 3 ft away from the body during sleep.) In addition, research showed that bedtime procrastination played an intermediary role between smartphone addiction and poor sleep quality.

The authors found smartphone addiction was positively correlated with eating disorders. In addition, the *Mobile Phone Addiction Index* (MPAI) scores were significantly positively correlated with the frequency of eating fast food, eating late-night snacks, and drinking carbonated soft drinks, and significantly negatively correlated with the frequency of physical activity and sleep duration. Previous studies also suggested that smartphone addiction can lead to changes in lifestyle-related factors, resulting in irregular eating. While the authors note some limitations to this work, there is one key question. There are many scales to measure problematic mobile phone use and there can be little argument that use of these phones can be problematic; but is it best considered as an "addiction?"

The study results confirmed the close associations between smartphone addiction and eating disorders, as well as between eating habits and lifestyles among college students. In accordance with the results, early screening and management of smartphone use among university students is recommended. To lower the risk of addiction to their phones, parents and teachers should pay more attention to a student's mental state to cultivate healthy eating habits and lifestyle characteristics and to improve their abilities of self-regulation. The modification of dietary habits and lifestyle factors needs to be considered when developing strategies and interventions to prevent smartphone addiction among college students

The authors concluded that Smartphone addiction is significantly associated with eating disorders, eating habits, and lifestyle. The influence of dietary habits and lifestyle needs to be considered to help prevent smartphone addiction among college students.

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## **Inpatient Treatment for Anorexia Nervosa**

### ***Treating anorexic patients as individuals was one key to successful inpatient care.***

When patients receiving inpatient care for AN are labeled as treatment-resistant, it may be possible that they have not had treatment suited to their unique needs. This was one conclusion from a recent study by Dr. Rebekah Rankin and colleagues at Western Sydney University School of Medicine, Sydney, Australia (*J Eat Disord.* 2023. 11:95). The researchers examined the lived experiences of inpatients through a systematic review of 11 studies involving 159 participants (156 females, 3 males) 12 to 45 years of age.

Four major themes emerged from their research: (1) patients felt there was no such thing as individualized treatment; (2) patients described the often-restrictive setting of inpatient treatment as

"living in a bubble," (3) patients described the impact of meeting others with AN and the downside of comparisons, and (4) patients wanted to be viewed by clinical staff as more than 'just another anorexic.'

### **Theme 1: Lack of individualized treatment**

When an individual first enters an inpatient treatment facility, the emphasis is naturally on weight loss and its associated health complications. Because of this, the emphasis is naturally on addressing the physiologic symptoms of the eating disorder. In 7 studies, the participants were disappointed with this nearly exclusive emphasis on physiologic rehabilitation at the cost of psychological wellbeing. Individual values and identity, and treatment goals were important to most patients, particularly soon after admission. In a study by Colton and Pistrang, for example, participants felt that the main goal of their inpatient treatment was to "fatten them up" and restore weight instead of working with psychological recovery and wellbeing (*Eur Eat Disord Rev.* 2004. 12:307). In other studies patients engaged in acts of resistance to preserve their identity.

### **Theme 2: 'Living in a bubble'**

According to patients, the highly regimented schedules and the inpatient treatment setting acted to separate them from normal external experiences. Most participants had a sense of ambivalence about the inpatient setting. On the one hand it made them feel "stuck" and unable to get out, but on the other it gave them a "safe space" and a "safety bubble" that protected them from the outside world and acted as safe haven. The restrictive setting also removed chances to use unhealthful behaviors associated with their eating disorder.

### **Theme 3: Living with others and with a 'similar demon'**

Inpatients being treated for AN live in a similar environment. According to the authors, for many patients this is often the first time they have met or interacted with other people with an eating disorder. This often helps normalize and validate their experience, helps them learn new coping skills, and gives hope for recovery. One downside is that the eating disorder can also be triggered by the close proximity of other patients, and an inpatient can watch others' progress, appearance, and everyday practices. Patients at different stages of recovery can also stir the distress associated with comparisons with other patients.

### **Theme 4: 'I am not just another anorexic'**

Study participants stressed the importance for healthcare professionals and treatment teams to see them as individuals, not as just another case of AN. They mentioned that too many staff members were too busy, with not enough time to listen or to care about what they did, just as long as they complied with treatment. Their feelings about not being understood by clinical staff members seemed to encourage a climate of resistance. In contrast, when they felt seen and acknowledged as individuals, inpatients were more likely to participate in recovery-oriented behavior and to seek help more readily and easily.

During inpatient treatment, patients often live away from home for several weeks or months. They typically go through several transitions of treatment: reconciling with the AN diagnosis and understanding that they needed medical intervention; adjusting to treatment and the treatment environment, and reflecting on and integrating the experience. Most patients had positive and negative feelings about their experiences. Readiness for change was another important element. Some had to select whether they were willing to let go of the eating disorder to collaborate in treatment. Ironically, in the group of those wanting to get better and to let go of their eating disorder, some temporarily acted as perfect obedient patients yielding to the clinical team. The authors noted that participants' values, treatment goals, and connections to their identity outside the eating disorder diagnosis also appeared to have an impact on how participants viewed their diagnosis and treatment.

Whether a patient engaged in inpatient treatment was not just a matter of a patient agreeing to stop using a set of unhealthful behaviors but the consideration of identity, values, and purpose outside the eating disorder. Thus, factors separate from treatment, such as life events, personal values, self-

reflection, life goals, and a personal understanding of AN as a disorder are likely to influence individual motivation for change (*Aust Psychol.* 2023. 58:1; *Int J Eat Disord.* 2013. 46:482).

### **An important role for clinical staff members**

Clinical staff members were critically important in the formation of patients' experiences. When patients were seen as individuals and more than just another case of AN, they were more likely to use recovery-oriented behaviors. The ability of staff members to "hold hope" for an individual patient's recovery seems to help strengthen patient motivation and a connection to sense of self or identity as someone other than a person with an eating disorder.

The authors suggest that adopting person-centered and recovery-oriented treatment approaches that stress patient safety and autonomy will be more successful when it is balanced with both the physiologic and psychological needs of the individual.

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## **An Italian Study Shows Lower Than Usual Mortality Rates for ED Patients**

### ***Lower mortality was attributed to a system that coordinates diagnosis and treatment.***

Mortality rates among eating disorders patients have long been a concern, particularly among anorexia nervosa patients. AN has a mortality rate that is around 12 times higher than the mortality rates from all other causes (*Annual Review of Eating Disorders.* CRC Press. 2018.66-76).

A recent study in Florence, Italy, has reported lower mortality rates among those with eating disorders (*Acta Psychiatr Scand.* 2023. 147:122). The study was conducted using data from the Eating Disorders Treatment Network (EDTN) that serves the area in and around Florence. A total of 1277 individuals with EDs were included in the authors' study, including 368 with AN, 312 with BN, and 597 individuals with Binge Eating Disorder (BED). Twenty-two patients (1.72%) died during a median follow-up of 7.4 years. AN and BN participants were mostly females (97.6% and 97.8%, respectively), and median age was 22.5 years. Males made up 13.6% of the study group, and their median age at clinical evaluation was 43 years. The median age of onset was 17 years for AN and 17.5 years for BED. The standardized mortality ratio (SMR) was 2.49 among AN patients, and 2.07 among BN patients—(these SMR's might suggest somewhat elevated risks but due to small sample size, these results were not statistically significantly elevated).

The mortality rates among all ED patients did not significantly differ from that of the general population of the same age and sex, with an SMR) of 1.19. Among BN patients, the mortality rate rose significantly after 10 years of clinical evaluation.

### **What explained the lower mortality rates?**

It is of note that the sample size was small for studies of this type, and the observation period was relatively short; both factors may have influenced the results. Still, the results are encouraging.

Dr. Giovanni Castellini and fellow researchers at the University of Florence and Careggi University Hospital, Florence, attribute the lower mortality rates in their study to the establishment of the Eating Disorders Treatment Network (EDTN) that serves the area in and around Florence. The EDTN in Florence is a regional treatment referral center specializing in eating disorders. inpatient medical treatment, residential rehabilitation treatment, and day hospital care. The findings of the study may reflect in part the results of such a coordinated approach. A multidisciplinary team provides evidence-based treatment

across different levels of care: outpatient, inpatient medical treatment, residential rehabilitation treatment and day hospital care. The findings of the study may reflect in part the results of such a coordinated approach.

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## **Restrictive Eating Disorders Are Increasing Among Teens**

### ***More information is needed about negative and positive life events.***

Little is known about the role of life events in adolescents and the subsequent development of restrictive eating disorders, or REDS. What is known is that the incidence is increasing among adolescents 15 to 19 years of age: the incidence is now reported as 40 to 100 cases per 100,000 population among females and 1 to 4 cases per 100,000 population among males. Among younger teens, such as those between 9 and 14 years of age, REDS have been reported among 13% of females and 7% of males (*Lancet*. 2010. 375:583). A recent study from Italy concluded that obtaining early information about traumatic events may help prevent new events, and improve patient outcomes among adolescents (*Children*. 2023. 10:376).

### **Health costs to teen patients**

The health cost to adolescent patients can be high: REDs have the highest mortality risk rate among psychiatric diseases, and the degree of severity is associated with moderate to high levels of psychosocial and work impairment (*Opin Psychiatry*. 2020. 33: 521). Environmental and individual biological vulnerability are then thought to be involved in the development of eating disorders. The recent COVID lockdown also had an effect on the development and exacerbation of eating disorders, such as AN and atypical AN, among others. In one group of patients 8 to 18 years of age who were hospitalized for the first time during the pandemic, 33% reported that the only environmental factor they correlated with the onset of their AN was the experience of being "locked down."

Several studies have shown the significance of physical, sexual, and psychological abuse, as well as emotional and physical neglect in eating disorders. Childhood sexual abuse is the most extensively studied form of traumatic experience related to eating disorders, and it may play a role in the development of AN. The difference between sexual and non-sexual early stressful life events in predisposing to a later eating disorder is still a topic of active research (*BMC Psychiatry*. 2021, 21, 501; *Int J Eat Disord*. 2022. 55, 1079-1089).

### **On the other side: protective life events**

Protective life events could include family environmental factors and the social environment. A major review in 2017 clarified the role played by personal and protective life events in the development of REDS. Protective life events could be general, such as family support and cohesion, or more specific, such as the importance given by the family to eating meals together, avoiding negative comments about weight, or growing up in a family where thinness or physical attractiveness are not overemphasized (*J Eat Disord*. 2017. 5:1218).

### **A study of trauma**

From March 2020 to May 2022, Dr. Giorgia Baradel and colleagues at the University of Pavia, Italy, studied 33 female adolescent patients 12 to 18 years old who were referred to the authors' hospital in Pavia as inpatients, outpatients, or day-hospital patients. After completing a series of questionnaires, the authors found that nearly 88% of the teens reported having had a traumatic life event in the past year, as reported on the *Coddington Life Events Scale* (CLES).

All the young patients were interviewed about their family and medical histories, and 29 of the 33 teens reported having had at least one traumatic life event in the 12 months preceding enrollment. Life events could be either positive or negative, and each had a specific value: the most recent events had a greater impact than the older ones. The higher the associated scores, the more stressful the life event was, and the more psychological readjustment it required to overcome.

The authors noted that the reaction to the event could also be influenced by a patient's perception of whether the event was positive or negative. Such life events are mainly family-related traumatic events, such as domestic violence, and physical, sexual, or emotional abuse. This is in line with the existing literature that has mainly focused on events occurring during childhood or early adolescence.

### **Life events and severity of RES**

The second aim of the authors' study was to assess the relationship between the presence of life events, either traumatic or protective, and the severity of REDS and patients' psychological maladjustment. There were no statistically significant correlations between the presence of life events in the 12 months before enrollment and the patient's clinical severity, according to the *Eating Disorder Risk Composite and General Psychological Maladjustment Composite* variables. Supra-threshold life events reported on the CLES during the previous 12 months did not correlate with the subsequent clinical worsening of symptoms. According to some authors, the presence of childhood traumatic events is involved in the development of biological changes in the stress response system. This leads not only to a greater susceptibility to further traumatic experiences but also to a different ability to cope with stressful events, such as REDS themselves.

The authors pointed to several limitations of their study. First, the sample size was relatively small, and they hope to replicate their current results in larger samples of patients. Second, the CLES is a new measure, and it only taps the preceding 12 months. The authors feel it would also be helpful to study earlier periods, to better clarify the role of traumatic events that occurred in childhood.

### **Including protective life events**

Concerning the clinical practice with adolescent patients, the authors urge researchers not to limit the investigation of traumatic life events to childhood but also to explore more recent periods.

In Italy, national guidelines indicate family therapy for AN (FT-AN) as first-choice treatment of children and adolescents. But the authors note that regardless of the therapy employed--it could be useful to consider the role of trauma. On the other hand, they feel it could be interesting to investigate whether therapeutic approaches that aim at treating young patients exposed to traumatic life events also target REDS symptoms or psychological characteristics often associated with eating disorders. According to the authors, their study considers both the traumatic nature of life events but also its protective nature, which appears to play a key role in the definition of personalized treatment. Indeed, they report that protective life events could be used as strengths in therapeutic

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## **Taking Weight Stigma Out of the AN Treatment Equation**

### ***Healthcare providers may be a primary source of weight stigma***

Like wisps of smoke, weight stigma can slip quietly into the treatment of eating disorders, according to a recent report. Weight stigma is "the social denigration of an individual on the basis of weight and body shape," and development of negative attitudes toward an individual because of his or her weight. Larger

people often face criticism that they are lazy or less competent amid assumptions that their body size and shape are somehow the result of a moral failing (*Obesity*. 2009.17:941). The individual then may internalize this and criticize herself on the basis of others' judgments.

Focusing on the patient's weight during eating disorders treatment can add to weight stigma, leading to poorer treatment results, according to researchers at Arizona State University, Phoenix, and the Mayo Clinic, Rochester, MN. Dr. Mindy L. McEntee and her colleagues at Arizona State University write that healthcare providers may be a primary source of weight stigma (*Front Psychiatry*. 2023. 14:1157594. doi: 10.3389/fpsyt.2023.1157594). As a result, a clinician may spend less time with and be more critical of patients with higher weights. This then interferes with communication, leads to loss of trust, respect and support. Patients may withdraw from or refuse to follow treatment recommendations.

### **Misuse of BMI**

One area to be aware of is using body mass index (BMI) during the initial diagnosis of AN or to gauge treatment progress. Referring to BMI and using terms such as "overweight" or "obese" reinforces arbitrary classifications not supported as a measure of individual health, according to the authors. BMI is a diagnostic criterion for AN, leading to higher-weight individuals being labeled as having "atypical AN," or AAN, which leads it to be perceived by some as less severe; this can then interfere with immediate and lifesaving services. Weigh-ins can also be problematic, and the authors argue for clear communication about weighing at the outset of treatment.

The authors recommend a number of steps to encourage weight inclusion in eating disorders treatment and research. These include understanding and communicating with patients and policy makers that weight is not synonymously linked to health, clarifying that weight is not a sole criterion for an eating disorder diagnosis or for recovery, and shifting from weight-centric to weight-inclusive care.

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## **QUESTIONS AND ANSWERS: Psychedelics for Eating Disorders?**

**Q.** One of my patients, a 30-year-old with long-term AN, recently asked me about adding a psychedelic agent to her current treatment regimen. I have many doubts about this, including possible harm. Are there any benefits to adding such an agent to her treatment? (*S.Y., Camden, ME*)

**A.** A quick answer at this time would be No, because not enough study has been done about adding psychedelics, for example, to a normal treatment regimen.

Some information about the growing work on adding psychedelic agents to eating disorders treatment regimens has come from a group of Swiss researchers at the University of Fribourg and the University Hospital Zurich, both in Zurich, Switzerland (*Euro Neuropsychopharm*. 2023. 75:1). Dr. Abigail Caldera and colleagues found preliminary evidence that psychedelic-assisted therapy (PAT) showed potential in treating some common comorbidities of eating disorders, including mood disorders, post-traumatic stress disorder, and substance abuse disorders among patients with AN and BN (*CNS Drugs*. 2020. 34:925). They found little data on binge eating disorder, or BED.

Specifically, according to the authors, preliminary evidence suggests that PAT could be beneficial in the treatment of AN and BN, as well as several common comorbidities. Patients with AN have disturbances in their view of body weight or shape and feel an undue influence of body weight and shape on their self-evaluation, intense fear of weight gain, and/or behavior interfering with weight gain.

Previous accounts of psychedelic use in people with EDs suggest that psychedelics may improve distorted



body image, normalize maladaptive reward processing, reduce behavioral and cognitive rigidity, and aid in trauma processing. The ability of psychedelics to relax higher-order beliefs may account for some of this, as may their ability to promote acceptance of difficult thoughts and emotions. Changes arising during or shortly after a psychedelic experience may additionally have a lasting impact on the brain via psychedelics' effects on cortical neuroplasticity.

Specifically, according to the authors, preliminary studies support more research into therapy with psilocybin, ketamine, and ayahuasca. Ayahuasca is a psychotropic beverage from South America, derived from *Banisteriopsis caapi* and *Psychotria viridis*. The beverage contains alkaloids such as Î²-carbolines and dimethyltryptamine (DMT), which alter the psychoactive functions associated with perception and thought processes. People in Brazil, Colombia, and Peru widely consume it.

Safety is always a concern. The potential impact on comorbid psychopathology should be considered, as should interactions with other medications. The risk of serotonin toxicity, in particular, may be substantial. Persisting perceptual problems can occur in the weeks after a psychedelic experience,

Some side effects of psychedelics are particularly relevant for those with eating disorders. For example, vomiting is a common effect of ayahuasca.

One caveat is that the majority of the evidence so far appears to be from case reports and case series. While valuable, these can provide an unduly positive impression (as negative results are less likely to end up as case reports). Still, given preliminary results and plausible therapeutic mechanisms, there is a clear rationale for future studies into PAT for eating disorders, according to the authors. Larger, controlled trials investigating the safety and efficacy of PAT with different substances for different ED diagnoses are needed.

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## Counteracting Treatment Resistance Among AN Patients

### *One definition does not fit all.*

Why does a patient with AN resist treatment? According to Dr. Hassan Nagy, clinical researcher at the Larkin Health System, Miami Beach, FL, a combination of many factors is involved. These include familiar factors found in an AN diagnosis itself, including intense fear of gaining weight and dietary restrictions, excessive exercise, critical perceptions by others, and genetic factors, to name but a few (*Avicenna J Med.* 2023.13:1)

Resistance to treatment has no set definition, say Dr. Nagy and his colleagues, but treatment-resistant AN is usually identified as persistent AN lasting from 7 to 10 years. *The Diagnostic and Statistical Manual-5* classifies treatment-resistant anorexia in relation to BMI, severity of symptoms, need for additional supervision, and inability to perform daily functions. Broomfield et al. classified repeated failed treatment efforts as the second most common diagnostic criteria for a diagnosis of severe and enduring AN (SE-AN). Severe BMI, according to the DSM-5, is a BMI <15 kg/m<sup>2</sup>. Hospitalization is called for when the patient has a heart rate <50 beats/minute in the day and <45 beats/minute at night. Body fat <10%, body temperature <96°F, arrhythmias, refusing food, and unsuccessful outpatient treatment all factor into the diagnosis.

Dr. Nagy and his colleagues report that many patients, particularly those who fall into a pattern of obsessive and restrictive behavior, are very prone to refuse treatment. Environmental and genetic risk

factors with a more susceptible neurobiology are also at play in the resistance to treatment in AN and BN (*BMC Psychiatry*. 2013.13:292). Resistance is a common ordeal among AN patients. Many express that they do not want to physically mature into an adult female body to avoid being separated from their parents and given added responsibilities, Others don't have the experience of being autonomous, which can lead to poorer self-esteem. It is also thought that the cycle of compulsive and restrictive actions gives an anorexic patient a sense of control, and raises his or her self-worth.

### **Treating the treatment-resistant patient**

One size does not fit all, say the authors. Those who work with chronic AN patients view quality of life the most important goal. Treatment requires a balance between interventions that focus on physical safety and weight restoration and treating psychological stress first.

The authors suggest five ways to help manage a patient with treatment-resistant AN.

1. Provide a course of carefully measured intensity with palliative care. First, assure the patient that weight is not the objective of managing AN, and the patient can negotiate and collaborate with the entire treatment team-this will prevent panic and regression.
2. Encourage the patient to explore intellectual pursuits or hobbies that stimulate mastery and cognitive function.
3. Encourage patients to find a social activity that will prevent isolation. This could be spending more time with a family member or friend, going to church or spending time at a favorite spot, such as a restaurant or museum, or attending a support group.
4. Improving nutrition that does not cause weight gain.
5. Educate the family and relevant others about the psychopathology underlying treatment resistant AN, and provide solace and support so they can avoid showing anger and irritation towards the patient.
6. Perform regular physical examinations, so the clinician and the team, along with the patient, can be kept up to date about the medical status and can make informed decisions about supportive steps to be taken.

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## **Bulimia, Anger, and Aggression in Teens**

### ***Gender was one area of difference in this Russian study.***

Extensive research has tied bulimia nervosa to difficulties with emotion regulation as well as impulse control. These problems may increase the risk for affective and anxiety disorders, and can also lead to suicidal behavior, binge-drinking, and obsessive-compulsive disorders. Previous studies have reported that impulsivity and negative affect underly aggression in adolescents with BN (*Compr Psychiatry*. 2008. 49:364).

Gender has been one of the main predictors of differences in the forms of aggression. Boys are known to use direct aggression significantly more often than girls (*Aggress Behav*. 2006. 32:68), but results from studies evaluating social aggression among both genders have been mixed. Authors have reported either greater or no gender differences between girls and boys with BN (*Curr Opin Psychol*. 2018. 19:39). Dr. Roman Kuposov and researchers from Northern State Medical University in Arkhangelsk, Russia, designed a self-assessment study to examine the relationship of aggression to "clinical level of bulimia symptoms" (CLBS) in adolescents (*BMC Public Health*. 2023. 23:833).

### **A study of BN, anger, and aggression**

The final study group included a representative sample of 2613 adolescents 13 to 17 years of age from northwestern Russia. Slightly more than half (59.5% ) were female, which reflected the local public school population. The participants were students in the 6th to 10th grades, from Arkhangelsk, a city of about 39,000, where approximately 30,00 adolescents are in the 13- to 17-year-old age range. Aggression and anger were assessed with the Trait Anger Scale of the *State Trait Anger Expression Inventory*, the *Anger Ruination Scale*, and scales that weighed physically and verbally aggressive behavior.

### **Gender differences**

CLBS were higher among girls than boys. Mean aggression ratings were higher among those with CLBS than those without; this was true across genders. Anger and aggression were significantly higher among boys on all scales, except for anger rumination. While boys scored higher on verbal and physical aggression in both the study and control groups, the research team noted only slight differences in social aggression. Other studies have shown the same pattern.

In both groups, there was a relationship between age and anger and aggression; higher scores were associated with increasing age. The subject of bullying raised the possibility that age might play a role among individuals with eating disorders. Because of conflicting results in similar studies, the authors point to the need for further studies to clarify this connection between bullying and eating disorders.

*Limitations.* The researchers also listed a few limitations. The cross-sectional design precluded drawing inferences, and a longer study might better define the observed associations. Because the study was conducted in northwestern Russia, the results shouldn't be generalized to other populations, including clinical groups, say the authors—but this is a relatively unique aspect of the study, as research samples of those with ED from Russian are uncommon. Ideally, direct observations and reports from parents and teachers might have strengthened the findings.

The study results underscore the potential relevance of anger in understanding and treating those with symptoms of bulimia.

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## **In the Next Issue**

### **Predicting Relapse Among AN Patients**

Age and comorbidities are just two of the several factors that can war of possible relapse among AN patients. One helpful step is assuring the patient that weight is not the objective of managing the disorder, and it is possible to negotiate and collaborate with the entire treatment team.

PLUS

### **Brain-Gut Interactions**

And

### **Evaluating Day Treatment Programs for Children and Adolescents**

### **Online Programs for High-Weight BED Patients**

**And, much more...**

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