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Early Intervention for Eating Disorders

Policy changes may affect access to services.

Gaining access to treatment for eating disorders may take years, or may not happen at all. Many obstacles stand in the way, including geography, cost, and lack of insurance coverage. Recently, the results of a global study propose ways to improve access to treatment for patients, and to increase early intervention.

A team led by Karina L. Allen, from the Eating Disorders Outpatient Department at Maudsley Hospital, London, have proposed a series of policy changes and services to help improve early intervention for eating disorders (*Eur Eat Disord Rev*. 2023. 31:320). Despite the fact that eating disorders carry a disease burden similar to anxiety and depression (Butterfly Foundation for Eating Disorders; **https://butterfly.org.au**), costing billions of dollars each year, little investment has been made to research the reasons behind this, according to Dr. Allen and her colleagues.

Why is this important?

Early intervention for those with suspected eating disorders leads to better outcomes (*World Psychiatry*. 2020. 19:233; *Canadian J Psychiatry*. 2020.64: 492). The authors' study also showed that most individuals do not accept evidence-based treatment until many years after their symptoms first occur. The interval between the first signs or symptoms and seeking treatment ranged from 2.5 years for AN and 6.0 years for binge eating disorder, or BED (*European Eat Disord Rev*. 2021.29:329).

Several reasons may produce the delay. Individuals may not be aware of the problem or have little motivation to change or to seek help. Clinicians may not detect an eating disorder or even when they do, they may take a 'wait and see' attitude, according to the authors. Another factor in delayed detection is lack of accessibility to services, including long waiting times for treatment, leading to worsening symptoms and poorer outcome when treatment does become available (*Behav Res Ther*. 2012. 50:487).

Takeaway Points

- **Commercial and government-funded insurance plans vary by state, which becomes a major barrier to early intervention among those without sufficient insurance. Low-intensity and community-based programs may help.**
- **Emphasizing the long-term cost benefits may help encourage patients to seek care.**
- **Insurance barriers can delay care and thus prevent the initial stages of an eating disorder if symptoms are defined as too early or too mild.**

Few studies on early intervention are available.

Germany and Great Britain have been leaders in efforts to lessen the time between initial diagnosis and treatment, and to improve earlier intervention. Most information has come from the First Episode Rapid Early Intervention for Eating Disorders, or FREED program. This program was developed for emerging adults (16- to 25-year-olds) who have had an eating disorder for less than 3 years.

The PSYCHNET public health intervention in Germany is designed to change the delay between diagnosis and early treatment of eating disorders by using health literacy campaigns, school prevention efforts, specialized outpatient services for AN patients, an internet health guide, and a multidisciplinary network of healthcare professionals.

In Australia, early intervention has used a modified FREED approach. In Canada, the authors report that largely due to territorially mandated public health care, eating disorders services vary widely across the country's 10 provinces and 3 territories. One way to get eating disorders services into the community more quickly may be through primary care settings, according to the authors.

And, finally, in the US, insurance coverage is a key determinant of access. Commercial and government-funded insurance plans vary by state, which becomes a major barrier to early intervention among those without sufficient insurance. According to the authors, one approach is to use low-intensity and community-based programs. For example, they cite use of interpersonal psychotherapy, an evidence-based treatment for BED and BN. This is provided through college counseling centers. The Body Project for patients with established eating disorders involves 8 weekly 1-hour group therapy sessions that aim at decreasing the thin-ideal (**The Body Project/| National Eating Disorders Association**). Student Bodies-Eds has an early intervention focus, and has also been successfully used in Germany.

Study recommendations

The study found wide variations in how eating disorders treatment is accessed and provided worldwide. First, services and policy makers can use early, evidence-based eating disorders intervention. Insurance barriers can delay care and prevent the early stages of an eating disorder if symptoms are defined as too early or too mild.

Changing the emphasis on the long-term cost benefits may also help. Early intervention needs to provide continuous care for 12- to 25-year-olds, the population at greatest risk for developing an eating disorder. The authors also urge clinicians to apply early intervention throughout the lifespan for adults older than 25. This may be accomplished with swift entry to care through active outreach, self-referral options, and strong links to other relevant organizations and services.

From Across the Desk

With the July/August issue, *Eating Disorders Review* will celebrate its 34th year in publication. The focus of the first issue in 1990 was addressing the controversy over pharmacotherapy versus individual psychotherapy. Dr. James Mitchell's lead article addressed that very topic.

Dr. Mitchell argued that the best treatment was the one that answered the question: Which therapy or combination of therapies works best for the patient? This question remains today, as clinicians continue to investigate novel approaches to diagnosis and treatment. One current controversy involves decisions about treatment when patients refuse it at the risk of their lives. Articles in coming issues will address both sides of this problem.

Clinicians are still searching for the best ways to reach and help patients, including those with barriers to care, such as cost, lack of insurance, or geographic distances (see "Early Intervention for People with Eating Disorders" and "Single Session Intervention" elsewhere in this issue]. The challenges continue as many patients delay seeking treatment for years after symptoms first appear.

Eating Disorders Review will continue to bring articles and news on diagnosis and treatment for you. As always, we will seek and publish articles with current information that readers can apply to their everyday practice. Happy 2024 to all.

—MKS

Update: Record Eating Disorders Funding Announced at the University of Louisville

Dr. Cheri Levinson and colleagues at the University of Louisville were recently awarded a $11.5 million dollar grant from the National Institutes of Health. Dr. Levinson, associate professor at the University of Louisville College of Arts and Sciences, and Director of the Eating Anxiety Treatment (EAT) Lab at the University of Louisville, was also awarded the NIH Director's New Innovation Award. The President of the University added that this was the most well-funded research in the University of Louisville's history. The first study will examine eating disorders among children 6 to 12 years of age; the second will be used for the EAT Laboratory and Clinic (EAT Lab) program at the University, to identify how anorexia nervosa contributes to suicidal ideation or other self-harm. The final study will be used to create and disseminate a novel personalized treatment for eating disorders and to integrate social determinants of health (food insecurity, racism) into treatment.

BED and Addictive Behaviors

Some similarities may help screening and treatment for patients.

While addictive behaviors and binge eating disorder (BED) do not mirror one another, some characteristics of addictive behaviors can be helpful in screening and treating people with BED. Though it is tempting to categorize the two as similar, a recent study by Alexandra Paul and colleagues at Johns Hopkins University School of Nursing in Philadelphia showed distinct differences between BED and addictive behaviors (*Substance Abuse and Rehabilitation*. 2023. 14:P77).

BED involves recurring episodes of binge eating and consuming a large amount of food in a short period while feeling a loss of control over eating. BED is classified as: mild (1 to 3 episodes a week; moderate (4-7 episodes per week); severe (8-13 episodes per week), and extreme (14 or more episodes per week).

Food Addiction

Addiction to food, which is assessed with the *Yale Food Addiction Scale* (YFAS), affects around 20% of adults (*Eur Eat Disord Rev*. 2022. 30:85), and is not yet a formal diagnosis recognized by the *DSM-5*. As the authors note, there is often a phenotypic overlap of food addiction with BED. BED and addictive behaviors are similar in that they both feature a loss of control, consuming food or other substances in larger than intended amounts, and continued behaviors in spite of adverse consequence and greater clinical distress. The neurobiological profiles are also similar, according to the authors.

The authors note that both BED and addictive behaviors are underrecognized and underdiagnosed in spite of available and effective treatments for both. Despite the fact that the lifetime prevalence of BED is estimated to be 1.9%, it is often underdiagnosed, and thus may go untreated. In one survey, 93% of general healthcare providers and 89% of psychiatrists could not correctly identify the diagnostic criteria for BED (*J Nurse Scholarsh*. 2019. 51:399). Additional barriers to screening of addictions as well as BED include time and workflow constraints.

Current pharmacological treatment also often falls short. At this time, the only FDA-approved medication for treating BED is lisdexamfetamine (Vyvanase™), which is usually prescribed at a dose of 30 mg, then increased by 20 mg weekly, to reach a recommended dosage of 50 to 70 mg per day. Use of lisdexamfetamine has reduced binge eating rates by 32% to 40% (*JAMA Psychiatry*. 2015.72:235).

Lisdexamfetamine also includes a warning about abuse and dependence. Other medications, such as selective serotonin reuptake inhibitors (SSRIs), have also been useful in BED cases. Only the antiepileptic agent topiramate decreases both binge eating and weight gain--either alone or when combined with cognitive behavioral therapy (CBT). In the few trials published, pharmacotherapy appears to be less effective than psychological treatment for BED (*Biol Psychiatry.*2005.57:301).

Would abstinence work?

Treatment goals for BED are aimed at reducing binge eating episodes, and ultimately are designed to enable patients to abstain from binge eating. In contrast, the treatment goal for substance-related disorders is total abstinence. Behavioral and psychological therapies most often used for addictions include CBT and 12-Step programs (*J Consult Clin Psychol*.2019. 87:109389). According to the authors, when an “addictive approach” is used in BED treatment, it merely makes it more challenging for vulnerable individuals to moderate their intake. And, with this approach, foods may not be viewed as “forbidden,” but may actually have chemical properties that give them a greater propensity to cause binge eating. Programs such as Overeaters Anonymous and 12-Step programs encourage abstinence from certain foods. These programs have not been tested among BED patients, and further research is needed, according to the authors.

Chronicity

Addictions are often seen as chronic relapsing brain disorders because permanent neurobiological changes take place that cannot be completely cured even with remission (*N Engl J Med.*2016.374:363). The few available long-term studies of BED show that about half of individuals make a full recovery after receiving a single treatment, without need for continued monitoring. Paul and her colleagues concluded that despite the similarities between BED and addictive behaviors, there are notable differences.

Impulsive and Compulsive Traits and BED Among Students

A large internet-based study searched for risky behaviors.

Binge eating disorder (BED) is the most common eating disorder, affecting all age groups, and is linked to significant comorbidity and development of physical problems such as diabetes and obesity. The mean age of onset of BED is later than that for AN or BN, and usually occurs in early adulthood. One group at increased risk of BED includes university students, who have high levels of life stresses from academic pressures and major life changes.

Jeremy E. Solly, PhD, from the Department of Psychiatry at the University of Cambridge, and a team of collaborators recently used the internet to evaluate the vulnerability to develop BED in a large group of college students (*CNS Spectr*.2023. 28:61). Two areas of particular interest to the researchers were compulsivity and impulsivity. Impulsivity is the tendency to take on behaviors or actions that are inappropriate, premature, or risky, while compulsivity refers to repetitive acts performed according to rigid rules or as a habit.

Earlier studies reported an incidence of BED of 13% in this age group, and noted that binge eating behavior affects as many as 50% of female students (*J Eat Disord*. 2019. 7:33). To follow their theory that BED was linked to a wide range of comorbidities, including impulsivity and compulsivity, the authors sent an internet-based questionnaire to 10,000 randomly selected students at a large midwestern university. To encourage participation, the authors devised a prize draw, where 10 participants would be randomly selected to receive computers and gift certificates; one $1000 certificate was also rewarded 449 responses.

The authors asked participants about consumption of caffeinated soft drinks during the past week, along with use of e-cigarettes and consumption of alcohol. In other areas, the students were asked if they had used a variety of products such as nonprescription amphetamines, cocaine, opiates, inhalants, marijuana and prescription pain medications. All participants also completed the *Alcohol Use Disorders Identification Test* (AUDIT). (A score ≥8 indicated potentially harmful alcohol use.)

Impulsive and compulsive behaviors

The students were asked about how many caffeinated soft drinks they had consumed over the past week, whether they had been treated for psychological/emotional problems, and if they were currently taking prescribed mental health medications. Other questionnaires screened for a number of comorbidities, including possible post-traumatic stress disorder, as well as generalized and severe anxiety. Impulsivity was assessed by the *Barratt Impulsiveness Scale, Version 11* (BIS11). Another addition was the *Rosenberg Self-Esteem Scale*, where a score <15 indicated low self-esteem.

In the final evaluation, 3415 college students completed the survey, and 83 (2.4%) had a positive screening outcome of BED; 77.1% of those were female.

Other factors, such as year in college or racial/ethnic group and grade point average, didn’t differ significantly between those with a diagnosis of BED and those without.

The largest effect came with examination of BED with trait impulsivity and compulsivity. The authors also found that BED was associated with higher AUDIT scores, consistent with earlier studies of links between BED and alcohol use disorder.

To the authors’ knowledge, theirs is the first study to investigate trait compulsivity in BED—and finding compulsivity and impulsivity in this group adds to the understanding of the neurobiological basis of BED. The wide association of mental disorders in this group, even with small effects, may point to the need for screening for disordered eating in a range of psychiatric presentations. The authors pointed out that earlier studies used scales unsuitable for measuring compulsivity, such as relying on measurement of obsessive-compulsive symptoms. They suggest that future studies test a range of populations with self-report measures such as they used, including cognitive tasks with self-report questionnaires.

The authors concluded that the largest effect came from associations with trait impulsivity and compulsivity.

Food Insecurity

One group of adolescents have an increased risk of future eating disorders.

Food insecurity is often defined as a lack of access to healthy, safe, and affordable foods that promote optimal health and well-being. The numbers vary, but one estimate is that more than 34 million people, including 13 million children, have food insecurity each year in the US (**What is Food Insecurity? | Feeding America**).

Jason Nagata MD, and a group at the University of California-San Francisco, have linked food insecurity in adolescents to a higher risk of developing binge eating and binge eating disorder (BED), or BED and other specified eating disorders (OSFED-BED) (*Int J Eat Disord.*2023. 56:1233).

Nagata's study was designed to find an association between food insecurity and binge eating in a national cohort of 9- to 14-year-old children. Logistic regression analyses estimated the associations between food insecurity at two time points: at baseline, year 1, and at year 2 (exposure). At the 2-year follow-up, the authors also reviewed binge eating, subclinical BED (OSFED-BED), and the outcome of BED, based on results from the *Kiddie Schedule for Affective Disorders and Schizophrenia* (KSADS-5). The KSADS-5 is a semi-structured interview designed to detect affective disorders such as depression, bipolar disorder, and anxiety disorder among children and adolescents.

Results at follow-up

The prevalence of food insecurity at the beginning of the study was 15.8%. At 2-year follow-up, 1.7% of the adolescents had been diagnosed with BED or OSFED-BED. In the case of binge eating, 6.2% of the study group reported binge eating. The researchers reported that food insecurity was associated with 1.6 higher odds of developing BED or OSFED-BED, and 1.31 higher odds of having binge eating symptoms.

Dr. Nagata and colleagues recommend that clinicians consider adding food insecurity to their regular screening programs for patients with eating disorders. Another suggestion is that clinicians help provide access to adequate food support.

Risk Factors for Certain Eating Disorders

An 8-year study singled out low and high body weights.

According to Stanford University researchers, few prospective studies have pinpointed risk factors that predict future eating disorders. Drs. Yuko Yamamiya and Eric Stice recently reported that certain risk factors are connected with anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and purging disorder (PD) (*Behav Ther*. 2023. doi.org/10.1016. Available online before publication).

The study assessed data from 492 teenage girls ranging from 11 to 15 years of age, who were followed over 8 years. The girls were recruited from 4 public and 4 private middle schools in Texas. The factors followed included: pressure to be thin, thin-ideal internalization, body dissatisfaction, dietary restraint, negative emotionality, peer and parental social support, modeling pathological eating patterns, and body mass index (BMI). These characteristics were selected because of past findings that the dual pathway model theorizes that pursuit of the thin body ideal leads to body dissatisfaction, which increases the risk for dietary restraint and negative affect (*Abnorm Psychol J*. 2019. 128:119).

Drs. Yamamiya and Stice hypothesized that the pressure to be thin, thin-ideal internalization, dietary restraint, and increased BMI would predict certain eating disorders, especially BN, BED, and PD.

The two novel findings from the authors' study were that girls with low body weights are at greater than normal risk for AN.

Parents' Grief During Caregiving

Mothers and fathers had different levels of depression and anxiety.

Parents are often longtime caregivers for their children and teens with AN. In a recent study, parents with adolescents who have AN showed high levels of burden, emotional distress and grief (*Eat Weight Disord*. 2023. 28:16). The current study is part of a larger longitudinal muti-center study, EVHAN (Evaluation of Hospitalization for AN).

Dr. Jeanne Duclos, of the University of Lille, France, and her colleagues designed their study to examine parents' and adolescents' characteristics related to parental burden and grief in AN, and links between the two. They noted that only one other study had examined the grief that parents feel during caregiving (*Curr Psychiatry Rev.* 2008. 4:162). And, even evidence-based programs such as Parent-Focused Treatment (Lock and Grange. 2013. *Treatment Manual for anorexia nervosa: a family-based approach, 2nd ed.* Guilford Press) do not address parents' experience of loss and grief during caregiving for their child with AN.

A study beginning with admission to inpatient therapy

The authors' study included 80 mothers, 55 fathers, and 84 adolescents hospitalized for AN. All data from the parents and their child were collected during the first 2 weeks after the adolescent was admitted for inpatient treatment. The experience of caregiving burden was assessed with the *Experience Caregiving Inventory,* and grief was assessed with the Mental Illness version of the *Texas Revised Inventory of Grief*. This questionnaire, used to study grief reactions to the death of a loved one, was modified to study grief as a part of a relative's mental illness and the "loss of that person as he or she was before the development of the illness."

The study collected information about the teen with AN, including gender, age, family composition, and educational and/or professional levels of the family. All patients had *DSM-5* diagnoses of AN. The onset of AN, AN subtype, and body mass index (BMI; kg/m^2) less than the 10th percentile up to 17 years of age and less than 17.5 for patients 17 years of age and older. The researchers also used the *Eating Disorders Examination Questionnaire* (EDE-Q 5.2).

Parental and teen data

The 55 fathers had a mean age of 47 years, and the mothers had a mean age of 46 years. Forty percent of the fathers were in the upper-to-high-middle class, and 49% of the mothers were classified as middle class. Twenty-six percent of the mothers were categorized as in the lower-middle-class category. Most patients were girls (96.4%; mean age:16 years). This sample had been diagnosed with AN for nearly 2 years, had a mean BMI of 14.3 on admission, and their lowest BMI was a mean of 13.61. The group was nearly evenly divided between restrictive AN and purging type AN.

Both parents expressed more grief when their child's clinical state was more severe. Fathers' grief was related to their own levels of depression and anxiety, while mothers' grief was influenced by their own levels of depression and alexithymia. Even though fathers actually had higher levels of alexithymia, mothers' emotions were more deeply related to their own grief, showing a more profound feeling of loss for their child.

Applying the results to parental caregiving

The authors feel that the information they gained may help clinicians to more carefully evaluate the elements of parental caregiving and "provide more targeted therapeutic interventions." They note that loss and grief work would not be complete without also directing attention to the teen and who he or she "may be in the future." They reiterated that between 50% to 60% of teens with AN will eventually improve or fully recover. Helping parents to address their intolerance of uncertainty may be highly effective, according to Dr. Duclos and her team. The concept is to help parents work on their intolerance of uncertainty, and the goal is to encourage encouraging parents to normalize the experience of ambiguous loss. and to regain a sense of mastery and hope for their child.

The authors pointed out that fathers need specific help to decrease their levels of anxiety; usually the mothers' burden is given priority. This may be partially due to the fact that fathers' attendance is often poor in family-oriented treatment, and decreases over time. Society in general, say the authors, tends to accept this pattern and thus unknowingly makes the mother the agent of change, merely increasing the mother's distress. They also note that direct interview techniques are much preferable to the use of self-report questionnaires, which tend to minimize levels of the concept being measured.

The authors hope their results will help promote development and use of specific loss and grief programs for fathers, mothers, and children with AN. They have added some components of the non-death loss and grief-oriented theories to their own multifamily therapy and parent group programs for teens with AN. Studies of larger groups are needed, they note, to make way for identifying and helping to resolve parents' feelings of loss and grief while they care for their child with AN.

Clues to Why AN Symptoms Lessened During the COVID-19 Epidemic

Investigators found two possible answers.

The mystery concerned girls and women with first-onset anorexia nervosa who reported fewer severe symptoms during the COVID-19 epidemic. A meeting abstract presented at the American Academy of Child and Adolescent Psychiatry (AACP) meeting in New York City last October provided additional clues.

Katrien Bracke, MD, of Erasmus Medical Center, Rotterdam, the Netherlands, and colleagues sought to explain the effects of the COVID epidemic and comorbid psychotherapy among girls and women with AN. A comparative cohort study included a group of healthy girls and women aged 12 to 24. Then the investigators compared the symptoms among participants with first-onset AN and the healthy controls. The comparisons were made before the onset of the COVID-19 epidemic (May 3, 2017, to March 2020) and during the epidemic (March 16, 2020, to October 2021). The groups were relatively small (pre-pandemic period, n=37; peri-pandemic period n=38, and the AN group (pre-pandemic n=49; peri-pandemic period, n=30).

AN patients had less internal insecurity, fewer body shape concerns

The investigators found that during the epidemic, AN patients felt less internal insecurity and were less dissatisfied with their body shape than before the epidemic. Those with AN in the peri-pandemic group also reported having fewer eating disorder symptoms overall compared with patients with AN in the pre-pandemic group. Patients in the peri-pandemic group had fewer symptoms of anxiety compared with patients in the pre-pandemic group. However, according to the authors, at the 1-year follow-up, patients in the peri-pandemic group with AN had lower body mass indexes (BMI, kg/m^2) than the pre-pandemic AN patients. The authors surmise this may have been due to less access to health care services during this time.

What made the difference? According to the investigators, the fall in symptoms might be explained by fewer social pressures and fewer contacts with their peers during the epidemic.

QUESTIONS AND ANSWERS: Hepatic Disorders and Anorexia Nervosa

Q. I don't see much information about the effects of anorexia nervosa on the liver. Have you seen any new studies? (*J.Z., Baltimore*)

A. You might be interested in a recent case reported by Dr. Jodi-Anne Wallace at the University of Florida, Gainesville, and a group from Asheville, NC. As reported in the *European Journal of Case Reports in Internal Medicine* (2023.doi: 10.12890/2023.003675), a 30-year-old woman with a 17-year history of AN was admitted with weight loss, hypocalcemia, and electrolyte abnormalities. Her lab results, especially transaminases, were of particular concern. Her body mass index, or BMI, was 10.29 kg/m^2.

On admission, her transaminase levels were much higher than normal. For example, her alkaline phosphatase level (ALP) was 150 units per liter, or U/l (normal range: 35-129 U/l); her aspartate amino transferase (AST) level was 99 U/l (normal range: 0-37 U/l); and her alanine transaminase (ALT) level was 110 U/l (normal range: 0-41 U/l). She refused to have a liver biopsy. She was admitted to a medical service for stabilization before being transferred to an inpatient psychiatric unit.

Her caloric intake was poor during hospitalization, and 9 days after admission her hepatic panel was grossly abnormal. Before nasogastric tube refeeding, her AST levels peaked at 817 U/l, ALT levels at 1066 U/l, and ALP levels at 457 U/l. After a nasogastric feeding tube was inserted, serum levels slowly returned to normal. Her transaminitis was determined to be secondary to severe malnutrition. When she was discharged 45 days after admission, her AST had decreased to 87 U/l, ALT to 151 U/l, and ALP to 158 U/l.

More than 40% of patients admitted with AN have elevated AST or ALT levels, with varying ALP levels (*Intern Med*. 2008. 47:1447; *Intern Med*. 1998. 37:32). A special subset of patients with BMIs lower than 15 kg/m^2 have a higher incidence of transaminitis than those with anorexia and higher BMIs (*Singapore Med*. 2015.56:488). Some of the causes for elevated transaminase levels in AN patients include hepatic necrosis from ischemic hepatitis, hepatic autophagy, and transaminitis induced by refeeding. This particular case underscored the fact that AN causes silent liver dysfunction, and rarely shows outward physical manifestations. If it is not recognized and if anorexia is not treated, it can lead to severe effects.

Single Session Interventions

Many questions emerged after the concept was presented.

The concept of using a single session to intervene for persons facing barriers to care for suspected eating disorders was first suggested by Jessica L. Schleider, PhD and colleagues (*Int J Eat Disord*. 2023. Dpi.org/10). The concept was to overcome the barriers that keep up to 80% of people from receiving counseling and care for eating disorders. The idea of single sessions was proposed to develop a pathway to developing accessible programs. The sessions can be stand-alone or added to clinical support sessions. Although the session may be the last for the individual, any single session has benefits, according to the authors. They note that further investigations should target eating disorder risk factors and symptoms that the single sessions cannot address, such as purging and binge eating [Also see â€œEarly Interventions for Eating Disorders,â€ elsewhere in this issue.]

The suggestion was quickly followed by many questions from a number of eating disorders professionals, including Australians Jake Linardon, PhD, and Matthew Fuller-Tyskiewicz, PhD, of Deakin University, and Dr. Tracey D. Wade, of Flinders University Institute for Mental Health and Wellbeing, Adelaide, South Australia (*Int J Eat Disord*. 2023:56:867, and *Int J Eat Disord*. 2023. 86:853).

The clinicians asked a number of further questions about the single sessions, including identifying an individual who would be a good candidate for the single sessions; what are the best treatment mechanisms to use; what is a â€œgoodâ€ outcome; and where should the single sessions be held?

Should treatment waitlists be used? Further studies may help clarify these questions.

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In the Next Issue

Eating Disorders in Men

Stigma is a major barrier to diagnosis and treatment for eating disorders among men. Approaches to screening and diagnosis need to be updated.

PLUS

- 'Food Rules' and Binge Eating
- The Impact of Listing Calories on Menus
- An Intervention for those with Type 1 Diabetes and Disordered Eating
- Vegetarianism and Its Effect on Eating Disorders
- The Continuing Debate on 'Terminal Anorexia'
- And much more...

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