

# How do eating disorder patients eat after treatment? Dietary habits and eating behaviour three years after entering treatment

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**ABSTRACT. OBJECTIVE:** Improvements in psychological symptoms and weight have often been demonstrated following eating disorder (ED) treatment, but it is not clear to what extent eating behaviour itself is normalised. This cross-sectional study aimed to investigate dietary habits and eating behaviour in ED patients three years after entering treatment. **METHOD:** ED patients (N=70) were divided into those who had recovered (N=36), and those who still suffered from bulimic (N=18) or anorexic (N=16) psychopathology. Patients were compared to a female normal control group of similar age (N=61), and assessments were made on a dietary questionnaire, as well as the BDI, EDI-2, SASB and SCL-90. **RESULTS:** With some notable exceptions eating patterns in recovered patients resembled those of controls. Dieting was most evident in recovered and current bulimic patients, while restrictive eating and vegetarianism was found in recovered or current anorexic patients. A majority of the patients with ongoing EDs avoided fatty foods. **DISCUSSION:** Risk behaviours such as restrictive eating, dieting and food avoidance, may have an important impact on relapse rates, and it may therefore be imperative to continue to monitor eating behaviour in ED patients following treatment termination to ensure better long-term outcome.

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## INTRODUCTION

Disturbed eating behaviour is a core feature of eating disorders (ED), and normalising such behaviour is a key goal of treatment. However, investigation of eating patterns in recovered patients has been limited (1-3). Most studies of eating behaviour have involved patients who are seeking or have recently entered treatment (4-9). The empirical work that has been carried out on eating behaviour after treatment suffers from several problems, such as small samples (1, 3), assessment at discharge with no follow-up (1-3), a tendency to measure overall eating behaviour rather than distinct patterns of eating behaviour in relation to different types of food and diet (1-2), small or no control groups (1-3), focus on either Anorexia Nervosa (AN) or Bulimia Nervosa (BN) and excluding patients with Eating Disorder Not Otherwise Specified (EDNOS) (1-3), as well as failure to examine the relationship of eating behaviour at fol-

low-up to other aspects of psychopathology (1-3).

Reviewing long-term outcome in AN, Steinhausen (10) found that normal body weight was attained by 60% of patients, but normalisation of eating behaviour was attained by only 47%. In a Swedish ten-year follow-up study of adolescent AN, half the anorexics had recovered in terms of normal weight and regular menstruation; however, if full recovery also included no disturbed eating patterns and/or attitudes toward food and body shape, only 40% reached recovery criteria (11). Jäger et al. (12) investigated outcome in BN eight years after entering treatment on either an in- or out-patient basis. Binge eating, bulimic behaviour and depression changed relatively rapidly during treatment, while the number of "normal" meals and restrictive eating took longer to improve (12). Improvements in psychological symptoms and weight have thus been examined in many studies, but it is not clear to what extent normalisa-

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tion in eating behaviour is established and maintained after termination of treatment (13). Andersen et al. (1) emphasised that if normalisation of eating habits is a critical treatment goal, it should be standard procedure to measure this before and after treatment. What's more, it is unclear whether eating behaviour plays a part in risk of relapse.

Given these shortcomings in the literature, we wanted to examine eating behaviour after ED treatment and whether lack of normalised eating behaviour is related to residual psychological symptoms, which previous studies suggest may in turn increase risk of relapse (10, 14). Dietary habits and eating behaviour were investigated in ED patients three years after entering treatment in a comparatively large heterogeneous sample of eating disorders that comprised both full syndrome and EDNOS patients. Patients were divided into subgroups (i.e. recovered, and current anorexic or bulimic behaviour), and these were compared to a female control group of similar age. In order to clarify factors related to risk for relapse, the study also aimed to examine the association between eating behaviour at follow-up and self-reported psychological symptoms in recovered patients.

## METHOD

The present research was conducted within the framework of a project evaluating three publically funded specialist units for eating disorders in Stockholm, Sweden. Participating centres offered a wide variety of treatment forms such as inpatient, day-patient, and outpatient treatment, individual, family and group therapy, nutritional treatment and counselling, psychoactive drugs and expressive forms of treatment using dance and art etc. Treatments were those typically delivered by specialist ED services in the community. Although the treatment was individually designed depending on patient's needs, there were also important similarities across forms and methods of treatment. Standard symptom-based interventions focusing on the restoration of normal eating patterns were consistently present, complemented by supportive interventions as well as interventions focusing on problems with interpersonal relationships, self-image and/or expression of affect. A battery of self-report and interview-based measures was used to assess eating disorder and general psychopathology at initial assessment, and subsequently after 12 and 36 months. All patients provided informed consent, and the Regional Ethical Review Board,

Karolinska Institutet, Stockholm, Sweden approved the study.

### Participants

A random sample of patients entering treatment at the three units between August 2001 and July 2002 was used in the present study. Initially, 110 patients entered the project. However, for the purposes of this study, only patients who had been assessed at 36-month follow-up were included. Data on diagnosis was missing for one patient, one patient had died, and the remaining patients could either not be reached or declined to participate. At follow-up patients were divided into three groups: recovered (N=36), anorexic psychopathology (N=16) and bulimic psychopathology (N=18). Diagnoses were set according to DSM-IV (15). In order to increase group size for statistical analyses, EDNOS patients were grouped together with full syndrome patients with similar eating disorder psychopathology. AN and EDNOS type 1 and 2 (i.e. anorexic-like) were merged to form the anorexic group, while patients with BN and EDNOS type 3 (i.e. bulimic-like) formed the bulimic group. There is evidence (16) that few differences in psychopathology exist between AN and EDNOS type 1 and 2 on the one hand, and between BN and EDNOS type 3 (17) on the other hand. Age ranged from 15 to 50 years (M=26.2, SD=6.5), and all patients were female with one exception. Body mass index (BMI) ranged from 12.4 to 44.0 kg/m<sup>2</sup> (M=22.4, SD=5.6). Mean duration of ED at presentation was 8.4 years (SD=6.7) and ranged between 6 months and 35 years. Mean treatment length was 18 months (SD=13.5), range 3-36.

A group of normal controls that only answered the dietary questionnaire was recruited between June 2004 and April 2005. Controls were found by asking students at high schools or universities, and employees in the Stockholm area to participate in a study investigating dietary habits. No effort was made to screen whether these participants suffered from eating disorders. The control group comprised 61 individuals, all females. Mean age was 21.4 years, (SD=9.2), range 15-61 years. Using an independent samples t-test it was found that the control group was significantly younger than the ED group as a whole,  $t(129)=3.5$ ,  $p<0.01$ .

### Measures

#### Eating disorder and background data

Background data on ED patients were obtained from a patient record for eating disorders (approved by The National Board of Health and Welfare) that documents sex, age, body

mass index (BMI, kg/m<sup>2</sup>) and diagnosis according to DSM-IV. ED severity was assessed using the PSR (Psychiatric Status Rating Scale) according to Herzog et al. (18), an ordinal, symptom-based scale. Once a diagnosis is established, the disorder is rated using the PSR to indicate the level of symptomatology. Full recovery from an ED is defined as at least eight consecutive weeks at a PSR level of 1 or 2. A PSR level of 3 or 4 indicates that some symptoms are present; patients with EDNOS often fall into this category. PSR 5 or 6 means that full DSM-IV criteria for either AN or BN are met.

#### Dietary questionnaire

The dietary questionnaire was not included initially in the project, but was developed before the 36-month follow-up. Data were therefore only obtained at follow-up. The questionnaire asked participants about diet (mixed or vegetarian), meal pattern (19), vegetable and fruit consumption defined as amount of 100 g portions per day (20), as well as consumption of bread high in dietary fibre, defined as amount of bread slices per day (21). Additionally, participants were asked if they avoided any food due to fear or anxiety, and if so what kind of food. A normal daily meal pattern was defined as comprising three main meals and two to three snacks (22, 23). If lighter meals were chosen for both lunch and dinner the meal pattern was not considered to be normal. Lighter meals were defined as eating only salads, soups, porridge, grains or bread. Less than two meals per day, or only lighter meals during the whole day, were considered to be restrictive eating. The dietary questionnaire also noted whether respondents were meeting or failing to meet two specific dietary goals set down by Swedish public health authorities: a recommendation of 5 servings of fruit and vegetables per day (23), and recommendation of at least 3 slices of bread high in dietary fibre per day, i.e. 3 g/MJ per day (21). Reliability and questions about meal pattern, fruit, vegetables and bread consumption have been validated previously in a population-based sample, and have been found to be acceptable (24).

#### Psychological self-report scales

EDI-2 (Eating Disorder Inventory, version 2) developed by Garner (25) measures eating disorder symptoms and related psychopathology. Only the subscales Drive for Thinness, Bulimia, and Body Dissatisfaction, which focus on eating disorder symptoms, were used in this study. The Symptom Index of the Symptom Check List (SCL-90), a 90-item self-report instrument, was used to assess overall level of

psychiatric symptomatology (26). Self-image was assessed using the SASB Intrex questionnaire (27). This questionnaire measures eight clusters of self-image: Self-emancipation, Self-affirmation, Self-love, Self-protection, Self-control, Self-blame, Self-hate and Self-neglect. The Beck Depression Inventory (BDI) was used to screen for depression (28). Scores on the BDI were calculated without the weight loss item, because of the difficulty in differentiating between weight loss as a symptom of depression and as a symptom of an eating disorder. However, question 19 "I deliberately try to lose weight by eating less" was used to identify those who were currently dieting.

#### *Procedure*

Intake data were collected by staff at participating treatment units. For the most part these were either clinical psychologists or licensed nurses with experience in the assessment and treatment of eating disorders. Administration of measures took place at initial diagnostic assessment prior to treatment, or within 2-4 weeks of commencing treatment at the latest. For follow-ups, patients were contacted by letter or by telephone if they were no longer in treatment, and an appointment for an interview at the unit was made. Questionnaires were posted with a request to return them prior to the interview. In those cases where patients were unable to attend personal interviews, telephone interviews were conducted (i.e. four individuals were contacted by telephone).

#### *Statistical analysis*

Logistic regression was used to examine the associations between eating behaviour and eating disorder status. When adjusting for age in the different outcomes, age was categorised as an ordinal variable (15-29, 30-39, ≥40). Odds ratios (OR) with 95% confidence intervals (CI) were computed. One-way analysis of variance (ANOVA) with post hoc Scheffé tests were used to test for potential between-group differences on continuous data. Post-hoc tests were conducted when *F* was significant (i.e. *p*<0.05). Effect sizes (E.S.) were calculated using Cohen's *d* (29). All analyses were performed using the Statistical Package for the Social Sciences (SPSS Inc. Chicago, version 11.0.2 for Macintosh OS X).

## RESULTS

Results of logistic regression with odds ratios, and normal controls used as the reference group (except in relation to dieting behav-

four where recovered patients constituted the reference group) are presented in Table 1.

#### Type of diet

More than half of the patients in the anorexic group (56%) were vegetarians compared to only 8% in the control group. The odds of eating vegetarian food at 36 month follow-up was considerably higher among both the clinically anorexic group and the recovered group compared to normal controls. These odds increased substantially when adjusting for age. Restrictive eating and dieting was significantly more common among vegetarians (70%) compared to individuals who ate a mixed diet (42%),  $\chi^2(1, 70)=4.5$ ,  $p=0.034$ ,  $w=0.25$ . Recovered patients who ate vegetarian food were more likely to eat restrictively or diet (80%) compared to recovered patients who ate a mixed diet (46%), Yates corrected  $\chi^2(1, 36)=3.1$ ,  $p=0.078$ ,  $w=0.29$ .

#### Meal pattern, restrictive eating and dieting

Before adjusting for age, the three clinical groups were over twice as likely to have a normal meal pattern compared to controls. When however, results were adjusted for age, the likelihood of the three patient groups' demonstrating a normal meal pattern dropped and resembled the control group. Among recovered and currently ill patients there was little variation in the proportion of individuals with a normal meal pattern. However, the likelihood of eating restrictively was significantly higher among patients with current anorexic characteristics compared to controls. When controlling for the effects of age, the likelihood of anorexic patients eating restrictively increased considerably compared to controls, but even recovered patients were still almost four times as likely as controls to engage in restrictive eating.

Current dieting was 63% among individuals with bulimic psychopathology, 21% in the anorexic psychopathology group and 30% among recovered. Since the control group did not, unfortunately, answer questions about dieting behaviour, recovered patients were used as the reference group when computing logistic regression on this variable. A considerable proportion of patients showing current bulimic behaviour (i.e. BN or EDNOS type 3) also reported dieting in order to lose weight. Patients in this group were 4-5 times more likely to engage in dieting compared to recovered patients. About half (48%) of the patients with an intake diagnosis of BN or EDNOS type 3 were currently dieting, compared to 25% of patients with other intake diagnoses.

**TABLE 1**  
Logistic regression: Odds ratios and 95% confidence interval (crude and adjusted for the effects of age) relating to specific dietary habits and eating behaviours among controls (reference group) and recovered, bulimic and anorexic patients.

	Reference group (N=61)		Recovered patients (N=36)		Bulimic patients (N=18)		Anorexic patients (N=16)	
	Crude	Adj.	Crude	Adj.	Crude	Adj.	Crude	Adj.
Ideal meal pattern	1 (Ref)	1 (Ref)	2.40 (0.98-5.85)	1.62 (0.62-4.19)	2.14 (0.70-6.55)	1.24 (0.37-4.15)	2.61 (0.82-8.28)	1.62 (0.48-5.53)
5 a day of fruit and vegetables	1 (Ref)	1 (Ref)	3.39 (1.18-9.79)	2.43 (0.80-7.43)	3.86 (1.10-13.6)	2.42 (0.64-9.23)	3.51 (0.94-13.1)	2.33 (0.58-9.26)
3 slices bread high in dietary fibre	1 (Ref)	1 (Ref)	2.70 (0.79-9.27)	2.34 (0.63-6.64)	1.40 (0.25-7.91)	1.15 (0.18-7.20)	5.09 (1.26-20.6)	4.29 (0.97-19.0)
Vegetarian diet	1 (Ref)	1 (Ref)	4.31 (1.34-13.9)	10.0 (2.31-43.5)	0.66 (0.07-6.03)	1.71 (0.16-18.8)	14.4 (3.75-55.3)	41.9 (7.03-249.9)
Restrictive eating	1 (Ref)	1 (Ref)	1.89 (0.67-5.32)	3.73 (1.07-13.0)	1.13 (0.27-4.73)	2.64 (0.50-12.5)	3.40 (0.99-11.7)	7.70 (1.71-34.7)
Dieting	na	na	1 (Ref)	1 (Ref)	4.54 (1.36-15.2)	4.93 (1.42-17.0)	0.76 (0.20-2.88)	0.78 (0.20-3.01)
Food avoidance	1 (Ref)	1 (Ref)	1.10 (0.48-2.55)	1.57 (0.61-4.03)	5.40 (1.59-18.4)	8.84 (2.23-35.1)	23.1 (2.86-186.7)	36.7 (4.16-323.9)

na= not applicable.

All three ED groups had a higher likelihood of eating at least 5 fruits or vegetables per day compared to controls. The proportion of patients that attained this goal varied from 30-33%; however, only 11% of controls met the goal. The odds ratios for ED patients declined, however, after adjusting for age. Compared to controls there was a significantly greater likelihood of currently anorexic patients reaching the nutritional goal of 3 slices of high fibre bread per day.

*Food avoidance*

There was a substantially higher likelihood of the two patient groups with current eating disorder psychopathology to avoid particular types of food compared to controls, especially among anorexics. The recovered patients tended to resemble controls in this regard, and showed little avoidance of food. Of the patients who practised food avoidance, 73% reported that they avoided fatty foods and this was consistent across patient groups (73% recovered, 67% anorexic group and 78% bulimic group). Among controls, 33% of those who reported food avoidance avoided fatty foods. The fatty food items that were most often reported were cream, oils, butter, cheese, potato crisps, ice

cream, mayonnaise and pastries. The next most common food to be avoided was food with high sugar content (43% among patients and 33% for controls), followed by fast-food like pizza, chips and hamburgers (30% among patients and 17% for controls), and other foods high in carbohydrates (25% for patients and 8% for controls). Distributions across the different clinical groups were fairly consistent.

*Risk behaviours and psychological symptoms in recovered patients*

Analysis of the relationship between current eating-related risk behaviour and psychological functioning among recovered patients was carried out using one-way ANOVA with a three-way categorisation of the amount of risk behaviour exhibited by each recovered patient (i.e. no risk behaviour, at least one risk behaviour, two or more risk behaviours). Results are presented in Table 2.

When compared to recovered patients who did not report any aberrant eating, recovered patients who reported two or more risk behaviours showed significantly greater Drive for Thinness (E.S.=1.7) and a tendency toward greater Body Dissatisfaction (E.S.=1.0) on the EDI-2. They showed significantly higher levels

**TABLE 2**  
Recovered patients that reported 0, 1, 2 or more disturbed eating behaviours (restrictive eating, dieting, food avoidance) at 36-month follow-up in relation to psychological measures: ANOVA, F, p and post-hoc Scheffé tests.

Variables	Number of risk behaviours						Analysis		
	0 (N=13)		1 (N=12)		2 or more (N=11)		F	p	p*
	Mean	SD	Mean	SD	Mean	SD			
EDI Drive for thinness	2.7	3.9	6.4	5.1	11.6	6.3	8.9	0.001	0.001 <sup>a</sup>
EDI Bulimia	0.1	0.3	1.5	2.2	1.9	3.9	1.8	0.176	
EDI Body dissatisfaction	7.7	7.8	11.7	9.4	15.5	8.5	2.5	0.097	
SASB Self-emancipation	43.2	10.1	44.5	16.6	34.4	15.4	-1.7	0.193	
SASB Self-affirmation	65.4	17.6	52.5	23.2	47.7	27.4	-2.0	0.158	
SASB Self-love	64.8	15.0	58.2	21.9	42.4	22.1	-4.0	0.028	0.032 <sup>a</sup>
SASB Self-protection	55.6	18.9	57.9	22.4	52.5	20.2	-0.2	0.820	
SASB Self-control	48.9	17.4	49.5	12.8	47.4	22.1	0.0	0.960	
SASB Self-blame	19.4	16.9	32.1	25.1	31.6	19.8	1.5	0.241	
SASB Self-hate	11.5	9.7	27.2	24.0	28.4	21.2	3.4	0.063	
SASB Self-neglect	15.4	12.2	26.9	22.7	26.4	17.4	1.6	0.206	
SCL-90 Symptom Index	0.4	0.2	0.6	0.4	0.7	0.4	2.8	0.079	
BDI Depression	4.5	4.0	8.6	7.2	14.0	11.1	4.2	0.019	0.019 <sup>a</sup>

\*Post hoc Scheffé test (pair wise comparisons between patients with 0 or 2 or more risk behaviours). <sup>a</sup>0 vs 2 or more.

of Depression (E.S.=1.2) on the BDI, and a tendency toward more psychiatric problems on the Symptom Index of the SCL-90 (E.S.=1.0), as well as significantly less Self-love (E.S.=1.2), and a tendency toward greater Self-hate (E.S.=1.1) on the SASB. There was a linear trend (Wilk's  $\lambda=0.33$ ,  $F(2)=2.8$ ,  $p=0.020$ ) between all continuous variables together and the ordinal measure of risk behaviour, suggesting an association between the level of disturbed eating and the level of overall psychological disturbance.

## DISCUSSION

The present research investigated differences in dietary habits and eating behaviour according to the patients' current eating disorder status three years after entering treatment. Patients were divided into those who were recovered, and two separate clinical groups who were still suffering from either anorexic or bulimic symptoms. These three patient groups were then compared to a reference group of normal controls. Our findings suggest that recovered patients resembled controls in important ways, and that some normalisation of eating habits had occurred. However, some aspects of aberrant eating persisted in recovered patients, in particular, vegetarianism and restrictive eating. The degree of aberrant eating in recovered patients was also associated with their general level of psychological disturbance, which suggests that eating pattern and psychiatric wellbeing are at least to some extent interrelated. There was an apparent high drive for thinness in the recovered patients who reported two or more eating-related risk behaviours. This may indicate the persistence of an overvaluation of ideals pertaining to body shape and weight among many patients who still endeavour to control their eating habits and weight despite recovery from fundamental manifestations of their eating disorders. The higher level of depression among recovered patients with aberrant eating behaviour suggests a persistence of affective problems that may also increase the risk of future relapse. Recovered patients who reported greater eating-related risk behaviour also had less positive self-image, which has previously been related to negative outcome (30).

The high prevalence of vegetarians in AN populations reported by others (31-34) was confirmed in our study. Recovered patients who ate a vegetarian type of diet tended to also eat more restrictively, and were more prone to diet, consistent with findings that weight-

recovered anorexics still restrict eating and experience poor appetite regulation (35, 36). Dietary history studies suggest that recovered anorexics maintain their weight by eating more or less the same foodstuffs as before treatment (9). In a college student population, Gilbody et al. (37) found that vegetarians scored higher on dietary restraint, but did not differ from non-vegetarians in the proportion who were currently dieting. Dieting and dietary restraint are overlapping, but not synonymous concepts. There is, however, limited evidence that dieting and dietary restraint are separable (38). Applying our definition of dieting, there was considerably more evidence of restrictive eating than dieting per se among patients with predominantly anorexic symptoms at follow-up. Interestingly, dieting was most common among patients with bulimic psychopathology at follow-up. Bulimics seem to have similar difficulties abstaining from dieting, as anorexics have abstaining from restrictive eating. In both cases there may be a persistence of underlying psychopathological schemas.

Treatment of eating disorders often includes confrontation with "forbidden" food in order to reduce the anxiety and fear of weight gain associated with such foodstuffs. To improve health and attain long-term recovery, treatment interventions often focus on helping the patient to accept a variety of foods, including fats, in appropriate amounts. A recent study showed that AN patients with good treatment outcome varied their dietary intake more, and had higher energy density and fat intake compared with AN patients with poor treatment outcome (39). Interestingly, although levels of food avoidance in general among recovered patients in our study were similar to controls, the majority of recovered patients still avoided fatty foods. This finding is similar to the work of Sysko et al. (36) who found that fear of fat was still present in anorexics relative to controls following weight restoration. The fear and anxiety associated with forbidden foods may impede recovery for some anorexics. In order to better aid recovery, it may therefore be important for clinicians to address more directly fears of "forbidden" food, and of fatty foods in particular. This could be done by encouraging exposure to such foods, discussing patients' feared consequences of ingesting them, and confronting underlying assumptions about fat specifically. What's more, as Warin (40, p. 88) states in her study: "Food refusal and fear of fat amongst those who are considered anorexics has another level of meaning beyond the desire to lose weight". It may, therefore, be important for clinicians to explore the wider meaning of a patient's fear of foods with a high fat content.

Although our work sheds important light on how ED patients actually eat after treatment, there are some limitations to the study. ED patients were assessed with standardised and reliable psychological self-report scales and expert ratings; however, the dietary questionnaire had not been previously tested empirically in ED samples. Future work could therefore focus on establishing more fully the psychometric properties of the dietary questionnaire in patients with ED. A possible criticism of the dietary questionnaire is that it focused primarily on the quality of dietary habits, rather than quantity of food ingested using close monitoring of eating habits. This could also be addressed in future work. Another limitation of the present study was its moderate size. In order to obtain larger sub-samples with predominantly anorexic or bulimic characteristics, EDNOS patients were grouped together with full syndrome patients with similar eating disorder psychopathology. Although this increased statistical power, it limited generalisability and could have obscured some of the relationships between anorexic and bulimic psychopathology. For example, three of the EDNOS patients that were placed in the anorexic group were binge eating/purging types. Since some studies suggest that such anorexics have a predominantly bulimic eating pattern (9, 34), some important differences may have been obfuscated. Future studies would therefore do well to use larger samples. Moreover, although the control group was somewhat younger than the ED group, and several studies (41-43) have shown that young female adolescents have problematic attitudes toward body shape, body weight, food and eating, this could be controlled for statistically in the logistic regression by adjusting for age. Finally, since we did not measure possible ED problems in the control group, we cannot be certain of how representative this group is of normal young females without eating disorders.

There is an important debate within the field of eating disorders as to whether it is the normalisation of eating that has an impact on psychological disturbance, or vice versa. To investigate whether eating pattern as such is a key component in recovery, future research should adopt longitudinal designs that have greater potential to elucidate processes of change in eating patterns in relation to psychological wellbeing. Although our work cannot shed light on the direction of such change, it suggests that it is important to monitor eating behaviour in ED patients. Patients that may recover in clinical terms from an eating disorder may still exhibit disturbed eating. In partic-

ular, restrictive eating, dieting or avoidance of fatty foods, could increase the risk of relapse. Clinicians should also be attentive to behaviours like vegetarianism and the use of unusual diets, which may not be unhealthy per se, but potentially detrimental in combination with a history of eating disorders. Eating healthy foodstuffs regularly, a major treatment goal, could be attained by many eating disorder patients, and this may provide long-term protection from relapse.

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