

# EATING DISORDERS REVIEW®



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## Highlights of the AED Annual Meeting

### A Call for Advocacy and An Exploration of Ethical Challenges

The annual Academy for Eating Disorders conference, held in San Diego June 11 and 12, featured clinical teaching workshops, plenary sessions, research presentations, and practical workshops. Two of the many highlights of the meeting included a call for advocacy for eating disorders and a thought-provoking discussion of difficult ethical issues in treatment.

**"A grassroots advocacy group could raise several million dollars to support better treatment for people with eating disorders." –Dr. Walter Kaye**

#### Getting the word out about eating disorders

In a keynote address, Dr. Walter Kaye, professor of psychiatry at the University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic, challenged AED members and others to get the word out about the seriousness of eating disorders. Dr. Kaye also outlined new findings showing inherited susceptibilities to eating disorders.

Dr. Kaye cited a *New York Times* article in which Tipper Gore said she favors full equivalence or parity in coverage for the recognized major mental health disorders, which she identified as schizophrenia, bipolar or manic depressive disorders, and major clinical depression. "Where are the eating disorders?" asked Dr. Kaye, "and why aren't they mentioned?" Dr. Kaye pointed out that anorexia nervosa

has the highest death rate of any psychiatric illness and that it is second only to schizophrenia in the number of hospital beds that are occupied. Further, he said, parity laws would require insurers to pay for all psychiatric treatment or care. Eating disorders need to be "on the table" when these kinds of issues are discussed, Dr. Kaye stressed.

#### New data may help de-stigmatize eating disorders

Dr. Kaye also suggested ways that new neurobiologic information can support the needs of people with eating disorders. First, he said, it is very important to include eating disorders as severe mental illnesses, which is the key to getting treatment paid for by managed-care programs.

Another advance will be developing new medications and better psychotherapies that target susceptibilities that may cause eating disorders. New genetic information will help de-stigmatize eating disorders, he said, adding that under-

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## Update

### When Can AN Patients Be Safely Transferred for Less-Intensive Treatment?

In many managed-care systems, clinicians are under pressure to transfer anorexic inpatients to less-intensive treatment as quickly as possible. A group at Johns Hopkins University has identified prognostic factors that can be used to determine the earliest point at which an anorexic patient can be safely transferred to a day hospital program. In a retrospective study of 71 anorexic patients, William T. Howard, MD, and his co-workers found that the risk of being readmitted to intensive treatment rose with each of the following: comorbid diabetes mellitus, AN longer than 6 years, and amenorrhea for more than 3 years. Patients who gained less than 2 lb while on the inpatient unit and those who had a lower body mass index (BMI) at admission (<75% normal) and a BMI <90% of normal at transition to day hospital treatment were also at increased risk. The study was presented in May at the American Psychiatric Association meeting in Washington, D.C.

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standing that certain people have certain susceptibility factors will help increase advocacy and support for these disorders. Advocacy may also help develop new psychotherapies.

### Grassroots efforts are needed

Although nonprofit organizations have done a great job thus far, Dr. Kaye told the audience that grassroots advocacy is a major key to getting the word out about eating disorders. He pointed to the success of organizations such as NAMI (National Alliance for the Mentally Ill), which has nearly 200,000 family members, more than 1000 affiliates, and a focus on

severe mental illness. Another example is NARSAD (National Act for Research in Schizophrenia and

Depression), which was founded 13 years ago, and which recently raised almost \$83 million to fund more than 2,130 grants. An advocacy group for eating disorders could raise several million dollars to support better treatment for people with eating disorders.

Dr. Kaye also called for an alliance among the national eating disorders organizations, particularly EDAP, NEDO and ANAD and ABBA, to pool resources and energies. In addition, he urged clinicians to help mobilize concerned citizens to push for special attention to eating disorders among policy makers (the insurance industry and medical and scientific communities). One important goal for such advocacy will be increased awareness among insurance companies that eating disorders are serious conditions that require appropriate coverage for diagnosis and treatment.

Finally, Dr. Kaye noted that in one study only about one-third of anorexic patients were discharged

at 90% of healthy body weight. He added, "Horribly, about a third are discharged at less than 85% normal body weight." This message should get out, he said, along with the message about why it is so important to keep people in the hospital under structured care until they reach a healthy body weight.

### Ethics and the treatment of eating disorders

A special plenary session moderated by Dr. Joel Yager, professor of psychiatry at the University of New Mexico School of Medicine, explored "Ethical Issues in the Treatment of Eating Disorders." Three panel members discussed forced treatment, the issue of

recovered eating disorders professionals treating people with eating disorders, and issues concerning treating

patients with chronic or terminal eating disorders.

### Forced treatment

Elliot Goldner, MD, Assistant Professor, Department of Psychiatry, University of British Columbia, and Director, Provincial Eating Disorders program, St. Paul's Hospital, Vancouver, BC, presented an ethical decision-making framework for determining how and when to use forced treatment. Such an approach makes better sense than a formulaic method, he said, because each patient and each family is different. "Our aim is to try to do good, and to achieve a good outcome," Dr. Goldner said. The decision involves asking whether forced treatment will actually do more harm than good and also must respect the patient's rights and freedoms and her family's rights to make this decision.

### Few patients recover quickly

Dr. Goldner cited a 15-year prospective study by Strober et al,

***"An ethical framework for determining how and when to use forced treatment makes better sense than a formulaic method, because each patient and each family is different."***

**—Dr. Elliot Goldner**

in which more than 75% of patients had made a full recovery from AN after 15 years. Of the remaining patients, 11% had at least a partial recovery after 15 years, leaving 14% of the original group who continued to have AN. Dr. Goldner pointed out that even with excellent treatment and outpatient follow-up, very few patients recovered quickly. As Dr. Goldner noted, a

***“The less training a recovered staff member has, the greater the risk of relapse.”***

***—Dr. Craig Johnson***

patient who is ill 5 years has a 28.9% chance of still being ill at 15 years. Someone who is still ill at 10 years has an 81.3% chance of still being ill at 15 years. He added that it is still not possible to predict what the long-term outcome will be for individual patients.

Dr. Goldner stressed that it is important to remember that there is a potential for harm in forced treatment and that clinicians must carefully consider the treatment decision before acting. *“What we do is very important,”* he said, *“but the how is also very important.”* A thoughtful decision-making process ideally includes the entire team of people who are doing the work because these are very emotional issues. The team should feel that they have a sound basis before they force any treatment. He also advised clinicians to explain the intent to do good, to make sure that the family members understand the rationale, and to be willing to negotiate. He also suggested avoiding punitive methods and balancing safety and economy, as well as preserving and promoting the patient and family’s autonomy. Finally, he advised, when planning forced treatment, get sound legal advice, since statutes and laws vary widely by jurisdiction.

### **'Been there, done that': When recovered professionals treat patients**

The issue of recovered professionals is both “an elephant in the living room and an elephant in the closet,” according to Craig Johnson,

PhD, Professor of Clinical Psychology at the University of Tulsa and Director of the Eating Disorders Program at Laureate Psychiatric Clinic and Hospital, Tulsa. The less we talk directly about it the more we end up talking around it, he said, and the less it is discussed, the

more shame-based the issue becomes. Dr. Johnson estimated “conservatively” that

about 30% of professionals have struggled with eating disorders themselves.

Dr. Johnson reported the results of his survey of recovered staff members at 10 treatment facilities. He telephoned 10 colleagues from large treatment programs (5 for profit, 5 nonprofit organizations) in the US, and asked a series of questions about how they dealt with this issue. He also checked with the AED and the International Association of Eating Disorder Professionals. The international group has a written a code of ethics about recovered professionals, while the AED does not yet have a well-defined policy, he reported.

### **Mixed reactions were the rule**

Among the 10 treatment programs, 4 actively embraced the use of staff in personal recovery. In contrast, one organization actively avoids discussion of recovery because of a bad experience; instead they have subtle job interview techniques to determine if a professional is in recovery. Five of the institutions had mixed feelings—they were looking for good clinicians; if the clinicians had personal recovery that could be seen as an advantage, but they did not actively pursue this.

The groups interviewed estimated that the relapse rate among professionals was from 10% to 20%,

and defined “recovery” as abstinence from binge-eating and purging for 1 to 2 years. Abstinence from binge-eating and purging was the easiest thing for them to talk about—almost everyone wished for normal weight, although the definition of “normal weight” was unclear. The issue of psychological recovery was extremely ambiguous, he reported and “seemed to fall to the eye of the beholder, or whoever was doing the interview.”

Since 1989, when Dr. Johnson joined the Laureate Clinic staff, 11 professionals with personal recovery from eating disorders had joined the staff; during the past 10 years, there have been 1 profound relapse and 1 minor relapse among these professionals, he said. Three other staff members had “wobbles,” or felt at risk for relapse. “I’ve learned that the less training the staff member has, the greater the risk of relapse,” he said. With less training, there is a much greater risk of problems with transference and countertransference, he added.

### **Advantages and disadvantages**

There are clinical advantages and disadvantages to having staff who are in recovery, he said. The advantages include the hope, motivation, empathy, creditability, and understanding staff members can bring to treatment. The disadvantages include a very narrow perspective, inflexibility, and problems with boundaries. Dr. Johnson noted that the greatest vulnerability to countertransference and relapse among recovered staff members occurs when they work with patients who have sexual or physical trauma that is directly related to the eating disorder.

### **Recommendations for the future**

Dr. Johnson recommended that, as the official organization for eating disorders, the Academy openly acknowledge that clinicians

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***“The chronically ill patient requires a different paradigm of care.”***

***—Dr. Michael Strober***

## NUTRITION NOTES

### Riboflavin Deficiency in Adolescent Girls with Anorexia Nervosa

Riboflavin is essential for energy production, good vision, and healthy skin and mouth tissue. Malnutrition from anorexia nervosa sets in motion a complex chain of events that culminate in riboflavin deficiency.

Riboflavin deficiency has been previously reported in anorexia nervosa patients.<sup>1-3</sup> Most recently, C.D. Capo-chichi and colleagues investigated the effects of malnutrition associated with anorexia nervosa and concomitant low thyroid hormone levels on erythrocyte and plasma riboflavin metabolism and urinary excretion of organic acids.<sup>4</sup>

#### Riboflavin's normal pathways

Normally, riboflavin is converted to 2 coenzymes, flavin mononucleotide (FMN) and flavin adenine dinucleotide (FAD) in tissues. Riboflavin kinase and FMN adenylyltransferase catalyze these conversions to FMN and FAD. FAD and FMN are stored in cells bound to flavoenzymes, and FAD is the predominant storage molecule. Only a small fraction of riboflavin is stored as free riboflavin in cells. The liver is the major site of riboflavin storage, and contains approximately one-third of total body flavins. The expression of the enzyme riboflavin kinase is regulated by triiodothyronine (T<sub>3</sub>). Thyroid dysfunction, resulting in hypometabolism, is a well-known metabolic adaptation in anorexia nervosa.

#### Study design

Thyroid hormones, riboflavin, riboflavin cofactors, and urinary organic acids (as indicators of riboflavin function) were evaluated in 17 adolescent girls with anorexia nervosa (mean age: 16 years; mean BMI 14.8 [10.2-16.3]), and a control group of 17 healthy control adoles-

cent girls (mean age: 13 years; mean BMI 20.5[17.1-25.1]) Refeeding of the anorexia nervosa (AN) group was being accomplished with an *ad libitum* diet, in which carbohydrate, lipid, and protein provided up to 51%, 40%, and 16% of calories, respectively. Riboflavin intake was 2.5 mg/day throughout the study. Caloric intake on days 0 (day of admission), 15, and 30 was 1625, 2000, and 3196 calories, respectively. Four patients received supplemental nighttime enteral feedings.

Fasting plasma thyroid hormones, erythrocyte and plasma FAD, FMN and riboflavin concentrations and urinary organic acids were assessed from blood and urine samples collected on day 0, and days 15 and 30 of the refeeding period for the AN group and one fasting sample from the controls.

#### Results: refeeding produced higher riboflavin levels

Compared to controls, the AN refeeding group had higher erythrocyte riboflavin levels (3.5 vs.<0.1nmol/mol hemoglobin; P<0.001), lower plasma FAD (57.8 vs.78.5 nmol/L; P<0.05), and higher urinary ethylmalonic acid levels (7.12 vs. 1.3 micromol/mmol creatinine; P<0.05). At admission, T<sub>3</sub> concentrations were low in the AN group and negatively correlated with plasma riboflavin concentrations (r = -0.69; P< 0.01), but became positively correlated (r= 0.59; P<0.05) after 30 days of refeeding.

The authors hypothesize that the insufficient conversion of riboflavin into flavoenzymes could be a result of energy depletion and a decrease in riboflavin kinase activity. Since T<sub>3</sub> regulates the expression of riboflavin kinase, a decrease in T<sub>3</sub> and resting metabolic rate could be responsible for a decrease in riboflavin kinase biosynthesis. This would decrease the production of FMN and FAD from new riboflavin entering cells, resulting in atypical

storage of free riboflavin in the cytoplasm of cells. In addition to the accumulation of riboflavin in the erythrocytes and lower plasma FAD concentrations in the AN group, a rise in the urinary excretion of organic acids was observed. These acids essentially serve as biomarkers of riboflavin-dependent enzyme systems in hepatocytes, and the increased urinary levels that were observed suggested that the riboflavin abnormalities were having an effect on biochemical functions.

The authors conclude that the low T<sub>3</sub> concentrations seen in anorexia nervosa could

alter riboflavin metabolism, resulting in elevated erythrocyte riboflavin concentrations, low plasma FAD levels, and elevated levels of urinary ethylmalonic acid and isovalerylglycine excretion. These findings have clinical significance because this suggests that an improvement in energy balance, and thus overall nutritional status (rather than simply providing the vitamin), may be necessary to correct the vitamin problem and to restore normal metabolic processes in anorexia nervosa.

—Tami J. Lyon, MPH, RD, CDE

***Vitamin supplements alone will not be enough.***

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# A New Questionnaire to Help Identify Young Girls at Risk for Eating Disorders

Eating problems in early childhood can predict more severe eating disturbances in adolescence. However, until recently, there were no tests specifically designed to detect factors that might place young girls at risk of developing eating disorders. In addition, the youngest groups studied have generally been middle school students. Almost no studies have been done among girls in elementary school.

The McKnight Risk Factor Survey-III (MRSF-III) is a questionnaire that examines a number of potential risk "domains" among girls as early as the 4th grade. A recent study found the MRSF-III to be a useful instrument to assess potential risks and protective factors for the development of disordered eating in preadolescent and adolescent girls (*Int J Eat Disord* 25:195, 1999).

## Methods

Several versions of the MRSF were pilot-tested before the MRSF-III was administered to 134 elementary school girls (4th and 5th graders), 243 middle school girls

(6th to 8th grade) and 274 high school girls (9th to 12th grade) in Arizona and California.

The ethnic background of the students was as follows: White, 52%; Hispanic, 24%; Asian-American, 13%; African-American, 4%; Native American, 2%, and "Other," 3%.

The Weight Concerns Scale, the Rosenberg Self-Esteem Scale, the Center for Epidemiological Studied Depression scale and the Child Depression Inventory were included in the administration of the MRSF-III to assess the validity of the new test.

Because of concerns that the younger girls might have difficulty reading and understanding some of the items on the MRSF-III, the Arizona investigators read the questionnaire aloud to 99 4th and 5th graders. The girls were invited to ask questions about any question they did not understand.

## Results

The test-retest reliabilities of the MRSF scales were high across all age groups, except for a few cases among the elementary students, according to Dr. Catherine Shisslak,

of the University of Arizona, Tucson, who directed the study.

For elementary, middle school, and high school students, the overall test-retest reliabilities for weight control behaviors were high. No significant differences were found between the oral and the non-oral tests.

## A few limitations

Dr. Shisslak also outlined a few limitations for the questionnaire. She believes that there are two possible reasons why the test was less consistent and reliable among the elementary school group.

First, the young students usually have lower levels of cognitive functioning that vary more over time than do those in middle or high school students. Like all self-report instruments, distortions and inaccurate reporting can occur.

Second, the younger girls may not have understood some of the terms and might have interpreted them differently from the older girls. Dr. Shisslak notes, for example, that elementary school students may not clearly understand what a "binge" is.

## Results from the 1998 National Eating Disorders Screening Program

The National Eating Disorders Screening Program (NEDSP) is a voluntary testing program designed to help uncover people with eating disorders in the general population and to encourage and help them seek treatment. Each year the program reaches an ever-larger number of young people at risk. This year's program, conducted early in February, was no exception.

According to Dr. David Garner, director of the Toledo Center for Eating Disorders, Toledo, OH, and colleagues, this year's program conducted screening at 1083 sites. He also noted that 69,374 individuals attended the screening sessions. As

reported at the annual Academy for Eating Disorders meeting in San Diego, more than half of the 35,897 individuals who were screened for eating disorders were college students.

### ***Many found to be at risk went on for suggested treatment.***

A modified version of the Eating Attitudes Test was used as the primary screening tool, then follow-up interviews were done by telephone two months after the initial screening on a representative sample of 937 participants.

### **More than a third were at risk**

Of those screened, then followed up

by telephone, 34.5% scored 20 or more on the EAT, and 89% of these were not in treatment at the time the screening program took place. During the interviews, the researchers learned that 15% of those interviewed reported vomiting during the past 6 months in an attempt to control their weight; 15% abused laxatives, 33% used diet pills, and 11% took diuretics. Thirty-eight percent were referred for further treatment.

Of the people who scored positively on the EAT and were then referred to a clinician, 42% actually went to see a clinician. Dr. Garner reported that 76% of this group underwent further treatment.

# Chest Pain in Anorexia Nervosa: What Does It Mean?

The first surprise researchers at the University of British Columbia encountered was finding that chest pain is so common among patients with anorexia nervosa. Their search of the literature from 1966 to 1996 showed that 87% of anorexia nervosa patients had experienced chest pain. Their next surprise was that no explanation for the chest pain was given for 38% of patients (*Int J Eat Disord* 25:219-222, 1999). The researchers also found that typical and atypical angina are surprisingly common among women with AN; the incidence was 11% and 9%, respectively.

Dr. C. Laird Birmingham and his colleagues note that chest pain felt by AN patients, particularly typical and atypical angina, might be due to ischemic heart disease. These patients are at increased risk of coronary artery disease (CAD). Major risk factors are presence of typical angina, postmenopausal status without hormone replacement therapy, diabetes mellitus, and peripheral vascular disease. Smokers, women with low high-density lipoprotein cholesterol levels and high total cholesterol (>6.85 mmol/l) also have a higher risk of CAD. The authors recommend that all patients with eating disorders be screened with a thorough history for chest pain, and other risks for CAD.

## QTC interval changes

Swedish researchers have concluded that ECG exams are an essential part of assessment of patients with eating disorders and continuing weight loss, even if no electrolyte disturbances are found (*Acta Paediatr* 88:304, 1999). This recommendation is especially important if the patient is severely underweight or is rapidly losing weight, according to Drs. I. Swenne and P.T. Larrson of Uppsala University Children's Hospital.

In a study of 58 teenaged girls with anorexia nervosa (mean age: 15.5), the scientists investigated risk factors for QTc interval prolongation and dispersion, two indicators of an increased risk for cardiac arrhythmias and sudden

death. The patients weighed 40.7 kg, and had lost a mean of 11.8 kg. This group was compared with 38 normal-weight teenaged girls with no known heart disease.

ECG studies of the anorexic patients showed bradycardia, a shift to the right of the QRS axis, diminished amplitudes of the QRS complex and T wave, and prolonged and increased dispersion of the QTc interval. The most important predictors of the QTC abnormalities were low weight, low BMI, and rapid weight loss immediately before the examination.

## CLARIFICATION AND CORRECTION

In the last issue, the early results of a study by Lauren Mayer, MD, and colleagues were reported in Update. The authors suggested that elevated REE/FFM among AN patients might contribute to the difficulties many patients experience in maintaining normal weight. However, as the authors have advised us, the difference between patients and controls has diminished as more patients have been added to the study. The authors report that their results are preliminary, and need to be confirmed by additional data.

In a second article, "Anorexia Nervosa: Uncovering Beliefs That Interfere with Treatment," Dr. Lucy Serpell, not Dr. Janet Treasure, was the senior author.

## BOOK REVIEW

### *Women's Mental Health in Primary Care*

(By Kathryn J. Zerbe, M.D.  
W. B. Saunders, Philadelphia 1999;  
380 pp; \$39.00)

These days it's rare for a textbook on any subject to be written by a single author. When a single-authored textbook appears on women's health, written by a female physician-psychiatrist who is also a graceful, fluid and elegant writer, and when that author's primary areas of scholarly interest have focused on eating disorders, psychoanalytic psychology, and feminist issues, what a natural for EDR.. To add to that pleasure and pride, the author is a member of our editorial board. Irresistible.

Readers of Dr. Zerbe's wonderful previous book, *The Body Betrayed: Women, Eating Disorders, and Treatment*, have deservedly come to expect poetic style, literary flare, and compassionate humanism. They will not be disappointed. Although this book is aimed at primary-care clinicians, it will be richly rewarding for all mental health professionals and others who deal with the wide range of women's health and mental health problems. Scattered through the various chapters on depression,

bipolar disorder, substance abuse, psychosis, sexuality and intimacy, the older patient (and, of course, eating disorders, trauma and violence, and many other subjects), are remarkably helpful mini-essays. Who can resist well-written, sensible sections such as "Patient Guidelines for Coping with Depression;" "Patient Guidelines for Coping with Trauma and Violence"; "Modern Tools for Helping Women Manage Stress"; "What Can Safely Be Advised Concerning Prenatal and Postnatal Exposure to Psychotropic Drugs?"; "A Practical Technique for Helping Women Achieve Sexual Satisfaction"; "Special Considerations for the Lesbian Patient"; and, for this virtually cradle-to-grave discussion, "Why is Alzheimer's Disease a Women's Mental Health Problem?" Of course, it goes without saying that the chapter on eating disorders includes superb guidelines for clinicians and patients for coping with eating disorders and obesity at all stages of life. Each chapter contains helpful annotated resources for patients and resources for primary care clinicians (translation: all of us). Bottom line: This book is a definite "keeper," one that you'll want to keep nearby and, in contrast to many textbooks, read cover to cover.

—J.Y.

*continued from page 3*

in personal recovery can make a significant contribution to the understanding of the etiology and treatment of eating disorders. Secondly, he feels that eating disorders professionals should offer guidelines to better define "recovery." Third, he recommended that clinicians have broad-based training with adequate experience treating other Axis I and Axis II disorders. This will help guard against the tendency of young recovered clinicians to arrange their curriculum and training to narrowly focus on treating eating disorders. Finally, he said, recovered staff members have an ethical responsibility to monitor themselves in whatever way is necessary to ensure that their patients are receiving the highest quality of care.

### **The Chronically Ill Patient**

Dr. Michael Strober, Professor of Psychiatry and Director of the Eating Disorders programs at UCLA, described some of the uniquely difficult and challenging aspects of treating patients who have had chronic illness, or those for whom the prospect of recovery is marginal.

Chronicity is not synonymous with treatment resistance, he said, explaining that treatment resistance is actually two separate phenomenon—avoiding treatment and the lack of responsiveness to treatment. About 10% of patients with AN will not recover: 5% will spend their adult life in a severely symptomatic state, and approximately 5% will die as a direct result of this disorder. "We can't forecast or determine in advance who will recover," Dr. Strober said, adding, "we know very little about the variables that prognosticate the natural course of any psychological illness."

Understanding the interior domain of the patient has very important implications for how one approaches care, he said. Anorexia nervosa, at least in part, rests upon a foundation of extremes of temperament. He described these patients as living "a psychic life that is constrained in the most profound

way, withered by the imperviousness of the individual to take anything from outside. To be in life in anorexia nervosa is to be utterly swamped by the incomprehensibility of what the individual experiences as an impossibly liquid, pulsating, dynamic of accommodation, collaboration, and interdependency."

### **A nontherapeutic alliance**

Care of the chronically disabled population, does not involve a therapeutic alliance he said, but a nontherapeutic one because there is no treatment for this end-stage disease, and there is an ill-defined, seamless boundary between the disabling and the restorative or protective aspects of illness. To the patient, the disease is existentially welcome, he said. It isn't a matter of denial because patients know they have a miserable existence. The patient longs for freedom from the tyranny of her symptoms but it is as if she knows she will never achieve this. So the therapist is in the position of seeking nothing, expecting little, and deferring to the patient as to the objective of the time spent together.

### **A different paradigm for care**

The chronically ill patient requires a different paradigm for care, he said, where one considers a fundamental shift in the balance of the relative cost of treatment against the anticipated effectiveness. In this paradigm of treatment, we do not treat, he said, but instead care for, stand by, and make up for disease, rather than offering treatment in the true or usual sense. Treatment is palliative, a holding management of carefully measured intensity. Further, he said, treatment of these patients requires an even-tempered manner, a tolerance for misery, a desultory pace of work, an acceptance of failure, and acceptance in some of the anticipation of death. A zeal for change can disrupt and destabilize, exacerbating symptoms.

Working with such patients poses unique qualities of transference and countertransference; unique and distinct from any other

psychological illness, Dr. Strober explained. He added that it is work characterized by shared experience of passivity, impotence, tedium, drudgery, and failure. Despite this, Strober said, "We do this work because it is fulfilling; we are enriched by the experience that we offer patients. We are enriched by the evolution and growth of the soul in this work."

*Mary K. Stein, Managing Editor, contributed to this story.*

## **Found: A Genetic Basis for SAD and Bulimia Nervosa**

Seasonal affective disorder (SAD) and bulimia nervosa are both characterized by overeating and a depressed mood. Initial data from the University of Toronto point to a possible role for genes mediating the enzyme tryptophan hydroxylase (TPH), essential for serotonin synthesis in both disorders.

Dr. Robert D. Levitan and colleagues initially tracked 3 serotonin genes involved in regulating TPH, the serotonin 2C receptor (HTR<sub>2C</sub>), and the serotonin transporter 5-HT<sub>2</sub> in women with either SAD and carbohydrate craving/increased eating or bulimia nervosa. They also collected parental control triads and cases with matched controls; all were genotyped for TPH, HTR<sub>2C</sub>, and 5-HT<sub>2</sub> polymorphisms. In an earlier study, the researchers found evidence of dysfunction at or downstream from central serotonergic receptors in female patients with SAD, giving further evidence of a serotonergic dysfunction in patients with SAD (*Arch Gen Psychiatry* 55:244, 1998).

In the current study, recently presented at the American Psychiatric Association meeting in Washington, Dr. Levitan reported an association between SAD and the TPH L-allele in both the parental control sample (22 triads) and the extended sample (n=47). In bulimia nervosa, the extended sample showed a significant finding in the same direction as for TPH (n=39), but the parental control sample did not reach statistical significance. No significant findings were reported for either HTR<sub>2C</sub> or 5-HTT. It is also important to remember that not all bulimic patients are depressed.

## Questions & Answers

**Q:** I'm treating a young adolescent with anorexia nervosa who has never had a period. To decide upon a healthy target weight, I usually figure on the patient's weight at which she was menstruating normally. How can I estimate what an "ideal" weight would be for this patient? (*V.S., Portland*)

**A:** You're right to think of "healthy" weight as the weight at which normal menstruation (and ovulation) will reappear. However, this obviously isn't possible for your patient. There are several rules of thumb that might be helpful. First, a healthy weight will be one at which normal physical, sexual, and psychosexual growth and development resume. You may be able to esti-

mate this and project where your patient should be by following her growth chart (the same charts that pediatricians use to track their patients' heights and weights). Second, studies have shown that when patients achieve weights of 90% of standard for their heights, 86% of those who have previously menstruated will have a return of menses within 6 months. In one group, return of menses was associated with a serum estradiol level greater than 100 pmol/L (30pg/mL) (Golden NH et al *Arch Ped Adol Med* 1997; 151:16). If menses don't return when expected, ordering serum estradiol measurements may give you a better gauge of the patient's physiological preparedness to start menstruating.

— J. Y.

### Calendar

#### INTERNATIONAL ASSOCIATION OF EATING DISORDERS PROFESSIONALS

*"Eating Disorders, Families, & the 21st Century"*

August 13-17 • Phoenix, AZ • For information: (800) 800-8126

#### ST. JOSEPH'S HOSPITAL EATING DISORDERS PROGRAM

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**By Ruth Striegel-Moore, PhD**

The growth of managed care has limited care for some patients, due to lapse of insurance coverage. Some practical strategies can make a big difference in patient care.

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