EATING DISORDERS REVIEW®

Published by Gürze Books,
specializing in eating disorders
publications and education since 1980.

ISSN 1048-6984

July/August 2000 • Volume 11, Number 4

Highlights of the Ninth Annual Conference on Eating Disorders

By Mary K. Stein
Managing Editor

AED Meeting Mirrors Growth of Research in Eating Disorders

The Ninth Annual Conference of the Academy for Eating Disorders (AED), held May 4-7 in New York City, reflected the growth and accelerated pace of research into the epidemiology, clinical manifestations, and treatment of eating disorders. More than 800 registrants from the U.S. and abroad participated in 3 days packed with plenary sessions, workshops, and research presentations. A special preconference clinical teaching day preceded the general meeting.

Epidemiology of eating disorders

During the first plenary session, Dr. Ruth Striegel-Moore, Professor of Psychology at Wesleyan University and a past president of the AED, noted that the population with eating disorders is far more diverse than previously assumed and thus challenges recent views of sociocultural status, ethnicity, and eating disorders.

"The widely held view of eating disorders is that that they affect white, affluent girls or women," she said. She added that the image of eating disorders as essentially a problem of the rich and famous has been prompted by early clinical descriptions, as in Hilde Bruch's well-known book, *The Golden Cage.* It is also underscored by media portrayals of eating disorders as an affliction of models and royalty. "These images also contribute to the erroneous assumption that eating disorders are basically about wanting to be beautiful; the psychological and cultural pursuit of thinness are complex and cannot be reduced to a simple formulation of vanity run amok," she said.

The category of eating disorders not otherwise specified (EDNOS) remains the most commonly used diagnosis for individuals presenting for treatment, said Dr. Striegel-Moore. Estimates are that more than half of all patients seeking treatment do not meet criteria for either anorexia nervosa or bulimia nervosa because the diagnostic criteria are too narrow, she said.

Socioeconomic and ethnic status

Dr. Striegel-Moore also reported that studies are showing an inverse relationship between socioeconomic level and some eating disorders. Individuals from lower socioeconomic

continued on page 2

Update

Being Teased About Weight Is Not So Harmless

Being teased about weight and/or appearance can have very negative repercussions, according to Michelle L. Williams and colleagues at the University of Montreal. Although the incidence of dieting and emotional eating is higher among adolescent girls, disordered eating patterns are present in elementary school children, too, and are significantly associated with the social experience of teasing. In a study of 171 children (70 boys, 101 girls) in grades 5 and 6, and 212 tenth and eleventh graders (113 boys, 99 girls), restrained eating was higher among those who were teased about being "big" or about other aspects of their appearance who were upset by the teasing than those who were teased about being big but reported not being upset about the teasing. At all levels of weight, those who were teased about being big and were upset by it reported higher levels of restrained eating than individuals who were not teased. The results of the study have important implications for primary prevention and intervention directed at children and teens.

ALSO IN THIS ISSUE

For Some Obese Children, Changing Eating Styles Beats Caloric Restriction 4

Book Reviews: *Making Weight: Men's Conflicts with Food, Weight, Shape and Appearance* and *The Adonis Complex: The Secret Crisis of Male Body Obsession* 5

Panel Tackles the Clinical, Research, and Policy Implications Surrounding Eating Disorders Not Otherwise Specified 6

Q&A: Are Atypical Antipsychotics Helpful for Anorexia Nervosa? 8

Study Links Obesity to Brain Patterns 8

Nibbles 8

EATING DISORDERS REVIEW®

Editor-in-Chief
Joel Yager, MD
University of New Mexico, Albuquerque

Managing Editor
Mary K. Stein

Associate Editor
Russell David Marx, MD
Princeton Medical Center Eating Disorders Program, NJ

Editorial Board
Arnold E. Andersen, MD
University of Iowa, Iowa City

C. Wayne Callaway, MD
George Washington School of Medicine, Washington, DC

Tami J. Lyon, MPH, RD, CDE
BestSelf, Inc., San Francisco, CA

Marsha D. Marcus, PhD
Western Psychiatric Institute, Pittsburgh

James E. Mitchell, MD
University of North Dakota School of Medicine, Fargo

Pauline Powers, MD
University of South Florida, Tampa

Cheryl L. Rock, PhD, RD
University of California, San Diego

Walter Vandereycken, MD, PhD
University of Leuven, Belgium

B. Timothy Walsh, MD
Columbia University College of Physicians and Surgeons, New York City

Stephen Wonderlich, PhD
University of North Dakota School of Medicine, Fargo

Alayne Yates, MD
University of Hawaii School of Medicine, Honolulu

Kathryn Zerbe, MD
Menninger Clinic, Topeka, KS

Publisher
Leigh Cohn, MAT

Copyright © 2000 by Gürze Books. All rights reserved. Reproduction, photocopying, storage or transmission by electronic means without permission from Gürze Books is strictly prohibited by law. Violation of copyright will result in legal action, including civil and/or criminal penalties, and suspension of service.

Eating Disorders Review® (ISSN 1048-6984) is published bimonthly by Gürze Books, PO Box 2238, Carlsbad CA 92018. 760/434-7533, fax 760/434-5476, email gurze@aol.com. Prior indexes and more information at www.gurze.com.

Missing issues will be replaced without charge if the publisher is notified within 60 days of publication. Otherwise, replacement and back issues are available for $10.00 by contacting Gürze Books.

Editorial questions should be addressed to Joel Yager, MD or Mary K. Stein c/o MD Communications, 302 S. Pinto Place, Tucson AZ 85748-6902, 520/296-6400, fax 520/296-6464; MKStein@azstarnet.com.

Subscriptions—see page 8.

continued from page 1

classes are more likely than middle- or upper-class persons to experience disordered eating, she said. The relationship between eating disorders and socioeconomic status may vary by disorder, and sample groups are often too small to ensure adequate statistical power.

She also cited two major reasons that minority populations are underrepresented. First, minority women generally are less likely to seek psychiatric care than white women, regardless of the particular type of disorder. Second, recent evidence suggests that service providers are less likely to ask minority women about eating disorder symptoms.

To date, the most rigorous epidemiologic studies of eating disorders have been limited to white populations either by default (studies included geographic areas with very small minority representation) or by design (the investigators assumed that eating disorders would be too rare among non-white populations). In this country, there are no nationally representative data on the prevalence and basic demographic characteristics of eating disorders, she said.

Exposure to risk factors

Are some populations at increased risk because they have greater exposure to a particular risk factor? Dr. Striegel-Moore and colleagues identified certain risk factors in their recent study of binge-eating disorder (BED). For white women, personal vulnerability factors included high levels of anxiety and depression, a focus on, and family criticism about, weight and shape. Other factors were inadequate parenting and minimal parental affection. Among black women, extreme childhood shyness was the only personal vulnerability factor identified. Most black women had a supportive and thus protective social network.

Does ethnicity affect clinical presentation or affect the course or outcome of the eating disorder? She reported that in a study of BED, there were significant differences in the clinical presentation of black American women and white American women. The explanation was that, among black women, eating disorders began to appear about 3 years later than for white women, and the black women had fewer dieting concerns. Black women were also significantly less likely than white women to seek treatment for an eating disorder: Only 7% of the black women in the study sought treatment for their eating disorder, compared with 25% of the white women. .

One suggestion: adjust diagnostic criteria for BED

Dr. Striegel-Moore called for an adjustment of the current diagnostic criteria, particularly for BED. To permit the systematic description of eating disorders symptoms that have associated clinical features, clinicians and researchers should work together to develop a set of standard assessment measures and submit those to create a database, she said. Dr. Striegel-Moore pointed out that just such an effort is currently being spearheaded by Dr. James Mitchell, the incoming President of the AED.

Dr. Striegel-Moore told delegates that broad-based participation, including efforts by the international community, will allow clinicians to explore ethnic similarities and differences among individuals from different cultures. "We need to work to reduce barriers to access to care in order to ensure that access is not limited to one particular segment of the population," she said.

Early influences on disordered eating.

There may be very early differences in feeding behaviors between female infants of eating disordered mothers and other infants, according to W. Stewart Agras, MD, Professor and Associate Chairman of the Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine. (Dr. Agras received the AED Research Award at the New York meeting.)

Dr. Agras told the audience at

the plenary session, "We know that mothers with eating disorders have exaggerated concerns about their daughters' weight and shapes. Also, eating disordered mothers tend to interact differently with their infants than do mothers without eating disorders. Children's eating difficulties are related to their parents' weight status, eating attitudes, and behaviors, " he said.

Dr. Agras cited a new study of preschool children with eating problems (*Psychol Med* 2000; 30(1):69). The results showed a strong association between children's feeding problems and maternal eating disorders. Direct observation of the children while feeding correlated with the mother's description of the child's eating pattern. Mothers of children with eating disorders were more likely to have a past history of an eating disorder, including current EDNOS. In effect, these mothers seemed to be "handing on" some sort of eating disorder to their infants, Dr. Agras said.

Dr. Agras then reported the results of a community study of 200 children and their parents begun about 10 years ago in an attempt to look at early psychosocial risk factors for eating disorders (*Int J Eat Disord* 1999;25:375). Dr. Agras and colleagues have followed the children from birth. Forty-two of the 200 mothers had past or present eating disorders, including EDNOS. The 42 mothers with eating disorders (ED group), and 153 mothers without eating disorders and their children were studied for 5 years.

Beginning at 2 weeks of age, the researchers measured the infants' sucking behavior in the laboratory. By 2 to 4 weeks of age, daughters of eating disordered mothers had a more "avid feeding style" than sons or the daughters of any other group; that is, they sucked much more quickly and vigorously than the other infants. Daughters of ED mothers also were much slower to wean from the bottle—almost 10 months later than the other infants. ED mothers expressed much more concern about their daughters' eating patterns than they did for their sons. Attitudes toward daughters were driven by the mother's own ideas about eating behaviors.

By 5 years of age, the effects of the mother's eating behavior could also be seen. ED mothers felt their daughters and sons were more "whiney and depressed" than the daughters and sons of non-ED. ED mothers reported secretive eating and overeating by their daughters. Dr. Agras noted that when mothers reported overeating in the child, it was common to find maternal restraint and drive for thinness. Inhibited eating by the child correlated with the mother's BMI.

In the next phase of the study, 54 males and 54 female children from the same group were interviewed for the first time. Very high levels of binge eating and purging were reported, but this was felt to be due to the fact that the children did not understand the concept of binge eating and purging. By the ages of 8 and 9, the concepts were much clearer to the children. At that time, Dr. Agras and colleagues studied dieting and negative affect. They found no differences in the frequency of any eating behavior between male and female children.

Innovations in obesity treatment

Susan Z. Yanovski, MD, Director of the Obesity and Eating Disorders Program at the National Institutes of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, reported that obesity is becoming a serious problem in the United States and has an impact on all areas of medicine.

> **THE COST OF OBESITY**
>
> ✓ More than half of US adults are now overweight (BMI ≥25).
> ✓ About 10% of African-American women over the age of 40 are severely obese (BMI > 40).
> ✓ Obesity is linked to more than 300,000 deaths per year, and second only to smoking as a cause of death in the US.
> ✓ Obesity leads to $99 billion in medical costs per year, and $52 billion per year in indirect medical costs.
>
> Source: S. Yanovski, MD

The increase in weight has been most marked among children. Today, according to Dr. Yanovski, about 14% of American children are above the 95th percentile in weight. She added, "With this has come an increase in diseases that we used to see only in adults—high blood pressure, sleep apnea, and, increasingly, type 2 diabetes."

This dramatic change over the past 15 years is due to significant lifestyle changes, including increased food intake, eating more meals outside the home, more snacking, and particularly, decreases in physical activity, she said. Children are spending much more time at sedentary activities that involve TV, video games, and computer games.

A goal: preventing childhood obesity

According to Dr. Yanovski, one goal is to help children avoid becoming overweight in the first place. One approach has been to manipulate their environment. She cited a recent study in which researchers investigated whether decreasing TV hours watching time would have an impact decreasing sedentary activities among 3rd and 4th graders (*JAMA* 1999;282:1561). The school-based 18-lesson, 6-month curriculum was designed to reduce the time children spent with TV, video games, and videotapes. Each family had an electronic TV time manager/alarm system that could be set for a specific number of hours per week. The goal was not to increase exercise, but to get children to spend less time in sedentary activities. At the end of 6 months, the children in the intervention group weren't necessarily more active, but their weight gain had slowed significantly.

Adult obesity

Dr. Yanovski noted that the percentage of mildly overweight adults, or those with BMIs of 25-30, hardly changed between 1960 and 1994. However, among obese women (defined as a BMI>30), obesity increased by16% during the two decades between 1960 to 1980,

but leapt upward by 50% during the 6 years between 1988 and1994.

Good behavioral treatment can help people lose weight over the short term, she said, but because weight loss is so difficult to maintain, there is increasing interest in pharmacologic treatments to help maintain long-term weight loss. The two agents currently approved for long-term weight control in adults, sibutramine (Meridia), a serotonin and norepinephrine reuptake inhibitor, and orlistat (Xenical), which inhibits absorption of about a third of dietary fat, are only modestly effective, but can be helpful as an adjunct to a weight loss program.

> ***"With increased obesity has come an increase in diseases in children that we used to see only in adults."***
> ***—Dr. Susan Z. Yanovski***

Dr. Yanovski pointed out that a number of antiobesity drugs are now in Phase 2 (studies in humans) clinical trials. Among these are topiramate (Topamax), an antiseizure medication that is also used in the treatment of bipolar disorder, and bupropion (Wellbutrin), which is both an antidepressant and also available as an anti-smoking medication (Zyban). Eli Lilly is now investigating whether R-fluoxetine is more effective or has fewer side effects than the parent drug, fluoxetine (Prozac). Ecopipam (SCH39166), a selective dopamine antagonist first used for treating cocaine abuse, is now being studied for treatment of binge eating. Ciliary neurotropic factor, which was originally developed for treatment of Lou Gehrig's disease (amyotrophic lateral sclerosis, or ALS), is now being studied for the treatment of obesity.

Preliminary multicenter trials of leptin continue, she noted. Side effects at higher doses of leptin continue to be a problem, she said and added that weight loss is not universal. At the highest dosage, 0.3 mg/kg/day, patients have had significant weight loss, compared to placebo. Dr. Yanovski said there is a need to find a way to give smaller doses or find a way to manipulate the molecules so the product can be given orally (currently it is injected). One of the benefits of leptin is that lean body mass is not affected with weight loss. This is unique among all weight loss agents currently available, she said.

Dr. Yanovski told the audience, "The eventual goal is not to think about obesity as a single problem, but to define the type of obesity with psychological and blood tests, and to weigh the genetic influences. Then we can target specific behavioral or pharmacological interventions," she said.

For Some Obese Children, Changing Eating Styles Beats Caloric Restriction

One of the greatest public health concerns is the recent upsurge in obesity among children. According to a Belgian psychologist, moderately overweight children can benefit from eating and lifestyle changes rather than using a traditional weight-loss diet (*Clin Child Psychol & Psychiatry* 1999; 4:1359).

Dr. Caroline Braet recently described a "child-friendly program" for treating moderately obese children, or those above 120% to 180% of normal weight. Dr. Braet and the University of Ghent youth-obesity group believe that one of the reasons dieting fails for children is that too much emphasis is given to slimming and too little to the possible negative effects of dietary restraint, which can be linked to development of eating disorders. Thus, the program stresses normalizing eating habits rather than weight loss.

One essential: Including the entire family

The program uses "a family-friendly" approach. Because the cooperation of the parents or other family members is crucial, and obesity often affects several family members, both parents and the obese child are always seen together during the assessment phase and during one family session before the treatment begins. Family sessions then resume monthly during the follow-up phase, for a year.

The program begins with an evaluation and establishment of a stable caloric balance for the child. Then, using cognitive behavioral techniques, the therapist promotes healthy eating rather than any reduction in calories. Children learn self-regulation skills during 12 once-a-week sessions lasting about an hour.

Good results reported in 1- and 5-year follow-ups

Since 1983, more than 200 obese children have been treated in the program. In a controlled study, at one-year follow-up, the mean weight loss was 9.84% for children treated individually, 13.08% for those treated as a group, and 14.67% for those who were enrolled in a treatment program that included a summer camp. The control group had a weight change in the opposite direction: +2.52%. At the first 5-year follow-up, between 70% and 80% of the children who were treated had not gained weight. In this group, 40% were no longer obese.

Not all excess weight will be lost

One of the more difficult things for family and child to accept is that children will not lose all their excess weight. Instead, a modest amount of weight loss is predicted and the rationale of "weight control" is emphasized. Some of the phrases used in the program are "eat differently, not less," or "maintain your weight while you are growing; it's the same as losing weight."

One limitation of the program is that for some obese children weight stabilization may not be enough. The program seems to work best with young children who are not overly obese and who have a lot of growth potential. Modified programs are necessary for postpubertal children and those who are severely obese (>180% of normal weight). In addition,

Dr. Braet notes that using this approach as the sole treatment for obesity is contraindicated in children with a history of trauma such as physical or sexual abuse or those with internalized problems such as depression.

BOOK REVIEWS

Men's Bodies — Tissues and Issues

Making Weight: Men's Conflicts with Food, Weight, Shape and Appearance
(Arnold Andersen, MD, Leigh Cohn, MAT, and Thomas Holbrook, MD. Carlsbad, CA: Gurze Books, 2000; paperback; 252 pp.; $14.95)

The Adonis Complex: The Secret Crisis of Male Body Obsession
(By Harrison G. Pope Jr., MD, Katharine A. Phillips, MD, and Roberto Olivardia, PhD. The Free Press, 2000; 286 pp; $25.00)

You'd never suspect it from looking at the cover articles of the men's fitness magazines at your local newsstands, but until now men had cause to feel neglected by the body dissatisfaction mavens of the academic community. In contrast to the scores of books written about women's issues about their bodies, eating disorders, and related topics, the literature addressed to males has been thin indeed. Now, almost simultaneously, two excellent books appear, addressed to both the lay and professional communities. Men with eating disorders and body issues (and women who care about these men) can now feel cared about, too. Although some degree of overlap is evident, the two books actually stake out independent areas of focus, so that the reader interested in these topics will benefit from reading both.

In *Making Weight*, three distinguished authorities review the current scene, describing how men differ from women (the short course) and how men's psychodevelopmental and sociocultural body-related issues contrast and compare with women's with respect to appearance. They discuss the social status, group identity, and sexual signals broadcast by various male body shapes and clothing fashions, and the implications of these issues for the evolution of psychological difficulties related to men's concerns regarding shape and weight. Dr. Arnold Andersen, whose clinical experience with males with anorexia nervosa may surpass that of any other psychiatrist in the United States, draws from his extensive clinical work and research with male patients to enrich these discussions.

Dr. Tom Holbrook's account of his own struggle with anorexia nervosa is a highlight of the book. This remarkably candid, self-revelatory story by an astute psychiatrist whose struggles permeated his medical and psychiatric training and subsequent practice is probably matchless in the annals of wounded healers. Although large numbers of women professionals who work with eating disorder patients have written of their own personal experiences with these problems, Dr. Holbrook's account is unique.

The last sections concern recovery, dealing with topics from basic nutritional information designed to foster realistic dietary and meal planning for gaining (or losing) weight, to psychological, social and spiritual aspects of recovery. A chapter on how loved ones can help and excellent lists of organizational, published and web-based resources add to the value of this reader-friendly book.

The Adonis Complex brings in two other major themes – male preoccupation with becoming "muscle-bound," related to obsessions and compulsions about body-building, muscle dysmorphia and anabolic steroid abuse, and the overall story of body dysmorphic disorder in men (also touched on briefly in *Making Weight*). Think about the old magazine advertisements aimed at men who feared being the "120-pound weakling" at the beach and who got into body-building to make certain that they were never teased or victimized for being scrawny. This book tells you what happens if they get carried away. Harrison Pope Jr. has conducted interesting research among body builders and anabolic steroid abusers, and has also researched changing appearances in male action figures, including GI Joe dolls and bulkier, hypermuscular male figures that put Arnold Schwartznegger and the hulks of the World Wrestling Federation's "Wrestle-Mania" to shame. All of these themes lend themselves to the great illustrations with which the book is peppered.

Pope and his colleagues have developed a computerized male body-image test, described in the book, and a self-assessment test regarding the Adonis Complex that readers can take concerning body preoccupations, associated behaviors, allocations of time and energy devoted to body care, and various social and psychological impairments resulting from body preoccupation in men. Not coincidentally, Katharine Phillips, one of the coauthors, is arguably the country's most prominent expert on body dysmorphic disorder. She has written eloquently about body dysmorphic disorder in a previous book, *The Broken Mirror.* In *The Adonis Complex,* we see the fruitful results of "muscle mania" meets "body dysmorphic disorder."

Selected chapters also touch upon eating disorders. The authors discuss risk factors among boys that might lead to these disorders, including issues of intimacy, social anxieties, and sexuality related to body-building (including but not limited to concerns dealing with homophobia and homosexuality). Useful chapters on what men can do to overcome body dysmorphic-related obsessions, compulsions, and underlying anxieties focus primarily on cognitive behavioral approaches and an appreciation for what antidepressant medication may do in some cases. This book, too, contains useful appendices, which include resource lists.

To sum up, two is better than one. Clinicians will want to read these informative books and recommend them to their male patients and their caring partners and family members. **— J.Y.**

Panel Tackles the Clinical, Research & Policy Implications Surrounding Eating Disorders Not Otherwise Specified

Eating disorders not otherwise specified (EDNOS) represent a spectrum of challenges and unanswered questions for clinicians, patients, and insurance companies alike. One of the greatest obstacles is the lack of a clear definition for this group of disorders, according to a panel of experts at the annual meeting of the Academy for Eating Disorders.

> ***If you look at the utilization of treatment for eating disorders, EDNOS is as serious as bulimia nervosa. —Dr. Ruth Striegel-Moore.***

Marsha D. Marcus, PhD, Associate Professor of Psychiatry and Psychology and Chief, Eating Disorders Program, Western Psychiatric Institute, Pittsburgh, who moderated the panel discussion, told the audience that there are many unknown aspects of the variants of disordered eating, both at the subthreshold and the symptom level. In addition, the symptoms of disordered eating as well as the clinical disorder may also be associated with morbidity. She added, "EDNOS are more likely to affect women of diverse backgrounds, women of color, and overweight women—women who often aren't included in clinical trials."

Lack of a clear definition hampers research

Part of the problem with EDNOS, according to Ruth Striegel-Moore, PhD, Professor of Psychology at Wesleyan University, Middletown, CT, is that since most clinical cases do not meet the full diagnostic criteria for anorexia nervosa or bulimia nervosa, patients have great difficulty getting insurance coverage for treatment. She added, "EDNOS are not just important because of the numbers of persons affected but also because they are is associated with significant impairment." High rates of depression, anxiety, and obesity are often found among individuals with EDNOS, she said.

The medical literature is also of little help because there is a lack of clarity in the language, she said, adding that other terms such as "subthreshold disorders" or "partial syndrome" may be used to refer to individuals who lack the core criteria for anorexia nervosa or bulimia nervosa. Because researchers and the media all use many different terms, it is difficult to draw conclusions about treatment and other facets of EDNOS.

Dr. Striegel-Moore reported that in her study of treatment utilization using a large database—4 million individuals over 1 year—people with EDNOS essentially received the same amount of treatment as individuals with bulimia nervosa, and they had comparable rates of treatment for other psychiatric disorders.

"If you look at the utilization of treatment for eating disorders, EDNOS is as serious as bulimia nervosa," said Dr. Striegel-Moore." In this health services use study, EDNOS was the most common diagnosis for patients receiving treatment for an eating disorder, and gender discrepancy was less pronounced in EDNOS than in anorexia nervosa or bulimia nervosa. EDNOS are clinically significant syndromes, she commented, as suggested by high rates of treatment, and the relatively comparable treatment duration.

Dr. Striegel-Moore noted that theoretical and empirical work is needed to clarify the definition of EDNOS. Working against this is the fact that most treatment studies thus far have focused on either anorexia nervosa or bulimia nervosa, leaving unanswered the question of whether evidence-based treatment will work for people with EDNOS, or if a different type of intensity of treatment is needed.

Body dissatisfaction and body mass index across ethnic groups

One of the areas of great concern is an increase in the numbers of overweight persons, particularly an epidemic increase among Hispanic and African-American women, compared to whites, said Marian Fitzgibbon, PhD, Associate Professor of Psychiatry and Preventive Medicine at Northwestern University Medical School, Chicago. Dr. Fitzgibbon pointed out that while overweight has become a problem among 34% of white women, it now affects 52% of African-American women and also about 52% of Hispanic women.

While genetics, diet and exercise, access to food, and recreational activities all have an effect on these numbers, part of the explanation also lies in differences in body image. Dr. Fitzgibbon explained that African-American women have a more positive body image than white women, so they feel more attractive even when overweight. The scant data available about Hispanic women are somewhat more controversial because their body image ideals are affected by acculturation. She explained that Hispanic women who came to the U.S. before age 17 have a body image similar to that of white women; those who immigrated to the U.S. after age 18 seem to have heavier ideal weights.

Dr. Fitzgibbon reported the results of a study that sought to correlate the level of body mass index (BMI) and body dissatisfaction. Among 389 women, differences in age, education, and BMI did not correlate with body dissatisfaction. However, there were differences in the rate and the level

of increase of body satisfaction as a function of ethnicity. White women experienced body dissatisfaction at a lower BMI than the other groups, while Hispanic women did not experience body dissatisfaction until they were overweight, and African-American women did not express body dissatisfaction until they were obese.

Dr. Fitzgibbon urged clinicians to be aware of differences in strategies of weight loss and weight gain in different ethnic groups of men and women.

Family studies of Binge-Eating Disorder (BED)

Although binge-eating disorders have not traditionally been viewed as heritable diseases, Dr. Lisa Lilenfeld, PhD, Assistant Professor of Psychology at Georgia State University, Atlanta, and her colleagues found that BED does seem to run in families. Dr. Lilenfeld and her colleagues recently studied 300 first-degree relatives of patients with BED.

Dr. Lilenfeld identified a potential relationship between alcohol abuse and BED. Substance abuse is more common in female relatives of BED patients than female relatives of non-BED patients. The results also suggest the possibility that substance abuse and BED may share a common etiology, specifically among women.

A common shared familial vulnerability factor may explain the elevation of substance use disorders in the female relatives of women with BED. There may be some common vulnerability factor that is manifested in some women as BED and in some others as substance use problems, she said.

Dr. Lilenfeld noted that family study data can be used to search out potential etiologic factors that are important in the development of BED. For example, she and her colleagues found elevated rates of anxiety disorders in relatives of the BED women. One explanation for this may be an etiologic link between BED and anxiety disorders. Anxiety disorders are also common in the families of BED women.

Health implications of EDNOS

The serious health implications of EDNOS are clearly reflected in conditions like functional hypothalamic amenorrhea (FHA), according to Dr. Marsha Marcus. FHA is cessation of menses in women who previously have had normal menstrual function and where there is no identifiable cause for the amenorrhea, she explained.

Dr. Marcus, Sarah L. Berga, MD, and Tammy Loucks postulated that stress alone or undernutrition alone do not cause FHA; instead, it is due to a combination of energy deprivation from mild calorie restriction, poor nutrition or exercise and stress in the form of unrealistic goals or performance pressure. The combination causes hypothalamic alterations and disrupts gonadotropin-releasing hormone (GnRH) pulsatility.

In Dr. Marcus's study, women with FHA (n=16) were compared with women with organic amenorrhea/anovulation (n=19) and eumenorrheic/cyclic women (n=15) on levels of eating disorder symptoms. Women with current or past eating disorders were screened out of the study.

FHA women scored higher on the Eating Disorders Inventory than either the cyclic women or the amenorrheic women in symptoms of bulimia, drive for thinness, and interoceptive awareness (a measure of sensitivity to internal cues associated with emotion, hunger, and satiety). Dr. Marcus noted that this was intriguing to the researchers because this was a group of women who were specifically screened to exclude frankly disordered eating.

On the bulimia test (BULIT-R), FHA women reported significantly more symptoms of bulimia nervosa than the two other groups. One-fourth of the women with FHA had scores above 85 on the BULIT-R test, while neither of the other two groups had scores in this range.

The symptoms of eating disorders but not those of depression discriminated FHA women from those with organic amenorrhea and control subjects. "Thus," Dr. Marcus pointed out, "for some women, FHA may reflect the adaptation to mild nutritional compromise or the attitudes and behaviors associated with disordered eating."

Dr. Marcus told the audience that psychological intervention designed to ameliorate subthreshold symptoms may promote restoration of ovulation in women with FHA. Her group is currently conducting a randomized control trial of cognitive behavior therapy for subthreshold eating disorders symptoms in the treatment of FHA. This may provide an alternative to expensive and risky infertility treatments. It may also help ameliorate serious side effects of amenorrhea, such as osteoporosis and heart disease, she said.

Finally, Dr. Marcus said, "We need to help our physician colleagues become more sophisticated in how they talk to young women about their behaviors and their body eating, weight, and shape concerns."

Working toward a health policy for EDNOS

Jonelle Rowe, MD, Senior Advisor on Young Women's Health for the Public Health Service, Washington, DC, told the audience that the lack of a clear definition of EDNOS also hampers efforts to promote a health care policy for these disorders. She urged eating disorders professionals to develop a consistent message in order to more effectively produce a nationwide campaign of public awareness.

She added, "The more we can engage the other parts of the public health community in our efforts, the better off we are—especially when we are talking about prevention and talking about young people. We should think about the issues of culture diversity and culturally competent messages, and get the message out to everyone that eating disorders are not just a white woman's disease."

Questions & Answers

Are Atypical Antipsychotics Helpful for Anorexia Nervosa?

Q: Some staff members in my facility are using low-dose atypical antipsychotics (Risperdal, Seroquel) to help manage the "delusional" thought processes that occur with anorexia nervosa. I am not particularly impressed with the results obtained from using these medications in this population of patients. Would you be so kind as to give me your opinion of this trend?
(J. Sommers, MD, Tulsa, OK)

A. Dear Dr. Sommers,
On the whole, there's little indication for using atypical neuroleptics in the usual, run-of-the mill patient with anorexia nervosa. However, recently clinicians at the University of Pittsburgh published two cases of treatment-resistant patients with anorexia nervosa treated with atypical antipsychotics (*Int J Eat Disord* 2000;27:363). The clinicians were targeting impulsivity, lability, and paranoia, but not specifically the "delusional" ideas to which you refer. These patients benefited, and gained weight. Their weight gain was sustained, at least in the short term, while they stayed on the medication. The impact may be due to the known weight-gain side of olanzapine rather than to any specific effects on anorexia nervosa per se. These side effects were also noted years ago when patients with anorexia nervosa were treated with typical neuroleptics such as chlorpromazine (Thorazine). There, too, patients maintained their weight gain only as long as they remained on the medication. Of note, olanzapine (Zypyrexa) may be more prone to produce weight gain than either Risperdal or Seroquel. The authors suggest that more research on the utility of olanzapine is indicated. **—J.Y.**

Study Links Obesity to Brain Patterns

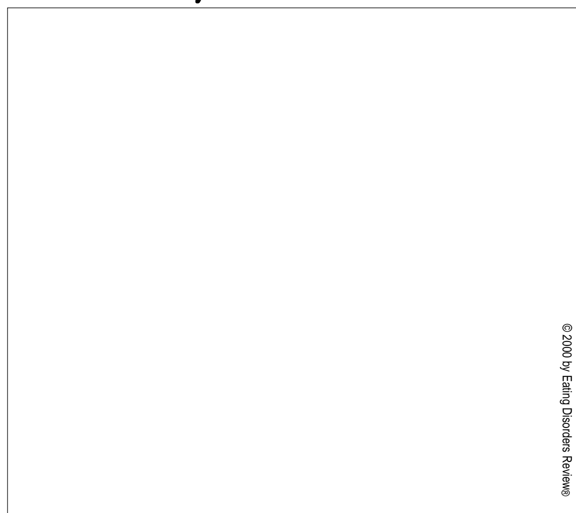
Obese people may gain weight when they eat because their brain takes longer to signal that they are full, according to scientists at the University of Florida and the University of Texas. The researchers used functional magnetic resonance imaging to study how human brains react when people eat.

Dr. Yijun Liu, assistant professor of psychiatry at the University of Florida College of Medicine, noted that in normal-weight subjects the brain reacts to food intake in about 10 minutes, while in obese people, the same reaction takes longer—about 14 minutes. As reported in *Nature* (June 29, 2000), 18 subjects fasted for 12 hours, then underwent brain scans as they were given a dextrose and water solution.

Dr. Liu and colleagues found that a peak in brain activity, lasting about two minutes, occurred about 10 minutes after people were given the water solution. The peak corresponded directly with increased sugar and insulin levels in the blood. The scientists believe the peaks are a "satiety signal" that tells people when they have had enough to eat. According to Dr, Liu, the results of the study showed a connection between the changes that occur in the human brain after eating and the traditional biochemical indicators in the body, which are increases in the levels of glucose and insulin in the blood.

Dr. Peter Fox, director of the Research Imaging Center at the University of Texas, said the study bolsters the long-standing adage: "Don't gobble your food."

Nibbles, by Hunter



© 2000 by Eating Disorders Review®

"Hunter" says, "No more clues, I want to remain anonymous!".

In the Next Issue

Bone Loss in Anorexia Nervosa: Mechanisms & Treatment Options

By Steven K. Grinspoon, MD and Elizabeth R. Thomas, NP • Massachusetts General Hospital, Boston

Bone loss is significant among women with anorexia nervosa. In fact, bone density more than 2 standard deviations below age- and gender-matched normative means is seen in more than half of patients.

PLUS

- A Patient Information Handout: Osteoporosis
- More Highlights From the AED Meeting: New Clinical Trials
- Should Significant Funds Be Allocated for Prevention of Eating Disorders?
- Nutrition Notes: Psychological Issues That Nutrition Professionals Should Consider

and much more…

EATING DISORDERS REVIEW®
SUBSCRIPTION COUPON

Gürze Books
PO Box 2238
Carlsbad, CA 92018
(800) 756-7533 Fax: (760) 434-5476
gurze@aol.com

One year subscription (six issues and index)

	Regular:	AED or IAEDP Members:
U.S.	❑ **$65.00**	❑ **$52.00**
Canada	❑ **$75.00**	❑ **$62.00**
abroad	❑ **$83.00**	❑ **$70.00**

Two year subscription

	Regular:	AED or IAEDP Members:
U.S.	❑ **$115.00**	❑ **$ 92.00**
Canada	❑ **$135.00**	❑ **$112.00**
abroad	❑ **$151.00**	❑ **$128.00**

(All payments US $ dollars)

❑ **Check enclosed** ❑ **Bill Me** ❑ **Credit Card**

We accept Mastercard, Visa or American Express.

Number: ____________ **Expr**: ______

Name ____________

Organization ____________

Address ____________

City ____________ State ____ ZIP ______

Phone ____________

Email ____________