

# EATING DISORDERS REVIEW®



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## Assessing Readiness & Motivation for Change: Challenges & Practical Advice

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Unlike many psychiatric conditions where symptoms are experienced as clearly distressing and disruptive, eating disorders are unusual in that the associated thoughts and behaviors often perform a valued function in clients' lives.<sup>1, 2</sup>

While individuals with other psychiatric conditions are often eager to be rid of intrusive and unwanted aspects of their disorders, many individuals with eating disorders typically express, either directly or indirectly, intense ambivalence about change.

Failing to fully recognize and articulate this ambivalence can lead to a number of treatment problems. For instance, it is common for therapists to initiate "action-oriented" interventions (such as increasing dietary intake) with individuals who are not yet ready to change. Such client-treatment mismatches typically result in clients failing to fully engage in therapy, or to drop out, and/or to relapse, all of which can result in frustration for the client and therapist.

When a therapist fails to recognize a client's ambivalence about recovery, the client may also be left wondering whether the therapist

fully understands her. This can further interfere in the development and maintenance of a good therapeutic alliance. Therefore, accurately evaluating ambivalence about recovery in individuals with eating disorders is of critical importance.

### Challenges to Assessing Client Ambivalence

Preliminary work has shown that determining a client's readiness for change may not be a straightforward task. For example, in one study, clinicians were asked to rate their clients' readiness for change after a 90-minute clinical assessment interview. In contrast to client ratings of readiness, which predicted a number of client change activities, clinicians' ratings were unrelated to nearly all of the client activities assessed (e.g., self-reevaluation, reinforcement management, and anticipated difficulty of recovery activities).<sup>3</sup>

A number of specific challenges

*continued on page 2*

## Update

### The Impact of Bulimia Nervosa on Pregnancy

Active bulimia nervosa (BN) raises the risk of miscarriage, prematurity, and postnatal depression, according to the results of a recent study at St. George's Hospital, London. Using a retrospective case-control study of women treated between 1988 and 1994, Drs. John F. Morgan and J.H. Lacey compared the course of 122 women with active BN during pregnancy with 82 controls with quiescent BN. Active bulimia nervosa was significantly associated with miscarriage (26% of subjects vs. 12% of controls), preterm delivery (23% in subjects vs. 8% of controls), and possible gestational diabetes (16% in subjects vs. 3% of controls). All women in the active group were binge eating regularly, and 95% were also inducing vomiting. None of the control patients were inducing vomiting. Although the study did not address the relative contributions of vomiting, binge eating, or extreme restriction of calories on pregnancy, the authors note that it is possible that BN precipitates these complications, for example, through altered insulin sensitivity and the subsequent effect on placental blood flow. The study was reported at the Academy for Eating Disorders annual meeting in New York in May.

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to the eating disorders may be responsible for this lack of accuracy. First, clients may be unaware of the extent to which they are ambivalent and consequently may be unable to clearly articulate their readiness for change. Alternatively, clients who strongly desire support may feel pressured to express greater readiness for change than they actually feel in order to gain approval and/or access to treatment. Finally, a complication unique to the eating disorders is that clients' feelings of readiness to change may differ by symptom. For example, clients may be quite interested in reducing some symptoms (e.g., binge eating), while not at all interested in changing others (e.g., restrictive eating).

### Strategies for Assessing Readiness and Motivation for Change

Given these challenges, what strategies are helpful in assessing client readiness? Although the application of readiness and motivation for change models for the eating disorders is in its infancy, there is a lengthy history of work on ambivalence about change in substance abuse populations.<sup>4</sup> Motivational Interviewing, a central part of this work, offers a number of guiding principles for working with individuals who have mixed or negative feelings about change. Many of these are incorporated into the Readiness and Motivation Interview (RMI),<sup>5</sup> a semi-structured interview designed to assess readiness and motivation for change in the eating disorders.

Regardless of whether or not a formal RMI is being conducted, a critical aspect to assessing readiness for change is interviewer stance. For instance, in the RMI, prior to beginning the interview, the assessor explains that the main point of the interview is to achieve a better understanding of the client's current experiences with eating. The assessor expresses curiosity and interest about the client's thoughts and feelings about recovery, particularly the parts the client does not want to change.

Given the challenges to assessing readiness, this stance is critical because it communicates awareness, acceptance, and understanding of ambivalence, and gives the client permission, perhaps for the first time, to explore and perhaps come to a better understanding of herself and her feelings about change. Of note, in the RMI, the assessor also assures the client that there will be no negative consequences to openly sharing and exploring these experiences. (It is therefore the assessor's responsibility to ensure that this is indeed the case; i.e., treatment is not contingent upon the client's responses, and/or treatment options are available for individuals at all stages of readiness.)

The format of the RMI involves reviewing each symptom of an eating disorder, as defined by the diagnostic questions of the Eating Disorder Examination (Cooper & Fairburn, 1987). Clients are asked to talk about the extent to which they experience each relevant area (i.e., binge eating) as a problem. The therapist then uses follow-up questions to explore why or why not each symptom is (or is not) a problem. For example, for the fear of weight gain question, the therapist begins by asking whether in the past four weeks the client has experienced a fear of gaining weight. If the answer is yes, the therapist establishes how many days this fear occurred, and then explores whether the client views her fear of weight gain as a problem. The therapist then prompts the client to determine how much of her is actively working to reduce the symptom, how much of her doesn't want to change the symptom at all, and how much of her *wants* to change the symptom, but isn't actually doing anything to change at this time. Clients who are actively working on change are also prompted to identify how much of the work they are doing is for themselves versus for someone or something else.

The RMI stance and form of questioning therefore produce a comprehensive picture of readiness

and motivation for change across different areas of the eating disorder. In the process, barriers to change are often also identified. Interestingly, in addition to providing clinicians with important information, some clients have told us that the opportunity to clearly articulate what they experience as a problem they wish to change, and also what they may not want to change, was also a useful, perhaps therapeutic, process for them.

### What Have We Learned Thus Far?

Interestingly, RMI scores reveal different patterns of readiness for different symptom types. For instance, among a sample of 98 individuals with mixed eating disorder diagnoses, individuals were most likely to be actively working on changing binge symptoms and least interested in changing purging and dietary restriction.<sup>7</sup>

Unlike clinicians' ratings of client readiness, which were unrelated to client recovery behavior, RMI assessors' global ratings of readiness were shown to predict a number of clinically meaningful outcomes.<sup>3</sup> For example, RMI assessors' ratings of the extent to which clients wanted treatment for their eating disorder were related to questionnaire reports of change activities, and actual completion of assigned recovery activities. This form of questioning may therefore be a useful addition to standard intake assessments. Ongoing work has also shown that RMI readiness ratings (e.g., pre-contemplation scores) predicted treatment engagement and treatment dropout. Collecting accurate readiness information may therefore be helpful in clinical decision-making.<sup>6</sup>

### Medical Risk

One of the most difficult situations clinicians face is managing clients who are critically ill and in need of urgent medical attention. Although the acuity of such clients' conditions may necessitate immediate intervention, the approach used to evaluate readiness and motivation for individuals in this group is

no different from that used with individuals who have less severe illness. That is, showing curiosity and interest regarding clients' concerns and wishes while clearly communicating the available non-negotiable options can de-escalate what can otherwise become a stressful confrontation. Critical to such conversations is empathy for the client (given that none of the options are typically desirable to her), and a frank and open communication style.

### Other Useful Tools

Aside from the RMI, a number of other tools have been developed to help clinicians better understand clients' experiences with and feelings about change. For instance, clients can be prompted to write letters to their eating disorder as a friend or foe.<sup>1</sup> This process may identify key themes for the individual, as well as critical barriers to recovery.

Another useful clinical tool is to assist clients in identifying the pros and cons of their eating disorder. The therapist can assist the client to generate reasons for and against change. This exercise may enhance the therapist's and client's understanding and awareness of the positive and negative functions of the eating disorder. The relative weight of pros and cons of an eating disorder can also be assessed in the form of a decisional balance questionnaire.<sup>8</sup> Other questionnaires that measure the stages and processes of change in the eating disorders have been adapted from the substance abuse literature.<sup>9</sup>

### General Recommendations

Assessing readiness for change in the eating disorders is greatly facilitated by a curious, open, nonjudgmental stance, in which the assessor makes it clear that there will be no cost to the client for exploring and talking about his or her ambivalence toward change. Ideally, this discussion would address all aspects of the individual's eating disorder, given that readiness and motivation for

change differ across eating disorder symptoms. Tools that identify clients' barriers to change may also contribute to the development of a better understanding of clients' experience of, and concerns about letting go of their eating disorder.

In order to facilitate discussions about readiness for change with clients, treatment options that address the needs of clients who are ambivalent about change must be available. The development and validation of such treatments is a critical area for future work.

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## Nutrition Notes

### MEAL SUPPORT, Part 1

Distorted beliefs about food and abnormal eating habits are a part of daily life for those living with an eating disorder. These thoughts and behaviors can prolong or prevent eating, which interferes with the client's nutritional status. As a consequence, clinicians are constantly challenged to develop and implement treatment plans that restore their clients' physical health, improve their nutritional status, and foster a healthier relationship with food. Meal support is a vital treatment component to accomplish these goals.

#### What Is Meal Support?

Meal support can be offered to groups of patients or individual clients in every possible treatment setting, from private practice, inpatient and ambulatory care programs to community-based treatment. But, no matter what the setting or the number of clients involved, meal support is about health care providers sitting down to a meal with clients and giving them emotional support.

Emotional support can be defined as giving clients encouragement and reassurance and helping them cope with their anxiety and fears about eating. Support staff can help encourage clients by highlighting their eating successes and give reassurance by emphasizing the physical and psychological benefits of renourishment. Health care workers can help clients lower their anxiety level by listening to them express their fears, distracting them with "healthy" conversation, and promoting relaxation techniques during the meal.

#### Benefits of Meal Support

While providing meal support to this patient population can potentially reduce the need for longer hospitalizations and more aggressive

and invasive refeeding methods (e.g., enteral tube feeding), the sole intent of meal support is not monitoring the client's food intake. Instead, meal support gives clients an opportunity to challenge rules and rituals that are dictated by their eating disorder. In the safe, structured environment of staff-supported meals, clients can begin to "normalize" eating habits that

*The table is a meeting place, a gathering ground, the source of sustenance and nourishment, festivity, safety, and satisfaction.*

*– Laurie Colwin*

attract unwanted attention when carried out in public. At the same time, clients can incorporate "forbidden foods" into their meals and gradually learn to feel safe with foods they wouldn't normally permit themselves to eat.

Meal support can also help clients dispel feelings of shame and isolation that are often associated with eating. By engaging in conversation with the staff about non-eating disorders topics (e.g., topics not related to food, weight/shape, exercise), clients can re-learn the social aspects of eating.

For staff members, meal support is an opportunity to develop rapport with clients and to observe their eating behaviors. These observations can supplement the client's medical and psychosocial assessments and highlight psychological and nutritional treatment issues that need to be addressed in individual and/or group therapy sessions.

Emotional support from staff immediately following a meal can help those clients who have urges to binge-eat, purge, and/or over-exercise after eating. Clients can interrupt the binge-eating/purge cycle by learning to exchange the familiar, but self-destructive eating disordered behaviors for more effective and healthier ways of coping. After meals, staff can organize activities such as journal writing, watching videos, or doing arts and crafts for clients. With time, post-meal support can teach clients

to distract and delay acting on their urges to purge or exercise.

#### Some Drawbacks of Meal Support

Clients may report feeling watched or self-conscious when eating with their health care providers. However, they may also feel more supported and less supervised when staff has a meal with them. Clients may also feel that their independence with eating is compromised during meal support; that is, they are eating to please the staff and not themselves.

When meal support is conducted with groups of clients, clients may feel compelled to compare their food intake and manner of eating with others. Meal support may be a frustrating experience when clients at different stages of nutritional recovery eat together. For clients further along in recovery, negative emotions can be triggered by the behaviors of those who have a very eating disordered mindset.

A drawback for the staff could be the amount of time available to offer meal support. Health care staff may already feel stretched trying to fit all their responsibilities into their workday. Treatment teams that have a limited number of staff members may have to go straight from therapy sessions into meal support, and thus don't have a "time-out" from clients.

#### Establishing a Meal Support Component

Offering an effective meal support component to clients requires a commitment from staff, who need to devote time and energy to ensure meal support is conducted in a consistent manner. The responsibilities inherent in providing meal support may at first seem daunting to the staff. But, with well-developed guidelines and appropriate staff training, health care providers from all professional disciplines can offer an effective meal support service to clients.

**Staff training.** Education and training sessions allow staff to

come together to discuss the process of supporting clients, their attitudes and beliefs about meal support, and issues of practice such as personal dietary practices and maintaining therapeutic boundaries.

Prior to implementing a meal support service, staff members need to determine the nutritional intake and behavior expectations for their clients. For example, are clients expected to eat 100% of their meals? Can clients eat diet or low-fat food items at meals? Developing meal support guidelines helps communicate these expectations to clients and outline how staff will provide support. Staff members need to decide how they will find the "fine balance" between providing clients with emotional support and ensuring that the program guidelines are followed.

**Guidelines.** Guidelines provide clients with a sense of safety and structure during meal support because they understand what is and what is not acceptable in terms of food intake and behavior. Health care providers may consider developing guidelines related to nutritional intake, such as the amount of food to be eaten at a meal, the replacement of uneaten food, and appropriate portion sizes. Other essential guidelines concern mealtime conversation, eating disordered behaviors at the table (e.g., excessive use of condiments or spices, or unusual mixing of foods), the time duration of the meal, clients leaving the table before the end of the meal, and post-meal support.

It is important that staff members are clear about the rationale behind each guideline. Before beginning treatment, staff can review the meal support guidelines with clients, explain the rationale, and clarify the responsibilities of the support staff. This knowledge may help clients make more of a commitment to meal support. Depending on the treatment program's philosophy, staff may wish to discuss their own dietary practices with clients at this time.

Because meal support can be an opportunity for staff to model

healthy eating for clients, staff may need to assess the appropriateness of their own dietary practices. Education and training sessions allow health care providers to make decisions about the eating and behavior expectations for support staff. Relevant questions that staff should consider are: What personal dietary practices are acceptable when eating with clients? Should staff members openly discuss their dietary practices and beliefs with clients? Are support staff expected to eat a complete meal? If staff members have too many dietary limitations, are they appropriate candidates for providing meal support? By answering these questions, health care providers can develop their philosophical stance regarding staff dietary practices at meal support.

**Setting boundaries.** Staff members may also consider developing a philosophical stance on professional boundaries. The social atmosphere of meal support can increase the likelihood of clients asking personal questions. Before becoming involved in conducting meal support, staff members need to define their therapeutic boundaries, including the information they do and do not feel comfortable disclosing to clients. As well, staff members need to consider how they will handle the meal support scenario of clients testing their professional boundaries.

The responsibilities inherent in providing meal support may seem daunting to health care workers. But, with well-developed guidelines and appropriate staff training, health care providers from all professional disciplines can offer an effective meal support service to clients.

*(Note.* Part 2, in the next issue, will outline meal support guidelines developed by St. Paul's Hospital Eating Disorders Program.)

### Suggested Reading

*Colwin, Laurie.* More Home Cooking: A Writer Returns to the Kitchen. *New York: Harper Collins, 1993.*

—Linda M. Watts, MA, RD

## Tailoring Treatment for Teens

Adolescent patients will have a much more successful course if therapists tailor treatment more closely to their age, according to Michael E. Berrett, PhD, and Randy K. Hardman, PhD, from the Center for Change, Orem, UT.

Drs. Hardman and Berrett told clinicians at the recent Eating Disorders Awareness and Prevention (EDAP) Training Conference in Scottsdale, AZ, that adolescents have different needs than young adults. In particular, adolescents seem to need more structure, more encouragement and praise, more planning, and more family involvement than older patients.

### Some special needs of teens

According to Drs. Hardman and Berrett, adolescents need:

- A sense of acceptance and belonging in a circle of peers.
- A sense of being important and valued in the family.
- A sense of spirituality, purpose, and meaning in life, which gives them hope.
- A growing sense of self and identify through identification, individuation, and "noticed self experience."
- A growing set of principles in which one's life is anchored.

Drs. Berrett and Hardman stress that teens should be encouraged to explore the differences between acceptance and approval and love versus approval/disapproval. Since many patients literally "shut down" and feel numb, these clinicians encourage therapists to use honesty and empathy, along with group, individual, and family therapy interventions, to help young patients increase their skills in self-awareness and verbal expression.

### General guidelines offered

The two clinicians offered 6 additional suggestions for treating adolescents:

1. Involve the family in treatment from the beginning.
2. Build in more activity and less talk.
3. Be specific and direct.
4. Provide a clear structure for therapy.
5. Reward patients with immediate encouragement and reinforcement, stressing hope and a vision of the future.
6. Set small short-term goals.

## Coping Strategies Therapy for Bulimia Nervosa

(By David L. Tobin. Washington, DC: American Psychological Association, 2000. 272 pp; \$39.95)

In this scholarly, provocative, and thoughtful book, David Tobin, a clinical psychologist with a strong research background, pushes us to think beyond cognitive behavior therapy (CBT), interpersonal psychotherapy, and supportive-expressive therapy, those manual-based modalities for the treatment of bulimia nervosa for which current empirical studies exist. Dr. Tobin leads us to more comprehensive forms of psychotherapy that are tailored to individual differences and needs.

Coping strategies therapy stresses the importance of assessing each individual's state of readiness for change and co-morbidities, then individually fitting the psychotherapies to these clinical realities. Coping strategies therapy recognizes and uses the contributions of the currently available evidence-based, manual-aided therapies, but goes further. Since CBT and interpersonal therapy assume that the patients being treated are, in fact, ready for change, a large number of patients in the real world, who are not yet sufficiently motivated, may not be able to take advantage of or to benefit from them. Trying to engage patients in these active treatments prematurely may lead to a waste of time and resources.

Besides incorporating the valuable elements of CBT and other proven therapeutic modalities, coping strategies therapy rests on three additional basic pillars. The first pillar is the transtheoretical model, focusing on motivational states, based on the studies and theories of Prochaska and others, which have been so influential over the past two decades in treatments for alcoholism, substance abuse, and other disorders requiring behavior

and lifestyle change. The second pillar is the dose-effect "theory" of Howard and others, showing that the outcomes of psychotherapy for certain problems are clearly related to the number of sessions (and possibly the duration of time) over which the therapy is administered. The third pillar is coping theory, starting with the work of Lazarus and Folkman, and extended by many others, including Tobin's own work. Coping theory incorporates constructs of problem-focused and emotion-focused coping and levels of engagement and disengagement with problems and emotions.

Tobin labels various aspects of treatment as "doses." The book details the "doses" of therapy (focus and number of sessions) that are appropriate for individuals in different stages of motivation (pre-contemplation, contemplation, preparation or action), and illustrates the use of those doses in individuals who tend to use each particular form of coping. The first three doses are very similar to Fairburn's descriptions of his now-classic CBT. To this Tobin adds "dose 4," taking from 50 to 100+ sessions, aiming to resolve more deeply ingrained emotional dysregulation, maladaptive interpersonal patterns, and environmental contingencies. This usually involves a focus on the therapeutic relationship as well as other psychotherapeutic strategies, i.e., longer-term psychotherapy.

What distinguishes Tobin's program from others is, in part, a description of criteria for suitability for each of the doses. Dose 1 involves a diagnostic stage of 1-2 sessions, suitable for all. The assessment process is very well described, and I highly recommend this discussion to clinicians. Tobin then defines the types of patients he sees as suitable for moving on to dose 2, involving self-management skills training, usually occurring in sessions 3-8. To benefit, patients should be at least at the preparation stage of motivation. The presence of severe personality disorders, very low or very high weights, bipolar affective disorder, psychosis, or substance dependence may preclude suitability. Dose 3 involves a variety of

interventions designed to increase coping skills using cognitive, focal, dynamic, interpersonal and relational approaches and may take up to session 20 sessions. Dose 4 is suitable for patients with urgency or crisis who manifest long-term maladaptive personality and interpersonal problems, substance abuse, and/or medical instability, and who may be in a pre-contemplation stage.

The emphasis is on active and attentive psychotherapies, but there are no new therapeutic strategies offered here. Rather, the basic assumption is that in a truly integrative manner the clinician will strive to use the right strategy for the right person at the right time. Tobin provides a large number of clinical examples and vignettes to illustrate these concepts. Given the wide array of potential choices for potential patients, Tobin can only provide guidelines; it's impossible to reduce this "therapy" to a simple manual.

Tobin addresses the shortsightedness of managed care insurance coverage that doesn't take the patient's true needs into account and that push treatments which may not be suitable. He suggests that by individually tailoring the best treatment for the individual, costs of care may be less in the long run. The therapy programs he describes are not interminable.

Although many readers may find some statements in the book to be controversial and even opinionated, on the whole the effort is very valuable. Individual readers will have to judge how successful Tobin is in actually incorporating motivational analytic techniques derived from the transtheoretical model into these psychotherapies; I would have liked more emphasis on this point. Similarly, there's little discussion of family or couples therapies, which may be very helpful for some patients in comprehensive treatments. But, on the whole, these ideas are refreshing. They just need to be tested out in clinical trials. Like the aeronautical engineer said as he looked at the blueprints of a proposed new aircraft, "It looks good on paper—but will it fly?"

—J.Y.

# Binge Eating Disorder: Diagnostic Criteria Need Fine Tuning

Unlike anorexia nervosa and bulimia nervosa, no criteria about dysfunctional attitudes about eating, weight, or shape are included in the DSM-IV diagnostic criteria for binge eating disorder (BED). According to Drs. Carlos M. Grilo and Robin M. Masheb of Yale University School of Medicine, cognitive criteria—as well as behavioral diagnostic criteria—should be added to the diagnostic criteria for BED (*Comprehensive Psychiatry* 2000; 41:159).

The researchers reached this conclusion after studying 129 women who met DSM-IV criteria for either BED or bulimia nervosa (BN), purging subtype. The women were divided into 3 groups, including obese patients with BED (n=51), non-obese BED patients (n=32), and patients with BN (n=46), and compared using the Eating Disorders Examination-Questionnaire (EDE-Q). The BED groups were older and had a higher body mass index (BMI) than the BN group.

Although binge-eating frequency was similar among the 3 groups, the BN subjects purged regularly, and the groups differed by dietary restraint, even after controlling for BMI and age. The BN group had significantly higher dietary restraint than both BED groups. Finding that dietary restraint was significantly lower in BED than BN patients is an indication that these patients do not restrict their eating even outside of binge-eating episodes. Thus, while BN patients tend to swing between excessive dietary restriction and binge-eating episodes that are clearly followed by purging, BED patients seem to have little control of chaotic eating marked by binge-eating episodes. This finding underscores the need for interventions aimed at helping BED patients structure and normalize eating during the day.

Those with BED also showed cognitive symptoms on the EDE-Q,

such as dysfunctional attitudes about eating and overvalued ideas about weight and shape, which were comparable to those seen in the BN group. According to the authors, this speaks to the potential importance of classifying this behavior and intervening. They believe that cognitive criteria should be added to future revisions of the official BED diagnostic criteria.

## Subthreshold BED

Results of another study pointed out the need to further evaluate the severity criterion currently specified for BED (*Int J Eat Disord* 2000; 27:270). Dr. Ruth Striegel-Moore and colleagues compared a community-based sample of 44 women with BED, 44 women with subthreshold BED, and 44 healthy controls on demographic characteristics, BMI,

## Bulimia Nervosa: Finding Ways to Predict Who May Drop Out of CBT

From 15% to 25% of patients with bulimia nervosa drop out of cognitive behavioral therapy (CBT) prematurely. According to some researchers, treatment attrition rates may be even higher (Waller, 1997).

Dr. Zachary Steel and a team of Australian researchers recently found that depression and hopelessness as well as wide fluctuations in adult weight put patients at higher than normal risk of dropping out of CBT treatment. In the authors' small study, 43% of 14 clients with a DSM-IV diagnosis of bulimia nervosa dropped out of treatment early. The severity of bulimic symptoms wasn't a major factor in the decision to leave treatment (*Int J Eat Disord* 2000; 8:214).

Before CBT was begun, the patients (97% of whom were women) were assessed with the Eating Disorder Inventory-2, the Body Satisfaction Questionnaire, the Beck Depression Inventory, the

eating disorder symptoms, and psychiatric distress. To be included as a subthreshold BED case, binge eating had to occur at least once a month for the previous 6 months. The women were all participants in the New England Women's Health Project, a community-based study of risk factors for BED.

After adjusting for significant group differences in BMI, the authors found that the two eating disorder groups did not differ significantly on measures of weight and shape concern, restraint, psychiatric disorders, and history of seeking treatment for a weight or eating problem. Women with subthreshold BED appear to be at similar risk for obesity and psychiatric distress as women with full-syndrome BED. Because eligibility for treatment covered by health insurance often depends on diagnostic status, the authors believe a re-evaluation of the severity criterion for BED is warranted.

Beck Hopelessness Scale, the Locus of Control of Behavior Scale, and demographic and behavioral measures.

No differences in severity of bulimic symptoms were found between patients who completed CBT treatment and those who dropped out. However, non-completers had significantly higher depression and hopelessness scores as well as elevated levels of external locus of control. Clients who dropped out had greater fluctuations in weight. Those who completed treatment had an average weight range of 17.5 kg (SD=5.8 kg) and dropouts had an average weight range of 26.6 kg (SD=14.0 kg).

The authors note that their study results suggest a need to focus treatment directly on factors such as hopelessness and depression in addition to standard bulimia treatment, to make certain patients are better able to participate in CBT.

## Questions & Answers

### More on the Use of Atypical Neuroleptics for Anorexia Nervosa

*Editor's note:* In the last issue, we examined the fact that little published information was available about the potential use of atypical neuroleptics in the treatment of anorexia nervosa (AN). Several new recent case reports add to the growing impression that atypical neuroleptics may be useful in the treatment of some patients with AN. Since this is potentially such an important clinical issue, a more detailed review may be of interest.

A recent letter in the *British Journal of Psychiatry* (2000; 177) reported that several patients with chronic AN responded well to 5 mg/day of olanzapine. These patients had previously been unsuccessfully treated with conventional treatments, including antidepressants and psychotherapy, and at least one had received conventional neuroleptics. This patient was a 50-year-old woman ill since age 17, who gained from 74.8 to 116.6 lb (height: 5'2") over about 4 months. Another patient, a 30-year-old woman ill since age 18, had an increase in weight from 96.8 to 116.6 lb (height 5'6") over 9 months.

In both patients, psychological symptoms, including disturbances of body image, improved with medication, and treatment was ongoing at the time the letter was written.

A report in the *Journal of the American Academy of Child and Adolescent Psychiatry* (2000; 39:941) describes two

### Nibbles, by Hunter

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adolescent patients successfully treated with risperidone, 1.5 mg/day. The only side effect was mild sedation. A 19-year-old with a five-year history of restricting AN started at 80 lb (BMI 14.6 kg/m<sup>2</sup>). Sequential full trials of 4 selective serotonin reuptake inhibitors (SSRIs) did not help her major depression or weight. After discharge from 3 months of psychiatric hospitalization she was unable to maintain her 20-lb weight gain, and she was rehospitalized 4 months later. Venlafaxine, 150 mg twice daily, helped her depression but did not stem her weight loss. Within a week after 1.5 mg of risperidone was added to combat delusional thinking about weight and to avoid hospitalization, the patient's anxiety and obsessions about food diminished, and weight increased, rapidly at first, and then more slowly. Four to five months after initiation of treatment she had achieved 97% ideal body weight (IBW), and menses returned. Over the following 10 months her anorexic thinking improved and she remained at IBW with regular menses even after risperidone was tapered and discontinued.

The second patient was a 12-year-old girl with two years of restricting AN, initially seen at 83 lb, 79% IBW (BMI: 15.9), and hospitalized for treatment of bradycardia. When she was an outpatient, sertraline had been minimally helpful. In an effort to avoid another hospitalization, risperidone was started at 0.5 mg and gradually increased to 0.5 mg tid. This treatment was accompanied by a gain of 8 lb in the first month, diminished anxiety, new insights and increased energy. When the dose was lowered to 0.5 mg bid, she experienced a return of eating-related obsessional symptoms and declining insight, both of which improved when the dose was increased to 0.5 mg tid. Nine months after the start of risperidone, she weighed 103 lb, and menses returned. At the time the report was published, she had maintained her weight for 6 months and was described as psychologically improved.

These medications require close medical monitoring and are accompanied by certain risks and side effects. But, because of the high morbidity and mortality of AN and the considerable extent to which the disorder may be treatment resistant, even while the field awaits controlled trials these medications may already deserve consideration for selected patients.

-J.Y.

## In the Next Issue

### Identity Deficits as a Source of Eating Disorders

Karen Farchaus Stein, PhD, RN, and Linda Nyquist, PhD

The authors suggest that the relative absence of a rich and diverse collection of positive identities contributes to the disordered eating attitudes and behaviors that characterize anorexia nervosa and bulimia nervosa. They also raise interesting questions about the appropriate focus of clinical intervention.

#### PLUS

- **Nutrition Notes: Meal Support, Part 2.**
- **Parental Intrusiveness in Bulimia Nervosa**
- **Internalized Stigma and Binge Eating Among Overweight Women**
- **Treating Obese Women with Binge Eating Disorder and much more....**

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*Preventing Eating Disorders: A Handbook of Interventions and Special Challenges* (Piran, Levine, Steiner-Adair, eds.), 2-6

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