

# EATING DISORDERS REVIEW®



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## *Highlights of the 2001 AED Conference*

### Exploring Better Access to Care for Minority, Underserved Populations

Mary K. Stein, Managing Editor

At the 2001 Academy for Eating Disorders International Conference in Vancouver, May 17-19, more than 500 eating disorders professionals explored new ways to improve diagnosis and treatment of eating disorders among minority and underserved populations.

#### Obesity in Minority Populations

In her keynote address, Shiriki K. Kumanyika, PhD, MPH, reported that obesity has risen to frightening heights among minority Americans, particularly African-Americans. For example, she noted that although more than half of white Americans have a body mass index (BMI) greater than 25, and one-third have a BMI over 30, 40% of black women have a BMI greater than 30 and 30% have a BMI above 40. She added that at least half of adults in many African-American, Hispanic, American Indian and Pacific Islander communities have even greater rates of obesity.

"The epidemic of obesity has also reached down into the younger population in a terrifying way," she said, adding that 15% of all adolescents are now categorized as obese. She also cited the "outrage" of marketing of soft drinks to schools, noting that school administrators and others have sold access to students to get needed funds for the schools. "When vending machines enter the classroom, they bring a tremendous amount of calories to young

people," she said. This is compounded by an increase in portion sizes among most fast food outlets.

The increase in obesity among black women can be partly traced to environmental factors, including targeted marketing, lack of supermarkets or lack of access to healthy foods in many inner city areas, the rise and prevalence of fast food outlets, and lower levels of physical activity. Cultural norms also play a role. For example, Dr. Kumanyika explained that many older African-American women feel that heaviness is genetically caused, and that it is healthier to be overweight than thin. Even among young black women, thin black women may be viewed as "being on something," such as crack cocaine, or having a disease like tuberculosis or AIDS.

#### Targeted TV Marketing

Dr. Kumanyika from the University of Pennsylvania School of Medicine, Philadelphia, reported some intriguing findings about how targeted marketing of food plays a role in black obesity. Researchers at the University of Chicago Children's Hospital found that 60% more food and beverage ads ran

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## Update

### Athletes: Not Different From Others with Eating Disorders?

There is little valid support for the theory that athletes with eating disorders are psychologically different from their non-athlete counterparts, nor any justification for the label *anorexia athletica* or "activity anorexia," according to Dr. Caroline Davis and colleagues at Toronto General Hospital and York University, Toronto. As reported at the Academy for Eating Disorders meeting in Vancouver last May, Dr. Davis and colleagues studied 144 female eating disorders patients being treated at Toronto General Hospital. Patients were classified as "athletic" or "non-athletic" after a structured clinical interview. The "athletic" classification was only given to elite athletes or to those who had danced professionally. No group differences were found on the Eating Disorders Inventory or the SCL-90 (Symptom Checklist 90). Dr. Davis suggested that there is no support for the concept that athletes with eating disorders are less ill than other eating disorders patients, or that their symptoms are simply due to over-training and the intensive training frequently required of elite athletes.

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with television shows featuring black actors than ran with general audience shows. Thirty percent of the ads featured candy and 13% spotlighted soft drinks. Also, 27% of black actors in the shows studied were overweight, compared with 2% of non-black actors in general audience shows; and, these shows usually included food and meals, or characters eating.

Dr. Kumanyika also described results of focus group studies with 190 black women. Most of the participants had no training or education about obesity, food, or activity levels. The women reported eating constantly, eating large portions, and tasting everything while cooking. When the women enrolled in healthy eating programs, they continued to include prior foods along with the new and healthier foods. There also was a fear of feeling hungry, which might reflect a cultural memory of not having food, she said.

### Improving Treatment

Treating obesity among black women is challenging, Dr. Kumanyika said, and suggested certain changes that may improve outcome. Greater success might follow less-structured, more client-centered and culturally oriented weight-loss programs. Even when such approaches are used, the dropout rate is very high, often 50% or more, she said. Weight loss patterns are also different among white and black women, she said. In short-term studies, black women do more poorly than whites, but over the long term, weight loss equalizes among blacks and whites.

### Underserved Populations

In a plenary session moderated by Dr. Melanie Katzman, of New York Hospital and the Institute of Psychiatry in London, four panelists discussed ways to identify and provide better care for “the four M’s” of underserved groups with eating disorders. These include ethnic minorities, men, miniature people (children), and clients with multiple sexual orientations.

### Ethnic minorities

“Ethnic minority groups are largely invisible in our field,” Dr. Ruth Striegel-Moore, professor of psychology at Wesleyan University, and president of the Eating Disorders Research Society, told clinicians attending the plenary session. Fewer than 10% of studies published in eating disorders journals even provide a breakdown of study populations by ethnicity, she said, and it is basically assumed that the participants are white.

Dr. Striegel-Moore pointed out numerous reasons why a focus on ethnic minority groups is needed in the eating disorders field. First, U.S. census projections suggest that by 2050 half the population will fit into one of the current minority groups. Next, ethnic and minority populations in the U.S. and other industrialized nations typically fare worse on standard health indicators. Also, ethnic minority groups experience unique risk factors such as peer-group conformity pressures, ethnicity-based discrimination or racism, stresses related to acculturation, and intergenerational conflicts associated with younger generations trying to adopt the values and norms of the majority culture. Finally, access and response to treatment may vary by ethnic group, and information about group-specific service needs is critical for health services planning and implementation.

According to Dr. Striegel-Moore, the 2000 census data also showed that 1 in 4 Americans fits the criteria for a racial or ethnic minority, and black Americans and Hispanic Americans make up the two largest minority groups. She added, “These categories do not reflect explicitly the enormous cultural differences within groups, nor do they capture diversity in terms of immigration and acculturation status.” At the state level, vast differences are apparent in the ethnic distribution of populations. She added, “Hence, your experience as clinicians in terms of diversity of your client population will vary quite a bit, depending on

where you live in the U.S., and the experience of members of ethnic minority groups likely differ widely depending on the population density of their particular groups in the area where they live.”

### **Stereotypes Persist**

Dr. Striegel-Moore also cited what she terms “the myth of the golden girl” that helps perpetuate the stereotype that eating disorders affecting only affluent white women. This assumption arose from early case descriptions of eating disorders as problems of European girls from affluent families. This has been reinforced by incessant media portrayal of eating disorders as problems of the rich and famous, she said.

“Without nationally representative data on the incidence and prevalence of eating disorders in the U.S., we can only use anecdotal evidence that members of ethnic minority groups also develop eating disorders,” Dr. Striegel-Moore said. She also stressed that when trying to estimate rates of eating disorders in a given population, to be valid, studies should include several thousand participants.

Dr. Striegel-Moore cited results of her recent epidemiologic study of risk factors, focusing on African-American women as one minority group. The sample is comprised of young women who previously participated in a longitudinal study, The National Growth and Health Study. It was the first effort to determine in an epidemiological sample, rather than a sample of convenience, how common symptoms of eating disorders are in black women and what might be risk factors for this population group, Dr. Striegel-Moore said.

The researchers found that significantly more white women than black women met lifetime criteria for bulimia nervosa or binge eating disorder, and no cases of anorexia nervosa were identified among the black women. For some behaviors, there were no group differences, some were marked, and others depended upon where in the U.S. the participants were

interviewed, Dr. Striegel-Moore added. The impact of local differences in the total sample is profound, she said. For BED, there were no site differences, and white women were significantly more likely than black women to have experienced a binge-eating episode. The average age at onset of the eating disorder was significantly later among the black women than the white women. Thus, the study would have missed numerous black women, who might have developed an eating disorder later. “These results illustrate how sampling, whether by geography, socioeconomic status, or age, has a clear impact on the findings and that performing simple head counts as in the past, without a further exploration of the findings, may lead to inaccurate conclusions about ethnicity and eating disorders,” she said.

“In our field, we often hear that it is rare to have a client who represents an ethnic minority group,” Dr. Striegel-Moore added. In fact, the absence of patient registries reinforces the misconception that ethnic minorities do not experience an eating disorder, she said. In her study, only 5% of the young black women, compared to 25% of the white women, had received treatment for their eating disorders.

A previous study she conducted with Kathleen Pike and Denise Wilfley offered some explanation for the lower percentage of black women who seek treatment for an eating disorder. In the earlier study there was no significant difference between white and black women who sought treatment for a weight problem, but there were significant ethnic group differences between women who had received treatment for an eating disorder. The researchers realized that the black women who sought help for weight control could easily have been assessed for an eating disorder, but were not. Weight concerns are an important motivating factor for women seeking treatment, and service providers who work with clients who present with such

concerns should screen for the presence of an eating disorder, she said. Service providers could also educate the public about the common comorbidity of eating disorders with depression and anxiety disorders.

According to Dr. Striegel-Moore, reasons women in minority ethnic groups give for not seeking treatment for their eating disorder include financial difficulties, including inadequate health insurance; the belief that treatment won’t help; fear of being stigmatized; and lack of knowledge about treatment resources.

### **Improving Care for Ethnic Minorities**

Dr. Striegel-Moore urged clinicians to work for improved access to care by insuring financial resources to pay for treatment and by educating the public about the availability of effective treatment. She also advised the audience not to underestimate the value of case reports. Noting that clinicians still draw from Hilde Bruch’s detailed works, she told the audience that similarly detailed case records of ethnic minority women are needed, “so we may understand their experiences and determine how treatment needs to be adapted.” Even so, treatment approaches should be standard for all patients, she said, in the belief that empirically based treatments, such as cognitive behavioral therapy or interpersonal psychotherapy, work when properly provided. Assuming otherwise raises the risk of discriminating once again against this client group by withholding appropriate treatment, she stressed.

Dr. Striegel-Moore also urged clinicians to develop networks for both the clients and the providers, to enhance communication and dissemination of knowledge. Helping clients gain access to women with similar ethnic backgrounds may support the curative process that comes when one realizes one is not alone with a problem, she explained. Clients also learn common facts that

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exacerbate the problem and ways to help one another in the process of recovery and social action, she added.

Dr. Striegel-Moore also urged audience members to develop an awareness of minority groups and to create a treatment environment that is familiar and welcoming to minority clients, down to office furnishings and magazines in the waiting room. Recruiting staff from minority groups is also a helpful step, she said. Finally, she called upon clinicians to become involved in “a broad range of advocacy efforts, to assure that adequate resources are available to articulate standards of cultural competence in the treatment of eating disorders.” (Continued in the next issue: *Improving Access to Care for Children, Men, and Gay Men and Women*)

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## Pilot Program Increases Patient Motivation

Patients with eating disorders are often difficult to treat because of their ambivalence about therapy and lack of motivation to change. Typically they reluctantly enter therapy only after strong pressure by their families, friends, and physicians. Afterward, it's not unusual for them to drop out of treatment prematurely.

The goal of motivational interviewing is to help clients decide to change by recognizing the discrepancy between their present behavior and their life goals or values. The client, not the therapist, poses the arguments for change. This approach has proved helpful for people who are ambivalent about treatment because the decision to change is not imposed on them by someone else.

### Five stages of change

Dr. D. Blake Woodside and colleagues at Toronto General Hospital and the University of Toronto recently designed a pilot group program to increase motivation to change among 38 patients with eating disorders (*Int J Eat*

*Disord* 2001; 29:393). The program involved motivational enhancement therapy (MET), which is based upon the transtheoretical model of change. This model identifies 5 stages clients pass through while trying to change (pre-contemplation, contemplation, preparation, action, and maintenance). The goal is to identify which stages the clients are in, to help them move through and to achieve lasting change.

The MET intervention was based on a treatment manual designed for this study, and consisted of 4 hour-long sessions over 4 consecutive weeks. Some topics included the benefits and costs of having an eating disorder and predicting what life would be like in 5 years with and without the disorder.

### After intervention, many sought treatment

Nineteen patients completed the study protocol. The only statistically significant difference between those who completed treatment and those who did not was the prevalence of purging: 79% of those who dropped out of the study purged, compared with 42% of those who completed the study.

After the intervention, participants recognized that their disordered eating was a problem; there were decreases in depressive symptoms and interpersonal distrust and an increase in overall self-esteem. After 6 weeks, most of the group members had entered a treatment program.

One of the challenges for the researchers was recruiting patients for the program. Of the initial 38 patients who were assessed for this study, only 27 entered the intervention study. According to the authors, relatively high dropout rate is a good reflection of the very ambivalence and lack of motivation of this study population. The authors suggest that a controlled study with a larger number of participants and longer-term follow-up will help determine if the intervention program can help motivate patients to enter and remain in treatment programs.

## Light Therapy Brightens Outcome for Bulimic Patients

Many patients with seasonal affective disorder (SAD) have dysfunctional eating patterns, and many women with bulimia nervosa report that both their mood and bulimic symptoms worsen during the winter. According to one study, the use of light therapy apparently can help improve mood and reduce bulimic symptoms in such patients—at least for a time.

Dr. R.W. Lam and co-workers at the University of British Columbia, Vancouver, used light therapy to treat 22 women with SAD who met DSM-IV criteria for bulimia nervosa and major depressive disorder (*J Clin Psychiatry* 2001;63:164). The women were treated with an open-design, four-week trial of light therapy. Sessions involved a 10,000-lux fluorescent light box with an ultraviolet filter, used for 30 to 60 minutes per day in the early morning. Binge-purge diaries and depression scales were used to chart their progress.

### Mood improved and depression lessened

Light therapy significantly improved mood, and there was a 56% mean reduction in the Hamilton Rating Scale for Depression after treatment. The frequency of binges and purges per week also fell significantly, with a mean decrease of 46% for binge eating and 36% for purging. Two of the 22 women completely stopped binge eating and purging. Ten patients had remission of depressive symptoms. All patients tolerated the treatment well.

The authors noted that the positive effects of light therapy can be sustained over at least 4 weeks. They also believe that the low abstinence rate of bulimic symptoms in this study indicates that light therapy may be most effectively used as an adjuvant to medication and/or psychotherapy for patients with SAD and bulimia nervosa.

## Maturing Early: A Link to Bulimic Behavior

Early puberty and early advanced sexual development can increase the risk of bulimic behavior, according to the results of a recent study in Finland (*J Adolesc Health* 2001; 28:346). The Finnish researchers suggest that to help prevent bulimic behavior and for early intervention, attention should be given to girls that mature early and boys that mature either very early or very late.

The School Health Promotion Study is a classroom survey among Finnish adolescents about health, health behavior and school experiences. A total of 19,321 boys and 19,196 girls responded to the survey. The researchers used a questionnaire formulated according to criteria in the DSM-IV. The onset of puberty was assessed by self-reported age at menarche or oigarche.

Among the girls, early menarche, early sexual experiences and increasing age were linked to bulimic type eating. Among the boys, onset of ejaculations at the normal age was protective for bulimic-type eating and the risk rose among boys who were very early or very late maturers.

## An Unsuspected Road Hazard

That erratic driver in front of you may not be using a cell phone; instead, she might be in the midst of bingeing and/or purging. New research has shown that some people binge eat and purge while driving. They apparently stuff themselves with food and vomit it up while driving their car.

In a recent study, Dr. James Mitchell, president and scientific director of the Neuropsychiatric Research Institute, Fargo, ND, found that 73% of 26 eating disordered patients who were selected because they admitted binge-eating at least weekly in their cars also admitted binge-eating while driving. Sixteen percent of those

who binge-ate reported they followed this up with vomiting. Some pulled over to the side of the road first, but others used a container while keeping their eyes on the road.

According to Dr. Walter Kaye, of the University of Pittsburgh School of Medicine, a car can be a perfect place for a person with bulimia

nervosa or other eating disorders to hide their behavior. In fact, a car may be the most convenient place to be alone and to have some share of privacy. Although the study did not determine how many accidents might have been caused by bingeing in cars, 20% of this study's participants admitted to unsafe driving due to their binge eating.

## BOOK REVIEW

### *Body Image, Eating Disorders and Obesity in Youth: Assessment, Prevention and Treatment*

(Edited by J. Kevin Thompson and Linda Smolak. American Psychological Association, Inc., 2001; 403 pp, price: \$39.95; ISBN: 1-55798-758-0)

This well-edited book, compiled by two authorities in their respective fields, covers a broad array of subjects of interest to those working with weight-related issues in children and adolescents. Its four substantial sections, in turn, consider "Foundations," i.e., developmental aspects of eating and body image in children and adolescents; and "Risk Factors," including family function (and dysfunction), protective factors, and issues of sexual abuse (why not psychological abuse and physical abuse, too?). The two other sections include "Assessment," with separate chapters on physical status, body image and eating disturbances in eating disorders and obesity; and "Prevention and Treatment," dealing with body image disturbances, obesity and eating disorders in children and adolescents.

Written by well-known authorities in their respective areas, some of this work has appeared in other recent edited volumes that have focused on developmental issues and prevention. But other work described here has not appeared in the mainstream. Several chapters contain excellent evidence tables outlining major findings of the individual studies reviewed in the text. Although the 14 chapters in this volume include many superb ones, several particularly caught my eye. For example, Fischer and Birch's chapter on early development reviews what is known about the role of maternal diet in early taste and flavor experiences, influences of

breastfeeding and formula feeding, and food acceptance patterns in infancy and toddlerhood. It also addresses very early parental influences and modeling in shaping and controlling food choices, preferences, and dislikes.

Douchis, Hayden and Wilfley's review of obesity, body image and eating disorders in ethnically diverse children and adolescents draws attention to the tremendous epidemiological health problems associated with high rates of obesity in children and adolescents of particular ethnic groups (a phenomenon elsewhere referred to as the "New World Syndrome"), and discusses what is currently known of the social and cultural forces contributing to this trend. Empirical data on effective prevention and intervention in these areas is, unfortunately, extremely limited. Levine and Smolak review primary prevention, providing an excellent synthesis and literature review of body image disturbance and eating disturbance, and Robinson and Killen do the same for obesity prevention.

A final chapter by Sarwer on plastic surgery in children and adolescents takes us a little bit afield, considering the lengths to which children—and their parents—go to contend with body image dysphorias and body dysmorphic disorder symptoms, in addition to dealing with socially and sometimes physically impairing disfigurements. National statistics on cosmetic surgery for adolescents reveal that nearly 25,000 procedures were performed in 1998, about a third of these were rhinoplasties. Here's a bit of trivia for you: In 1998, surgeons performed 1840 breast augmentations for adolescent females, but 1862 breast reduction surgeries for gynecomastia in adolescent males.

All in all, this worthwhile collection will be most useful for individuals involved in school- and community-based programs concerned with early prevention of body image disturbances, obesity and eating disorders.

— J.Y

### Using E-mail in Clinical Practice

Like most registrants, I attended the 2001 Academy for Eating Disorders conference in Vancouver, British Columbia, for a variety of reasons. I wanted to reconnect with colleagues and learn about the latest research efforts, but ultimately I hoped to gather ideas that could potentially enhance my clinical practice as a dietitian. I was not disappointed!

One of several conference highlights for me was a presentation by Dr. Joel Yager, "E-mail as a Therapeutic Adjunct in the Treatment of Ambulatory Anorexia Nervosa," which was part of the plenary session *Emerging Technologies in the Treatment of Eating Disorders*. Dr. Yager, who is editor of *EDR* and professor of psychiatry at the University of New Mexico School of Medicine, Albuquerque, caught my attention by posing two thought-provoking questions. The first question was, is e-mail a clinically effective and user-friendly service that can engage treatment-resistant patients? The second question was, how can clinicians use e-mail as an adjunct to traditional eating disorders treatment?

In a case-series report, Dr. Yager described his initial experiences using e-mail with 15 adolescent patients seen for treatment of anorexia nervosa. Although the computer supplemented his clinical contact with patients, he emphasized that it did not replace face-to-face interactions and other treatment components such as psychotherapy or nutritional counseling. Using e-mail, Dr. Yager encouraged patients to correspond with him between sessions. He wanted to know what was happening in terms of their struggles with eating-disordered thoughts and behaviors.

### The Clinical Effectiveness of E-mail

He soon discovered that patients were more engaged in treatment when they realized he wanted to maintain contact with them. Several of his patients reported that e-mail was an incentive to do well because they were checking in on a regular basis. To provide him with updates, they had to pay attention

***One tip: To make online communication an effective treatment component, clinicians should be explicit about guidelines for e-mail correspondence.***

and become more aware of their behaviors every day.

By communicating progress reports several times a week or even daily, patients were essentially record-keeping—an integral cognitive-behavioral activity. In turn, Dr. Yager noticed a more effective use of his clinical time. Because patients had reported their behaviors via e-mail, their eating and exercise patterns did not require as much preliminary discussion during office visits.

### A User-Friendly Treatment Service

Dr. Yager presented interesting reasons why patients may be attracted to e-mail. Social psychologists have reported findings that suggest e-mail can change the identity and relative social status of the individuals engaged in this form of communication. The person sending the e-mail may no longer see herself/himself as subservient to the recipient. Instead, social and psychological studies have shown that e-mail may give greater voice to those who are less dominant in a relationship. "It is a democratizing type of interaction," stated Dr. Yager.

In addition, patients can use their electronic "voice" when they feel most inspired. For example, they can communicate their thoughts to their health-care provider at any time of day. The computer will take whatever they want to say, whenever they want to

say it, increasing the likelihood of patients reporting thoughts, feelings and behaviors that they may otherwise forget during sessions. "They may be able to look you in the computer better than they can look you in the eye," reported Dr. Yager. For this reason, e-mail may be especially useful for patients who are shy or have social phobias. It may be easier for them to

be emotionally honest and make a connection when they are not sitting in front of their care provider.

Based on his observations, Dr. Yager found that perfectionistic or obsessional patients did well with e-mail. In general, those who were impulsive in nature lacked the diligence to adhere to the routine of sending messages. E-mail also seemed to suit patients who valued honesty and integrity. "They will either tell you what is going on, or they won't say anything at all. You will get a blank screen," he said. Dr. Yager interpreted a patient's silence on e-mail as a sign of resistance, and explored possible barriers during office visits.

### Clinician's E-mail Habits

To make e-mail an effective treatment component, Dr. Yager believes clinicians should be explicit about their e-mailing habits. Patients need to know how often their clinician reads their e-mails and how they will respond. He informs patients that he responds with one or two lines of encouragement and not paragraphs of advice. While he acknowledges the patient's struggle, he intentionally avoids detailed messages because of confidentiality.

### The Limits of E-mail

Dr. Yager cautioned health-care professionals to obtain informed written consent from patients prior to engaging in e-mail. For those younger than 18 years, parental consent is needed. During the process of getting informed consent, patients should be made

aware that e-mail is not a secure and confidential medium. Dr. Yager advises patients not to put anything in a message that they would not want others to read or that might appear in court at some later point in time. According to guidelines recently established by the American Medical Informatics Association, e-mails are official documents that must become part of the permanent medical record. Dr. Yager recommended that care providers create separate files containing all e-mails received from each patient.

### Clarifying Appropriate Types of Communication

Finally, Dr. Yager advised clinicians to clarify their boundaries with patients and to discuss the types of communications that are appropriate. The social conversation inherent in e-mail makes caregivers more vulnerable to boundary violations. They need to be careful about the interactions they invite. However, he stressed that any message that contains thoughts of self-harm or threats to others should be treated like a clinical communication. Dr. Yager responds immediately to any distress communicated via e-mail by getting on the telephone and talking directly with the patient.

—Linda Watts, MA, RD

## Eating Disorders Are Similar in Men and Women

Because eating disorders are more commonly reported among women than men, it has been argued that the illnesses must be atypical in men and that there may be something different about males who develop an eating disorder, such as homosexuality.

The results of a large Canadian study dispute these arguments. After evaluating men with full or partial eating disorders, women with eating disorders and men without eating disorders in a community study, researchers

found few differences between men and women with eating disorders. However, they reported striking differences between the men with and those without eating disorders (*Am J Psychiatry* 2001; 158:570).

### Study population

The study compared 62 men with eating disorders with 3,769 men with no eating disorders and 212 women with eating disorders. The subjects were identified from a community epidemiologic study in Ontario, Canada. (Mental Health Supplement to the Ontario Health Survey). Subjects were interviewed in person by trained interviewers using the Composite International Diagnostic Interview, which generates both DSM-III-R and International Classification of Diseases (ICD-10) diagnoses. The government-sponsored study did not investigate sexual orientation.

The presence of a lifetime full or partial eating disorder was defined in the same way for men and women. Criteria for anorexia nervosa included abnormally low body weight (15% below the Canadian standard weight for age and height), overconcern with weight and shape, a self-perception of being overweight when others felt the person was too thin and, for women, 3 consecutive missed menstrual periods.

For partial syndrome anorexia, the subject had to meet the low body weight criterion but could have one negative response to the remaining criteria. A diagnosis of full and partial syndrome bulimia nervosa required recurrent episodes of binge eating; to meet the criteria for full syndrome, the subjects had to have been binge eating at least twice a week for 3 or more months before the study.

### Prevalence and gender

The prevalence rate (weighted) of full and partial eating disorders for men was 2.0%, compared with 4.8% for women. For full or partial anorexia nervosa, the female: male ratio was 2.0:1; for full or partial syndrome bulimia nervosa, it was

2.9:1. There were few differences in rates of comorbidity between men and women with eating disorders, aside from expected gender-specific rates of higher depression among women and higher substance abuse rates among men with eating disorders.

The rate for full syndrome eating disorders (anorexia nervosa and bulimia nervosa combined) in men was 0.3%, compared with 2.1% in women. There was a significant difference in the overall rates of full and partial syndrome in men and women; when broken down by type of eating disorder, the most marked differences were lower rates of full syndrome bulimia in men than in women; the reverse was true for partial syndrome bulimia.

### Men with eating disorders and those without

The men with eating disorders had more psychiatric disorders and appeared to have greater dissatisfaction with life than the men without eating disorders. The authors point out that the significantly higher rates of psychiatric diagnoses in men with eating disorders could be explained as a consequence of the eating disorders, but could also represent a factor leading these men to be more vulnerable to the development of an eating disorder. The quality of life of men with eating disorders was not as good as that of men without, which is an understandable reaction to the existence of a serious chronic illness such as an eating disorder—rather than to factors that might have existed before the eating disorder developed.

In the past, eating disorders were assumed to be gender-bound and, because they were so rarely reported in males, it has been suggested that there must be something different about males who develop an eating disorder. Most larger controlled studies of men and women with eating disorders have shown few differences in clinical presentation, psychometric measurements, or treatment response (*J Psychosom Res* 1994;38:471).

## Questions & Answers

### A Collapsed Lung Was this Due to Anorexia Nervosa?

**Q.** A patient with anorexia nervosa with whom I recently consulted had a past medical history of a collapsed lung, which her physician called spontaneous pneumothorax. Is this a recognized complication of anorexia nervosa? (A.L., Tallahassee, FL)

**A.** Spontaneous pneumothorax occurs when a subpleural pulmonary bleb (basically a structural bubble) bursts and air rushes into the pleural space between the lung and chest wall. The lung then collapses in response to this sudden build-up in air pressure where no air previously existed. Spontaneous pneumothorax most often occurs in young adult individuals with lean bodies, typically males. They usually present with acute chest pain and progressive shortness of breath. In instances where small amounts of air have leaked into the chest wall cavity, treatment can be conservative, and the air may be reabsorbed spontaneously. However, in pronounced cases, chest tubes must be inserted to help the air escape and to enable the lung to reinflate. One case has been reported with anorexia nervosa, and the authors assume that others have occurred as well (*Psychosomatics* 1998;39:162). However, a larger number of

patients with anorexia nervosa have developed "spontaneous pneumomediastinum." In this situation, high intrathoracic pressure, sometimes associated with vomiting, leads to high intra-alveolar pressure, rupture of perivascular alveoli, and escape of air into connective tissues and dissection of air into the mediastinum. Symptoms include acute pleuritic chest pain, shortness of breath, and neck pain, and several specific signs on physical examination of the chest. The important point here is that patients who are vomiters and who develop this syndrome require an immediate contrast esophagogram to rule out perforation of the esophagus (Boerhaave's syndrome). If untreated, this condition may lead to peritonitis and result in death, and must be attended to surgically as rapidly as possible.

—J.Y.

### Dating Violence Raises Risk of Abnormal Dieting

Teens who encounter unwanted sexual advances or violence during dating have an increased risk of turning to abnormal dieting afterward, according to a recent study at the University of North Dakota (*Int J Eat Disord* 2001;29:166).

A total of 2,629 girls in grades 9-12 at 40 schools in North Dakota completed voluntary and anonymous, usable questionnaires about dating violence, unwanted sexual advances, purging, and use of diet pills. About 10% of the girls reported using purging behavior, and 12% reported using diet pills during the past 30

days. Fourteen percent of the girls had experienced a violent dating situation or unwanted sexual contact. In similar studies, sexual contact rate ranged from 16% to 33%.

The odds of purging were 3 to 4 times higher for girls who reported a violent sexual incident than for

girls who did not report such experiences. Between 20% and 25% of girls who encountered some form of sexual violence also reported purging in the past 30 days. Eighteen to 22% of girls who reported sexual violence had consumed diet pills during the past 30 days. The associations between sexual violence and purging remained significant even after controlling for family environment.

## In the Next Issue

### Infection-triggered Anorexia Nervosa

By Mae S. Sokol, MD

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus, or PANDAS, can affect younger patients. The causative agent is Group A streptococcus, the same bacterium that causes strep throat.

- Patient Information Sheet: Detecting and Treating PANDAS
- Reaching Underserved Populations: Children, Men, and Gays

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### Nibbles, by Hunter

