

EATING DISORDERS REVIEW®



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Highlights of the 2002 International Conference on Eating Disorders

Sociocultural Influences and Eating Disorders Around the Globe

Mary K. Stein, Managing Editor

The Academy for Eating Disorders' annual conference took on a global flavor in Boston this year. Nine hundred clinicians from the U.S. and abroad had a choice of hundreds of reports and presentations, plenary sessions, dozens of seminars, two satellite symposia and a clinical teaching day.

In a plenary session moderated by Dr. Daniel le Grange, assistant professor of psychiatry and director of the Eating Disorders Program, University of Chicago, four panelists took the audience on a trip around the globe to examine the effects of culture and gender on eating disorders.

South Africa: Youth at increasing risk

Dr. Christopher P. Szabo predicts that the unique and complex social and political transformation taking place in South Africa will lead to an increased risk of eating disorders. As urbanization continues, Dr. Szabo said, the current trickle of cases of eating disorders reported in South Africa "will turn into a flood." Dr. Szabo is currently the only academic mental health professional in South Africa working with people with eating disorders, and was a member of the group that reported the first 3 cases of eating disorders in black African females in 1995. He is associate professor of psychiatry at the University of Witwatersrand and director of the Adolescent and

Eating Disorders Unit at the H. Moross Centre, Johannesburg.

In South Africa, few data are available about any of the eating disorders, he said. What is known is that the tremendous migration of people from rural areas to urban settings has brought a clash of new and old sociocultural trends. For example, he reported that while there are efforts to get black women to lose weight to prevent heart disease and diabetes, many black women are very resistant to participate in weight loss programs because in the black community weight loss is associated with HIV and AIDS.

Dr. Szabo feels that South Africa is currently in a latent phase, where the incidence of eating disorders appears to be lower in blacks than in non-black populations. Although in his own experience he has seen very few cases of eating disorders among blacks, the stigma of having "a white man's disease" may keep some black Africans from seeking help. For example, he reported a case of a young black girl being treated for an eating disorder who was verbally attacked by black nursing staff. The staff asked her how
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Update

Reversing Drug-induced Obesity

A carbohydrate-rich beverage may help counteract the obesity that may accompany long-term use of psychotropic agents. Since serotonin increases satiety and regulates mood, Kristen M. Miller and colleagues at McLean Hospital, Belmont, MA, tested the effects of a food supplement believed to increase brain serotonin synthesis. The study group included 98 women (average body mass index, or BMI: 36) and 21 men (average BMI: 41) who were unable to control their food intake because of emotional stress or drug treatment. Thirty-eight women and 8 men were being treated with one or more psychotropic agents. All patients were given a 1400-kcal/day (women) or 1800-kcal/day (men) food plan for 12 weeks, which included 2 carbohydrate-rich drinks to be consumed before lunch and dinner. These drinks had been shown to increase the "plasma tryptophan ratio," raising brain tryptophan levels and thus stimulating serotonin synthesis. The patients also had intensive counseling, nutrition education and exercise sessions (5, 3, or <2 times/week). At the end of the 12 weeks, drug-treated and non-drug-treated groups lost similar amounts of weight (mean: 20 lb and 18 lb, respectively).

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Current Clinical Information for the Professional Treating Eating Disorders

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she could suffer from a 'white man's disease.' This prejudice was echoed by the girl's family. The girl remained in treatment and is now recovering.

"The important message," said Dr. Szabo, "is that eating disorders can affect everyone." He added, "Everyone, especially in an urban setting, is at risk."

Fiji: TV strikes with a vengeance

Anthropologist and eating disorders expert Anne E. Becker, MD, PhD, told the audience that television has had a tremendous and often negative impact upon the Fijian society. She noted that her studies add a little more to the mounting pile of evidence of the very insidious and very profoundly adverse effects of media imagery on the body image of young women.

Dr. Becker, who is director of the Adult Eating and Weight Disorders Program at Massachusetts General Hospital, and a professor of medical anthropology and psychiatry at Harvard Medical School, said that more than three-fourths of Fijians in a recent study reported that television teaches them what to do and not to do; more than 75% of subjects wanted to look more like television characters.

Her data suggest that the prevalence of disordered eating attitudes and behaviors is increasing among ethnic Fijian schoolgirls, and this trend appears to be associated with prolonged television exposure. "Data thus far suggest that there is a very clear and explicit relationship between what they see modeled on TV and their fantasy that if they can achieve the body, they can achieve that lifestyle as well," she said.

Fijian youth are also at increasing risk because their society is entering a cash economy for the first time and there is virtually no experience with this way of life, Dr. Becker said. Young people cannot look to their traditional avenues to know how to navigate the changing environment and their elders have no idea what to tell them. So,

they turn to television characters instead. Dr. Becker added, "I am personally disheartened to see that 2000 years of tradition has been so easily undermined by just a few years of exposure to televised images." In addition to TV, young women are now feeling pressure to enter the work world, particularly the tourist industry as hostesses and flight attendants; women who are selected for these jobs are thinner and fairer-skinned.

Disordered eating is only one of the problems that has arisen in the context of television, she said. Ten-year prospective data show that the prevalence of overweight and obesity has risen from about 66% to 84% among Fijian women. Television has also brought ads for high-fat Western foods, which are prestige foods in Fiji. On Fiji, Dr. Becker notes few psychiatric services or psychotropic medications are available through the Public Health Service. Thus, while the adverse effects of western media have reached the island, effective means for counteracting the effects have not.

Curacao: Shape, weight concerns affected by education, travel abroad

Eating disorders should be viewed as a marker of cultural change rather than as a function of or a response to thin ideals, according to Hans W. Hoek, MD, PhD, professor at the Hague Psychiatric Institute, the Netherlands, and professor of epidemiology, Columbia, University. Although eating disorders are currently rare in Curacao, the daily arrival of cruise ships is bringing western influences to the island, he said.

Curacao offers the perfect "living lab" to study eating disorders in a non-white, changing society, according to Dr. Hoek. The population is 79% black, 30% Creole, or mixed race, 7% white and 1% Asian, he said. The people of Curacao have been fairly thoroughly studied, and the health data are fairly complete, unlike the

situation described in South Africa.

Weight and shape are not of concern to most women of Curacao, he said, and a general health survey showed that most females, even those who were obese, were happy about their body weight and shape. As for body mass index (BMI), he added, men in Curacao weigh a little less than blacks and whites in the US. For women, however, the average BMI is 2 points higher than the average BMI for white women in the US. He pointed out that this is a 13-lb difference, and that health-care professionals are much more concerned about treating obesity than detecting and treating eating disorders.

Tourism and television do have an impact upon the island's society. Dr. Hoek added that those who are educated abroad have much more concern about weight and shape than those who haven't traveled abroad. AN does not seem to occur among the black population, and this group has a high tolerance for overweight. However, in a second group, those educated abroad and from a higher socioeconomic level, the incidence of eating disorders is similar to that of the U.S. and the Netherlands.

Dr. Hoek concluded, "One would expect eating disorders to occur in societies where there is at least a subset of individuals who may be struggling with two cultures, due to educational or immigration opportunities, or a subgroup that is being exposed to modernizing influences."

Rhode Island: Body image disorders in men

Body image concerns are relatively common and actually quite disturbing to men, according to Katherine A. Phillips, MD, associate professor of psychiatry at Brown University School of Medicine and director of the Body Dysmorphic Disorder Program at Butler Hospital, Providence, RI. Body image concerns are commonly reported in women, but when it comes to body image, men are really a neglected gender, she

said. Very little attention is paid to their concerns and very little research has been done in this area.

She told the audience that body dysmorphic disorder (BDD), a preoccupation with an imagined defect in appearance, is being increasingly reported among men. If a slight physical anomaly is present, even if it is not apparent to anyone else, the individual becomes obsessed about changing it or hiding it. The defect they perceive is either something that can't be seen by others, or is very minimal. About 1 to 2% of the population is affected. BDD can coexist with anorexia nervosa and other eating disorders.

Dr. Phillips then described one of the newer forms of BDD, muscle dysmorphia, a condition almost exclusively reported in men. Muscle dysmorphia is a pathological concern that one's body is not lean and muscular. This preoccupation with size and strength causes problems in functioning or distress, she said, in which an individual often gives up important activities because of a compulsive need to maintain his diet and workout schedule, and avoids situations where his body is exposed to others or endures them only with much distress and anxiety. While BDD has been known for more than a century, muscle dysmorphia has really been discussed and recognized only for the past few years and is not yet included in the *Diagnostic and Statistical Manual of Mental Disorders*.

Dr. Phillips asked the audience to consider the possible influence of sociocultural messages, media messages, and even action toys upon men's body image. In the same way that Barbie dolls send messages to girls, action toys may be having an effect on boys, she said. Studies are showing that action figures are dramatically increasing in size and muscularity and provide an exaggerated model of fitness (often attainable only with steroids) for young boys. Women's magazines are also including an increasingly high

number of unrealistically thin and muscular men. During the past 35 years, the number of photographs of undressed men has skyrocketed, while the percentage of undressed women hasn't changed much, she said. She added that during this time the average male centerfold in *Playgirl* magazine lost 12 lb of fat and put on 27 lb of muscle.

Dr. Phillips concluded that there is much to learn about treating muscle dysmorphia. For BDD, however, cognitive behavioral therapy can be very effective, and other approaches such as cognitive restructuring, exposure treatment and response prevention can be helpful for stopping the excessive and repetitive behaviors so common to BDD. SSRIs given at slightly higher dosages than are used for depression can be quite effective as well, she said.

Dr. Phillips told the audience that the first step in intervening in the disturbing trend of increasing body image problems among men is to recognize that sociocultural messages do exist and that men are getting messages similar to those that women have received for a very long time. These messages may contribute to body image dissatisfaction. Steroids are available and may be contributing to the rise of muscle dysmorphia. "We need to start educating boys and men about these influences, and to study them," she said.

(In the next issue, watch for highlights of the National Institute of Mental Health Plenary Session on Neurobiology and Genetics.)

Omissions and Corrections

It must have been the Ides of March: The date on the cover of the March/April issue should be 2002, not 2001. Also, the following line was omitted from the end of "Integrating Dialectical Behavior Therapy Into Exposure Therapy for Complex Posttraumatic Stress Disorder," by Drs. Carolyn Black Becker and Claudia Zayfert: Portions of the article first appeared in *Cognitive Behavioral Practice* 2001; 8:107, and are reprinted with permission. Finally, Dartmouth University is located in Lebanon, not Dartmouth, NH.

Bulimia Nervosa: Long-term Outcome Is Improved by Combined Therapy

Bulimia nervosa is a complex condition with many different facets. Given the broad range of its psychopathology, it is surprising that so few aspects of the disorder have been assessed in studies of its treatment.

—Fairburn et al, 1986

Cognitive-behavioral therapy (CBT) is widely recognized as the treatment of choice for bulimia nervosa (BN). But what about long-term effects? A 10-year follow-up study of 101 women has shown that patients treated with CBT or an antidepressant or both have better psychosocial adjustment than women treated with placebo (*Int J Eat Disord* 2002;31:151).

In 1990, Dr. James E. Mitchell and colleagues reported a study in which women who met DSM-III criteria for bulimia nervosa and who reported binge eating coupled with purging episodes at least 3 times a week for at least 6 months prior to the study. The women who qualified for the study were randomized to one of the following treatment groups: (1) CBT plus the antidepressant agent imipramine; (2) CBT plus placebo; (3) imipramine alone; or (4) placebo alone.

Follow-up: 92% participate

Approximately 10 years later, the researchers located 115 of the women who had completed 10 weeks of treatment in their individual categories; 101 participated in the follow-up. The women completed a number of structured clinically validated self-report questionnaires at baseline and follow-up.

Combination therapy worked best

The researchers found that the combination of CBT and antidepressant that improved short-term outcome in patients with BN also had a positive long-term effect, particularly upon social adjustment. According to the authors, this is the first study to indicate that treatment

with antidepressants impacts long-term outcome. Significant differences were reported between women in the placebo group and women in the three active treatment groups, but no significant differences were found among the three active treatment groups.

Among the women in the active treatment group, follow-up Social Adjustment Scale-Self-Report (SAS-SR) scores fell below reported norms for women with depression, alcoholism, and schizophrenia, below scores reported by women with BN, and below scores reported by women 3 years after treatment for BN. (On the SAS-SR questionnaire, the lower the rating, the better the psychosocial adjustment.) In all three treatment groups, the 10-year outcomes were sustained; those in the combination treatment group had significantly better psychosocial adjustment. In contrast, women in the placebo group reported SAS-SR scores similar to those among actively bulimic women.

Residential Treatment Eases Severity of Symptoms

A treatment program based on establishing relationships and understanding has a positive and lasting effect on the severity of symptoms in female patients, according to two clinicians at Rogers Memorial Hospital, Oconomowoc, WI (*Eating Weight Disord* 2001; 6:197). Pamela Bean, PhD, and Theodore Weltzin, MD, recently described their study of symptom changes among 99 consecutive bulimic and anorexic patients between admission and 6 months after discharge. A group of non-patient female college students acted as controls.

The Residential Eating Disorder Treatment Center at Rogers Memorial Hospital provides long-term treatment in a home-like setting. Patients participate in a program of daily living activities, psychotherapy, nutritional counseling, and health maintenance. Each has an individualized

treatment plan, and may take part in a variety of programs, including family therapy, experiential and movement therapies, education-school collaboration, and a weekend family program. According to the authors, residential treatment is less expensive than inpatient therapy, yet is more intense than outpatient or partial treatment programs.

Symptom severity was measured with the Eating Disorders Inventory

The severity of symptoms was gauged with the eight subscales of the Eating Disorders Inventory (EDI). These subscales measure drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, interoceptive awareness, and maturity fears. Anorexic and bulimic patients were analyzed separately.

Improvement in all sectors

The 47 bulimic patients had statistically significant improvements in all eight subscales of the EDI. The greatest reduction in symptom severity occurred in drive for thinness, bulimia, ineffectiveness, interoceptive awareness, and interpersonal distrust. The mean scores for body dissatisfaction on admission also improved after treatment.

The 52 anorexic patients showed similar statistically significant improvements in all 8 subscales of the EDI. The greatest reductions in symptom severity occurred in the same 4 subscales that showed the greatest improvement among the bulimic group: drive for thinness, interoceptive awareness, ineffectiveness, and feeling of interpersonal distrust. Significant changes also occurred in perfectionism and maturity fears.

Six months later

To date, 25 patients have completed and returned the EDI form. The authors are following up with these patients. Mean scores thus far are similar to those recorded at discharge, indicating that some improvements in symptom severity were maintained for at least 6 months in both groups of patients. Longer-term studies are needed to see the degree to which these improvements are sustained over time. Other studies are needed to compare the relative effectiveness of residential treatment to traditional inpatient and intensive outpatient interventions.

Exercise Augments Treatment of Obese Women with BED

Obese women with binge eating disorder (BED) may be helped by adding exercise to cognitive behavioral therapy (CBT) and extending the duration of therapy, according to a team of American and Australian researchers (*Int J Eat Disord* 2002; 31:172).

Dr. John P. Foreyt and colleagues recruited 114 obese binge-eating women through newspaper, television, and radio advertisements announcing a free obesity treatment program. The women had to be at least 30 lb overweight, and to have a history of sedentary lifestyle and occupation and no history of drug abuse. The women were randomly assigned to one of four groups: (1) CBT with exercise and maintenance, (2) CBT with exercise, (3) CBT with maintenance, and (4) CBT only.

Women in all groups received weekly 90-minute group sessions for 4 months, based on CBT treatment for BED outlined in a manual (Telch, Agras, and Rossiter, 1990). Registered dietitians with more than 5 years of training and experience in CBT treatment of obesity led the groups.

In the exercise section, subjects were instructed about how fitness relates to dieting and binge eating and how it helps break the diet-binge cycle. The women were also expected to exercise for at least 45 minutes three times a week at a central exercise department, and required to walk briskly at home once a week. All groups were treated during the first 4 months of the study; the maintenance group then continued for 6 more months.

Exercise enhanced CBT

Women in the CBT, exercise, and maintenance therapy group had significant reductions in binge-eating frequency compared to women who received only CBT. The women in the first group had a 58% abstinence rate at the end of the study and lost an average of 14

BOOK REVIEW

The Parent's Guide to Childhood Eating Disorders

(Marcia Herrin EdD, MPH, RD, and Nancy Matsumoto. Owl Books, Henry Holt and Company; 324 pages; \$16.00, paperback)

Here's a book I happily recommend for parents of children and teenagers with eating disorders, and to the children and adolescents themselves. After all, they should know what their parents know. The primary author, Marcia Herrin, is a highly qualified psychologist-nutritionist-clinician, who founded the Dartmouth College eating disorders programs.

This well-organized, easy-to-read, very current and well-referenced book weaves the author's own and several patients' stories in at the beginning, and then looks at risks, early signs and prevention. It describes when disordered eating becomes dangerous; avoiding parent traps; families' reactions and what families can do; risks to boys; medical consequences, including course and impact on growth and bodily organs; what friends, schools, and summer camps can do; nutritional and exercise planning; outcomes; treatment options; and resources. Her sources include the American Psychiatric Association's *Practice Guideline for the Treatment of Patients with Eating Disorders*, and it's clear that she's read and considered many of the sources that went into those guidelines.

The sections that give highly specific advice to parents are well

done, very practical, and make sense to me. The book's style is chatty and conversational, and the book is broken down into bite-size chunks, headed by clear, declarative statements, such as "Put issues of body size, shape and food in a political context"; "Explain at an early age that different kids have different body types: focus on body function over body shape and size"; "Ban teasing about weight"; and later, "Fight the disorder and not your child", and many, many more. There are lots of tables and inserts: early warning signs, risky dieting behavior; restricting through pseudo-vegetarianism; healthy exercise, and many others. Appendices have DSM criteria for eating disorders and body weight assessment tools, including BMI charts.

I had one small quibble—the list of eating disorders resources is incomplete, omitting the Academy for Eating Disorders (www.aedweb.org) site, the Cornell Westchester programs, the University of Toronto programs, and many other fine University-based programs in California (e.g., Stanford), Colorado (Denver Children's Hospital), Washington D.C. (National Children's Hospital) and many others, including several based in adolescent medicine services. In addition, the resource list favors private hospitals and clinics. Although I also understand the authors' good intentions of listing every treatment program they came across, regardless of treatment orientation, I look forward to a day when as a field we can offer patients and their families treatment choices based on some reasonable set of programmatic standards and data on clinical outcomes.

—J.Y.

lb. (2.2 body mass index, or BMI, units). BMI was significantly reduced in the subjects who were in the exercise and maintenance groups.

Mood improved

Another benefit of exercise was improvement in mood, as measured by the Beck Depression Inventory (BDI). Ten months into the study, there were significant

differences in BDI scores between exercisers who had received maintenance treatment and those who had not.

Throughout the study, women who did not exercise had higher BDI scores than did women who exercised several times a week. Those who exercised lost weight throughout the study, while nonexercisers tended to gain weight.

Preventing Disordered Eating: A Program that Worked

Many programs designed to minimize or prevent disordered eating patterns are unsuccessful. Despite varying designs, many of these programs do not help reduce eating disorder symptoms or overweight.

According to Drs. Eric Stice and Jennifer Ragan at the University of Texas, Austin, such failures may be due to attempts to cover a large amount of psychoeducational information about eating disorders in only a few sessions and over a short time. Would a program given over a longer period make any difference in students' attitudes and actions?

Stice and Ragan designed a semester-long controlled study of 88 undergraduate women who enrolled in a class entitled "Eating Disorders" or other upper-division seminars offered concurrently in the Department of Psychology at the University of Texas (*Int J Eat Disord* 2002; 31:159).

The authors included data from women only, although a few men were also in the classes. Their rationale was that eating problems are rarer in males than in females.

The intervention

The eating disorders class was described to potential participants as an evaluation of the effects of a class on students' attitudes and behaviors. Students in other upper-division psychology seminars were approached and asked to complete parallel pretest and posttest surveys to help the researchers evaluate the effects of another course.

The authors recruited students from upper-division classes for the matched comparison group. Participants completed the 30-minute pretest in a class setting, with other students and an instructor. Because the students could not be randomly assigned to the intervention and control conditions, the control group was matched to

intervention participants.

The advanced undergraduate seminar on eating disorders met for 90 minutes twice weekly for 15 weeks. Most of the sessions involved educational presentations and group discussions. The course focused on descriptions of eating disorders, epidemiology, etiology, risk factors, preventive interventions and treatments for eating disorders and obesity. Students were then required to develop a 20- to 30-minute class presentation on a topic of their choice and to

A 'stealth' intervention approach for college students may have played a part in this study's success.

write a 10-page paper on the same subject. Three written essays were also required during the semester.

During the class, the students were given a number of self-report questionnaires, including the Ideal Body Stereotype Scale, Revised, a scale that asks participants to indicate their level of agreement with statements concerning what attractive women look like (example, "Slender women are more attractive").

Symptoms of anorexia nervosa, bulimia nervosa and binge eating disorder were assessed with the Eating Disorder Diagnostic Scale (EDDS, Stice et al, 2000). EDDS responses were used to generate threshold and subthreshold diagnoses of current anorexia nervosa, bulimia nervosa, and binge eating disorder (DSM-IV). Subthreshold diagnoses required the presence of all the symptoms of the disorder and also that at least one of these symptoms was of subdiagnostic severity, such as binge eating only once a week.

Fat consumption was assessed with an adaptation of the Fat-Related Habits Questionnaire (Kristal et al, 1999). The participants are asked to indicate how often they eat high-fat foods, using a 5-point scale from "never" to "five

or more times a week." Body mass index (BMI=kg/m²) was based on self-report data.

Results

Participants in the intervention group showed significant decreases in thin-ideal internalization from pretest to posttest, as well as decreases in body dissatisfaction, dieting, eating disorder symptoms and body mass. No decreases in these areas were shown among the matched controls.

According to the authors, the most important finding was that the intervention seemed to result in a fourfold decrease in the rate of threshold and subthreshold eating

disorder diagnoses and a decrease in several risk factors for eating pathology. Another important finding was that those in the intervention group had decreased body mass (mean: 3% decrease), whereas controls had increased body mass (mean: 4% increase) over the same interval. Those with the highest initial body mass lost the most weight. Fat intake and depressive symptoms were not affected.

A 'covert' prevention approach

Why did this program succeed when others have failed? According to the authors, one explanation may be that the participants were not informed that they were in an eating disorder prevention program. Instead, they enrolled in what appeared to be an advanced seminar not advertised as an eating disorder prevention intervention. Could it be that individuals are less defensive about body image and disordered eating and more willing to try alternative perspectives when they are not aware they are participating in an intervention program?

An additional benefit of the so-called "covert" prevention approach is that it doesn't require insight into eating disturbances by the participants to entice them into enrolling in the course.

Weight Teasing The Long-term Effects

One of the many challenging issues adolescents must face is teasing about their weight. Teens may be especially sensitive to weight-related teasing since identity formation is a major developmental task of adolescence, and body image and self-esteem are closely woven together.

In one study in which 50 overweight girls were interviewed about weight-related experiences, all but two had experienced the stigma of name-calling and teasing (*Int J Eat Disord* 1996; 19:193). Numerous studies have also shown that teenage girls who are teased about their weight are more likely to develop psychological, body image, or eating disturbances. Results of a recent study underscore how common weight teasing is and its potentially harmful effects (*Int J Obesity* 2002; 26:123).

Project EAT: nearly 25% had been teased about weight

In a study of 4746 teens from 31 public schools and high schools from urban St. Paul/Minneapolis, MN (Project EAT), nearly a fourth of the students had been teased about their weight at least a few times a year. Although boys and girls reported being teased, girls were teased more often. Very overweight girls were teased at a higher rate—63.2% had been teased by peers and 47.2% by family members. Very overweight girls were also at the highest risk of being teased by family members. And, it wasn't just the overweight girls who were teased—48.8% of underweight girls had also been teased about their weight.

Among the boys, very overweight boys were most likely to be teased about their weight by both peers and family members, while underweight boys were more likely to be teased by peers but not by family members. Native American boys and Asian-American boys (39% and 35%, respectively) were

more frequently teased about their weight by family members than were Caucasian boys (20.9%).

Who was bothered by teasing?

Very overweight girls were most bothered by teasing by family and peers. A high percentage of underweight girls also reported being bothered by weight teasing by their family members. High percentages of girls in all body mass index categories reported that they were bothered by weight teasing by peers and family members; teasing bothered considerably fewer overweight boys. In contrast to the girls, the teasing, from any source bothered few of the underweight boys.

Did teasing matter?

Teasing about weight had a notable effect on students and an effect on unhealthy eating behaviors. Gender differences were noted: girls are teased more than boys and girls report being bothered more by teasing than boys are. Also non-overweight girls report higher levels of teasing than non-overweight boys do.

Significantly higher percentages of overweight girls and boys who were teased about weight engaged in unhealthy weight control and binge eating behaviors, compared to overweight girls and boys who were not teased about their weight. Although not addressed in this study, such behaviors lead to more severe eating disturbances later on.

What can be done about weight teasing?

The authors suggest that schools need to have clear-cut policies against weight teasing. Just as great strides have been made within educational and employment institutions in regard to tolerance for gender and racial differences, the authors call for similar steps to prevent weight-related discrimination. Educational intervention might be implemented with programs for staff and students in which participants learn about the complex etiology of obesity, are made aware of their own attitudes and behav-

iors toward persons of different sizes, and learn about the possible harmful effects of teasing others about weight. The high prevalence of teasing by family members also indicates a need for parental or family interventions in which family members learn about weight-related mistreatment and its potentially harmful effects.

Chitosan: Another 'Fat Blocker' That Doesn't Work

"Fat blockers" are a staple of late-night television and radio. Chitosan, frequently touted on radio and television as an "effective fat blocker," is a derivative of the polysaccharide chitin found in the shells of invertebrates such as shrimp and crabs. The manufacturer claims that chitosan blocks absorption of as much as 120 g of dietary fat per day and, as a result, promotes weight loss. However, when a team of researchers at the University of California, Davis, tested this claim, chitosan failed completely.

Because dietary fat that is not absorbed must be excreted in the feces, the researchers assessed the product's effectiveness by measuring fecal fat excretion among seven healthy male volunteers (*Int J Obesity* 2001; 26:119). The men, who were 23 to 30 years of age, with an average body mass index of 26, maintained a high fat intake (more than 120 g/day) for 12 days. On days 6-9, they took chitosan before meals and snacks, exactly as directed by the manufacturer. A charcoal marker was consumed on days 2, 6, and 10 to mark the baseline and supplement periods.

Fecal fat was unchanged

The product did not increase fecal fat content and therefore did not block fat absorption. In two other trials, chitosan taken for 4 and 8 weeks without restricting energy intake failed to increase weight loss over placebo (*Eur J Clin Nutr* 1999; 53:379 and *Meth Findings Exp Clin Pharmac* 1999; 21:357). The authors note that their study illustrates the importance of using clinical research to evaluate the efficacy of dietary supplements, most of which are not regulated.

In the Next Issue

Herbal Agents Used by Eating Disorder Patients

By James L. Roerig, PharmD, BCPP, and James E. Mitchell, MD

In their quest for weight loss and appetite suppression, individuals with eating disorders (ED) no longer need to obtain a prescription from a physician or use over-the-counter drugs to achieve these ends. Now, the whole arena of "dietary supplements" is open for them. Some of these products have unhealthy and even dangerous side effects.

PLUS

- **A Special Patient Information Sheet: Harmful Herbs**

- **A review of *Eating Disorders: The Journey to Recovery Workbook* and *Eating Disorders: Time for Change***

- **Predicting Treatment Use Among Women with Anorexia and Bulimia Nervosa**

- **Risk Factors for Eating Disorders Among Ballet Dancers**

- **Stanford's Online Self-Help Program, "Student Bodies"**

- **More Highlights from the AED Meeting: Neurobiology and Genetics and Nutrition**

And much more

Nibbles, by Hunter



Questions & Answers

Fluoxetine Over the Long Term

Q: I have a patient with bulimia nervosa who has been receiving fluoxetine for about 6 months. She is doing well, but how long should she stay on the drug? (*LM, Fort Wayne, IN*)

A: Fluoxetine is an effective treatment for such patients. In a recent controlled study of 232 patients who received fluoxetine or placebo, those who responded to acute treatment with the antidepressant had an improved outcome. When treatment is continued, they also have a decreased likelihood of relapse.

Steven J. Romano, MD and colleagues compared the safety and efficacy of treatment with fluoxetine versus placebo in preventing relapse of bulimia nervosa during a 52-week period after successful acute treatment with fluoxetine (*Am J Psychiatry* 2002; 159:96). Patients who met DSM-IV criteria for bulimia nervosa (purging type) were assigned to single-blind treatment with 60 mg/day of fluoxetine.

After 8 weeks of treatment, those who had a 50% or greater decrease from baseline in vomiting episodes during one of the two preceding weeks were randomly assigned to receive 60 mg/day of fluoxetine or placebo and then were monitored for relapse for up to 52 weeks. The criterion for relapse was a return to baseline vomiting frequency persisting for 2 consecutive weeks.

Patients treated with fluoxetine showed a longer time to relapse than placebo-treated patients. Other analyses, including frequency of binge eating episodes, Clinical Global Impression

severity, and Yale-Brown-Cornell Eating Disorder Scale score, indicated that fluoxetine treatment was statistically superior to placebo. Attrition was high in this study, especially during the first 3 months after patients were randomly assigned to treatment groups.

Although patients treated with fluoxetine had a significantly lower rate of relapse, symptoms did return over time. Thus, fluoxetine may need to be paired with other therapies, such as CBT, to maintain a lasting effect.

Good News

Christine Kelly, Editor-in-chief of *Young Miss (YM) Magazine*, recently announced that the magazine will no longer feature articles about dieting. In addition, the publication will include a range of models of varied sizes, to reflect a more realistic and lifelike view of teens.

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