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UPDATE

Residential Treatment for Obese Children

A 10-month residential program designed to treat obesity in children has shown positive initial results, according to Caroline Braet, PhD, of Ghent University, Ghent, Belgium. The effect of two extended treatment programs aimed at coping with binges and maintenance of weight loss were compared with a standard CBT treatment program implemented in a non-diet, healthy lifestyle approach. Children were referred for residential treatment for obesity. The children ranged in age from 7 to 17 years (mean age: 12.7 years), and there was a mean body mass index (BMI) of 32.5. The success of treatment was measured with the Eating Disorder Examination (EDE), Perceived Competence Scale for Children (PCSC) and Child Behavior Checklist (CBCL), which measures well-being. Dr. Braet reported that the inpatient cognitive behavioral non-diet approach was a valuable treatment option. During residential treatment, the children lost 49.2% of their overweight, and developed higher self-esteem and their body dissatisfaction decreased. At the 14-month follow-up, the children had regained a mean of 15.9% of their lost weight and had a mean reduction in BMI of 4.9 points. The children continued to eat in a healthy manner.

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Eating Disorders at Middle Age, Part 2

By Kathryn Zerbe, MD, and Diana Domnitei, BS
Oregon Health and Science University, Portland

Clinical Presentation

Eating disorders at middle life are often accompanied by addiction to stimulants or cocaine to reduce weight. Herbal remedies, over-the-counter medications, or prescribed medications are also ubiquitously used to counter the normal 5 to 10 lb weight gain of middle life. Some individuals literally exercise themselves to death, spending hours in the gym or fanatically racing from one activity to the next. These addictions may be a final common pathway to cause morbidity and mortality at middle life, an under-recognized issue in women's health care.

Just as the adolescent or young adult with body image disturbances, the individual at middle age may be unhappy with her appearance. However, because time and money are more available to them, affluent individuals may seek out plastic surgery to obliterate the signs of aging. Individuals may struggle with a psychological concern that gets channeled into an eating disorder; that is, the eating disturbance becomes a focus so that the individual avoids facing conflicts, losses, normative life-transition concerns (such as children going to college or aging parents) and even one's mortality.

Middle age is the time of life when one begins to "take stock" and to shift the focus from one's own life to encouraging and helping shape the lives of the younger generation. Psychologist Eric Erickson described the core issue of middle life as generating vs. stagnating. Any emotional or physical problem can prevent an individual from taking his or her place in the cycle of the generations. Eating disorders at middle life have both emotional and physical components that derail adaptive choices at this point in the life cycle. A focus on spirituality may enable some individuals to place greater emphasis on fundamental values, and personal transcendence, rather than on appearance, as a symbol of what constitutes a life lived well.

Treatment Recommendations

Part of the challenge in treating women with eating disorders at midlife is effectively educating them about the normal process of aging. They must come to terms with the fact that the thinness they enjoyed as younger women is probably an unrealistic goal in middle age. We recommend that clinicians tell the patient that female weight gain in midlife is a result of normal hormonal and metabolic shifts, which are likely the result of aging and menopause. Large weight gains should be avoided by exercise and an individualized nutrition plan, because fewer calories are needed than when one is young; however, for most patients some weight gain is inevitable. One of the few boosters of body image is regular exercise, which plays an even larger positive role on the body image of overweight women compared to normal-weight women. As noted before, excess exercise must be avoided.

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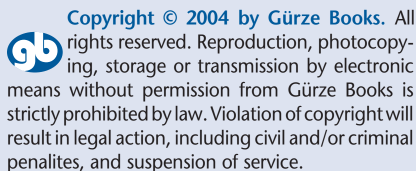

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Subscriptions—see page 8.

CBT is Effective for Post-Hospitalization Treatment of Anorexia Nervosa

Adults with anorexia nervosa (AN) have a high rate of relapse, continuing serious illness, and a mortality rate estimated at 5% per decade of follow-up. In what is believed to be the first empirical study of the efficacy of any form of psychotherapy for patients after inpatient treatment, Dr. Kathleen M. Pike and co-workers found that cognitive behavioral therapy, or CBT, was particularly effective for adults with AN (*Am J Psychiatry* 2003; 160:2046)

Patients were eligible to participate in the outpatient study if they had successfully completed inpatient treatment (defined as achieving at least 90% of ideal body weight) for at least 2 weeks, had normalized eating, and lived within commuting distance of the hospital. Thirty-three women were selected for the study.

CBT or nutrition counseling

The women were placed into one of two intervention groups: CBT or nutrition counseling, given in 50 individual sessions over the year after hospitalization. In both cases, the goal was to maintain the objectives achieved on the inpatient unit, to help patients improve and recover, and to prevent relapse.

The women were randomly assigned to their treatment group immediately before their first session in the outpatient trial, which was scheduled within one week after they were released from inpatient treatment. The nutritional counseling intervention was manual-based, and followed well-established principles of nutrition education and food exchanges. Treatment focused on specific dietary analyses and balanced meal planning.

CBT was given in a manual-based method consistent with recommendations specific to CBT for anorexia nervosa. Study physicians met with the patients monthly to monitor their medical condition. Antidepressant medication was continued throughout the outpatient trial and monitored by the study physician.

The patients were released from the study if their weight fell below a body mass index of 17.5 kg/m2, or about 80% of ideal body weight for more than 10 days; if the subject's medical condition was affected by exacerbation of anorexia nervosa to the point where inpatient care was once again required; or after exacerbation of non-eating-disorder psychopathology (such as attempted suicide) required additional care.

And, after a year…

The findings offered preliminary support for the use of CBT in the post-hospitalization treatment of adult anorexia nervosa. The criteria for relapse were met by 53% of the patients in the nutrition-counseling group, compared with 22% of those in the CBT group. Three women in the CBT group had relapses, due to weight loss, and one relapsed because of weight loss and increased suicidality. In the nutrition-counseling group, 5 women relapsed because of weight loss, and 3 were referred for alternative care because of severe depression, including active suicidal ideation in 2. The number of patients who dropped out early (defined as patients who discontinued treatment before session 10), was higher for those receiving nutrition counseling (3 of 15,or 20%) than for those receiving CBT (0).

A significantly higher percentage of women in the CBT group (44%, or 8 of 18) than in the nutrition-counseling group (7%, or 1 of 15) met modified Morgan-Russell criteria for a "good outcome." However, the authors point out that one of the limitations of these particular criteria is that they do not cover related psychological and behavioral variables that make up core criteria in anorexia nervosa. Thus, a person could have meet the study criteria for a good outcome but might still not be free of concerns about shape and weight or eating behavior.

'Full recovery' better among the CBT group

To counter this, the authors established an operational definition of full recovery by using the Eating Disorder Examination interview. Patients had to meet the criteria for good outcome and eating attitudes, and weight concerns had to be

less than one standard deviation above the mean of a comparison group without eating disorders, and binge eating or purging behaviors had to be absent. Using these criteria, 17% of the women in the CBT group met the criteria for "full recovery," compared with none of the individuals in the nutrition-counseling group.

At the time they were randomly assigned to CBT or nutrition counseling, 17 women were taking antidepressants; all the medications were begun on the inpatient unit because significant disturbances of mood continued despite weight restoration. The authors also attempted to determine if antidepressants affected outcome. No significant side effects from the medication effects were identified among those in the nutrition-oriented group. In contrast, the findings among the CBT treatment group suggested a medication effect: 7 of the 8 patients who met the criteria for "good outcome" were receiving medication, compared to 4 of the 10 who did not meet the criteria for good outcome.

Halting Ipecac Abuse

Ipecac syrup has long been used to induce vomiting after poisons or other toxic materials have been swallowed. It usually produces vomiting within 15 to 60 minutes. According to Tomas J. Silber, MD, of Children's National Medical Center, Washington, DC, ipecac abuse has repeatedly been reported as a cause of morbidity and mortality among teenagers and young adults.

Dr. Silber reported that ipecac abuse occurs predominately among young women who are either experimenting with purging, or those developing an eating disorder, or among those who already have anorexia nervosa (binge eating, purging type) or bulimia nervosa. About 5% of persons with eating disorders surreptitiously abuse ipecac, most in an attempt to lose weight.

Some of the more serious side effects of the widely used emetic include myocarditis with arrhythmias, myositis, gastroesophgeal disorders, including Mallory Weiss tears, diarrhea, and metabolic abnormalities such as alkalosis, hypokalemia, and dehydration. Once use of ipecac is halted, these conditions usually can be reversed. Deaths have been reported, usually in connection with cardiovascular problems.

Suspicious signs

Dr. Silber reports that detecting ipecac abuse requires a high index of suspicion. Some telltale signs include abnormal findings on standard electrocardiograms and echocardiograms and/or elevation of muscle enzymes (creatine phosphokinase, or CPK, and aldolase). In addition, emetine, the alkaloid in ipecac, can be identified in serum, urine, and tissue with high-performance liquid chromatography.

As Dr. Silber reported at the 2004 International Conference on Eating Disorders in May, toxicologists are currently questioning the value of using ipecac for childhood poisoning. According to Dr. Silber, changing ipecac's over-the-counter status, making it available only by prescription, could eliminate or significantly reduce its potential for abuse.

MIDDLE AGE continued from page 1

The journey of psychological discovery into the very source of the eating disorder is usually the keystone of the treatment process. Grappling with unresolved adolescent or adult conflicts or trauma, and addressing maladaptive behaviors such as smoking, food restriction, or drug abuse, or mourning personal issues and/or idealized body image can be costly in terms of time and money but hold the most hope for improvement.

In order for our patients to gain a sense of mastery over their feelings about aging, we encourage them to focus on why "staying youthful" takes on inordinate importance to them and try to help them to understand that nothing can stop the body from slowing down. In essence, existential issues must be dealt with by gently but persistently confronting denial.

Teasing apart the potential developmental antecedents of the body image disturbance that have led to and nurtured the eating disorder into existence includes helping patients to better understand themselves and their lives and the struggles that have shaped them into who they are today. This is vital not only for discovering and understanding the life events that have shaped the patients' eating disorders, but also for fully recognizing and appreciating their own personal growth. Doing so will allow them to gain the pride and sense of internal beauty that comes from the realization that they have lived a worthwhile life. Finding meaning in one's personal history provides a unique pathway to understanding the illness and ways to begin accepting the changes that accompany aging. [5,6]

Some patients ask for more specifics. We summarize these extant theories on aging and provide references for them to explore further. In particular, we direct them to the growing biographical and mental-awareness literature that describe positive modes for aging.

Conclusion

As women enter middle age, it becomes increasingly important that they accept the normal physical changes that accompany aging and maintain a positive body image. Because the average woman gains 5-10 lb per decade of life, the focus must shift from deriving excessive self worth from the external to personal development. These achievements include positive relationships with others and self-growth and are vital to making a successful transition into middle life. Greater awareness of the widespread body dissatisfaction among women in middle life, and particularly of those who have the additional symptoms of disordered eating and excessive exercise, will promote women's health at this crucial point in the adult life cycle.

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Ghrelin: A Helpful Marker and Hunger Stimulator, as Well

The recent discovery of ghrelin, an amino acid peptide, has added to our understanding of the body's control of food intake and energy balance. Ghrelin is secreted mainly by the stomach and duodenum, and stimulates hunger and promotes food ingestion. In contrast, leptin, another endogenous protein, increases satiety and reduces food consumption.

Results of two recent studies have shown that ghrelin can be a helpful marker of nutritional status among patients with obesity and anorexia nervosa, and that bulimia nervosa causes a profound dysregulation of this peptide.

A marker among obese and anorexic patients

In the first study, at the Hospital Infantil Universitario Nino Jesus, in Madrid, Dr. Leandro Soriano-Guillen and colleagues studied the effects of dietary intervention among 3 groups: 16 prepubertal children who were obese, 16 anorexic adolescents, and 41 healthy controls (21 were prepubertal and 20 were in Tanner growth stage 5). The researchers analyzed plasma ghrelin levels and their correlation with plasma levels of leptin, insulin, and insulin-like growth-factor-binding proteins 1 and 2 (*J Pediatr* 2004;144:36).

At diagnosis, ghrelin levels were significantly decreased in obese children (52% of control levels) and significantly increased in adolescents with anorexia nervosa (64% of control levels). After dietary intervention, ghrelin levels increased in obese patients without reaching control levels—even after the patients had a 50% reduction in body mass index (BMI). In adolescents with AN, ghrelin levels normalized after a 25% increase in BMI. Ghrelin levels correlated negatively with the BMI and positively with IGFBP-1 levels in controls but not in obese patients or in patients with AN.

Ghrelin's effect is blunted among patients with BN

In the second study, Dr. Palmiero Monteleone and colleagues at the University of Naples, Italy, compared the response of ghrelin and leptin to a meal in two groups—untreated women with bulimia nervosa and normal controls. Nine symptomatic drug-free bulimic women and 12 age-matched healthy women ingested a meal of 1,207 kcal (60% carbohydrate, 23% fat, 17% protein) at 12 noon.

The bulimic women were all of the purging subtype, with binge-eating episodes always followed by self-induced vomiting; none abused laxatives or exercised excessively. Three had a past history of anorexia nervosa, 2 had concomitant generalized anxiety disorder, and 3 had an Axis II diagnosis of borderline personality disorder. Control women were within 15% of their ideal body weight, had normal diets and no family history of mental disorders.

Blood samples were collected before, and then 45, 60, 90, 120, and 180 minutes after the meal. Plasma levels of ghrelin, leptin, insulin, and glucose were measured. Glucose and insulin levels were of interest because these substances have been claimed to modulate ghrelin secretion in response to food intake.

Results

There were no significant differences between the bulimic patients and the control women in age, body weight, BMI, body fat mass and body lean mass. In addition, pre-meal levels of ghrelin, leptin, insulin, and glucose did not differ between the groups.

The ghrelin response to food intake was significantly blunted in the bulimic patients, and postprandial profiles of circulating leptin, insulin, and glucose were not significantly different between patients and controls.

The authors reported that, just as with other studies, eating dramatically decreased plasma ghrelin concentrations in healthy subjects. In untreated symptomatic bulimic women, the suppression of circulating ghrelin by food intake was significantly blunted.

The authors note that study results suggest that ghrelin is a starvation-related hormone that functions as an indicator of short-term changes in energy balance. Therefore, its suppression after food ingestion may represent a peripheral signal involved in the regulation of a meal size by reducing hunger and/or increasing satiety. Thus, finding a blunted response of circulating ghrelin to food in symptomatic bulimics would support impaired suppression of the drive to eat following a meal, which could be responsible for an increased food consumption and binge eating among this group of patients. Laboratory studies suggest hat bulimic patients have diminished satiety responses to meals (Walsh et al, 1989) that, on the basis of the results of the study, could be mediated at least in part by impaired suppression of ghrelin secretion.

Precise mechanisms are still a mystery

The mechanisms underlying the altered ghrelin response to food in persons with bulimia nervosa are not known. Could altered glucose or insulin responses to a meal cause a blunted ghrelin response in bulimic patients? The authors didn't observe any difference in postprandial plasma glucose and insulin levels between bulimic patients and controls.

Another suggested theory is that the disordered eating, particularly chronic fasting-gorging behavior of bulimic women, impairs ghrelin's sensitivity to acute changes in energy intake. Despite the large amount of calories ingested during binge episodes, bulimics regurgitate a relatively large amount of calories through vomiting and may use prolonged starvation to reduce their daily caloric intake. Since insulin and glucose are believed to be involved in the postprandial mechanisms by suppressing ghrelin production, repeated abrupt decrements following chronic purging episodes may damage the sensitivity of ghrelin-producing cells to these physiological regulators. Then, even if bulimic have normal postprandial levels of circulating insulin and glucose, their sensitivity to food-induced ghrelin suppression could be impaired. The absence of changes in leptin levels immediately after a meal lends support to the idea that leptin is not involved in regulating meal size and postprandial satiety.

The study shows for the first time that the ghrelin response to food consumption is significantly blunted in symptomatic bulimics, whereas the short-term

leptin response is preserved. These findings support the authors' theory that in BN a profound disruption of some peripheral regulatory mechanisms is involved in both short-term and long-term regulation of feeding behavior and energy balance.

Eating Disorders in White and Black Women

In the U.S., studies of eating disorders have largely focused on white women and girls. As a result, the incidence of eating disorders among ethnic minority groups is still unknown, according to Dr. Ruth Striegel-Moore and colleagues (*Am J Psychiatry* 2003;160:1326).

Dr. Striegel-Moore and colleagues examined the prevalence of anorexia nervosa, bulimia nervosa and binge eating disorder in a community sample of young white and black women who had previously participated in the 10-year National Heart, Lung, and Blood Institute (NHLB) Growth and Health Study. A two-stage case-finding method was used, which involved a telephone screening, followed by an in-person diagnostic interview.

Eating disorders were more common among white women

A total of 86% of the original NHLBI Growth and Health Study participants responded, including 985 white women (mean age: 21.3 years) and 1,061 black women (mean age: 21.5 years). Among those who responded, 15 white women (1.5%) but no black women met lifetime criteria for anorexia nervosa. More white women than black women (2.3% vs. 0.4%, respectively) met the criteria for bulimia nervosa. Binge eating disorder was also more common among white women (27, or 2.7%) than black women (2.7% vs.1.4%, respectively). Few women, white or black, had ever received treatment for an eating disorder.

According to the researchers, the results suggest that eating disorders, especially anorexia nervosa and bulimia nervosa, are more common among white women than among black women. The low treatment rates in both groups suggest that all healthcare professionals need to be more alert to the possibility of eating disorders among all women, regardless of ethnicity.

BOOK REVIEW

Eating Disorders

(Mario Maj, Katherine Halmi, Juan José López-Ibor, and Norman Sartorius (eds). World Psychiatric Association Series: *Evidence and Experience in Psychiatry*, Volume 6. John Wiley and Sons, 2003. $135; 435 pp).

While some might initially find the price to be off-putting (even used copies are currently going for about $85 on *Amazon.com*), this excellent book is worth noting for several reasons. The World Psychiatric Association is well known for its series of distinguished volumes on various psychiatric topics, and the one addressing eating disorders is no exception. Each chapter has been rigorously written by outstanding experts, then peer-reviewed. But the significant feature that makes this book different from other texts is that every one of these chapters is accompanied by 11 to 15 highly informative, 2- to 3-page "critiques" by an additional large, multinational cadre of significant authorities. You participate in a world-class seminar complete with erudite discussions that alone come close to being worth the price of the book.

The six chapters cover classification, diagnosis and co-morbidities; epidemiology and cultural aspects; physical complications and physiological aberrations; pharmacological treatment; psychological interventions; and the economic and social burden of eating disorders. The discussants take up where the authors leave off—summarizing and underlining key issues, raising questions, pointing out gaps in the literature, and explicating uncovered theoretical and clinical implications, controversies, alternative explanations, and perspectives. They underscore where future research and clinical thinking should venture, and point out limitations that may never be adequately addressed. So, readers who study the text and commentaries gain a near-Talmudic experience.

All the sections deserve special recognition, but I'll simply mention the particularly lively discussions concerning classification—entailing what the core issues are in understanding eating disorders—and regarding economic and social burdens, relatively unstudied aspects of the field. My mentioning these two is not to slight the others. All of these chapters and discussions are well worth chewing on.

—J.Y.

ED Patients Commonly Use Herbal Remedies

Adolescents with eating disorders frequently use herbal remedies for various conditions and especially in an attempt to control their weight, according to a team at the University of Toronto *(Int J Eat Disord* 2004; 35:223).

Dr. L. Trigazis and co-workers studied 46 adolescent female volunteers, from 10 to 17 years of age, who were in a tertiary care pediatric eating disorder treatment center. The women met the diagnostic criteria for anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified. The participants completed a 92-item self-administered questionnaire that examined their use and knowledge of herbal remedies.

Of the 46 women, 37% reported using herbal remedies to decrease their appetite and to induce vomiting; 41% knew nothing about herbal remedies despite their use of these products. Only 24% reported that their physicians ever discussed herbal products or questioned them about using herbal remedies. The women reported that they did not use herbal remedies because of dissatisfaction with other types of medications or products.

The researchers also learned that the women did not regularly tell their physicians that they used herbal remedies, and that their physicians seldom gave them any information about using herbal products and the possible unpleasant or even harmful side effects of such products.

Because the perceived benefits, adverse effects and herb-drug interactions of self-prescribed herbal remedies by teens with eating disorders are still not understood, and much more research is needed in this area, according to the authors.

Elevated Cortisol Levels Persist in Obese Women with BED After CBT and Weight Loss

Hypercortisolemia, or higher-than-normal levels of cortisol, has been reported in persons with bulimia nervosa and obesity. Stress can precipitate binge eating, and increased cortisol is related to both central body fat and food intake after laboratory-induced stress.

Marci E. Gluck, PhD, and colleagues at St. Luke's Roosevelt Hospital, New York City, recently investigated the relationship between cortisol and waist-hip ratio (WHR) in 22 obese women (BMI >27). Eleven women had binge-eating disorder (BED) and 11 others acted as controls.

The women underwent a cold pressor test in which they immersed one hand in ice water for 2 minutes. Blood was drawn at several intervals and assayed for cortisol and insulin. Twenty women (10 BED, 10 non-BED) completed the second phase of the study, in which they were randomly assigned to either 6 weeks of cognitive behavioral therapy (CBT) and diet (5 non-BED, 5 BED) or to a wait-list control group (5 non-BED, 5 BED).

Higher cortisol levels reported in the BED group

The BED group had higher morning basal cortisol levels than did the non-BED group and a trend for greater AUC (area under the curve) cortisol levels following the test; this became significant after controlling for AUC insulin. Those in the BED group who had CBT lost more weight than did women in the control group. Waist-hip ratios did not differ between the two groups. WHR was related to AUC cortisol and peak cortisol response in the BED group only. There were no BED, intervention, or interaction effects on morning basal cortisol level after the stressor test, both before and after controlling for insulin. The correlation between WHR and both AUC cortisol and cortisol stress response after the stress test remained significant only for the women with BED.

A maladaptive axis?

Dr. Gluck and her colleagues note that their findings indicate the presence of a hyperactive hypothalamic-pituitary-adrenal axis in BED patients that is related to abdominal obesity and that persists even after treatment and weight loss. This suggests a maladaptive pattern of stress reactivity that could contribute to BED. Dr. Gluck's group described their findings at the 2004 International Conference on Eating Disorders in Orlando.

Aggressiveness: A Bridge to Eating Disorders Among Teens?

There is a positive link between a propensity to aggression and eating disorders among adolescents, according to results of a study of Italian teens (*Acta Psychiatrica Scandinavica* 2003;108:183).

Dr. Antonio Preti and colleagues used a series of questionnaires to assess 1,000 male and female adolescents aged 15 to 19, from Conegliano, a town in northern Italy, and from the surrounding region. The team used the Eating Attitudes Test (EAT), the Bulimic Investigatory Test of Edinburgh (BITE) and the Body Attitudes Test (BAT), as measures of abnormal eating attitudes and behaviors, and the Aggression Questionnaire (AQ) as a measure of the propensity to aggression. The AQ is a 29-item self-completed questionnaire that measures attitudes toward aggressiveness and its expression in everyday circumstances. Its four subscales measure the tendency to physical aggression, verbal aggression, anger levels and hostility levels. Body mass index was derived from self-reported data on weight and height, and the socioeconomic status was derived from a measure of crowding at home, based on the number of rooms available per person, excluding kitchens and bathrooms.

Results: more risk among females

Among the 818 adolescents who reported complete data, females scored significantly higher than males in all eating disorders inventories. The girls also had a higher likelihood than males to report scores above the suggested cut-off point for a clinically relevant eating disorder on the EAT, the BAT, and the BITE. Males scored higher than females on the AQ. In both genders, the researchers found no statistically significant links between age, SES, or BMI and AQ scores.

Abnormal eating patterns and aggression

In both genders, adolescents reporting abnormal eating patterns were significantly more likely to score higher on the AQ. Fifteen percent of females and 2.7% of males scored higher on the EAT than the suggested cutoff mark of 30; this compared with 11% reported in an earlier study of 359 young girls in Padua and 5% in a mixed female-male sample of 904 teens in Pavia, both large towns in northern Italy.

According to the authors, it is important to recognize patients' feelings of hostility and aggressiveness and to balance countertransference. Patients who are hostile and aggressive also strongly tend to neglect a therapist's advice, leading to poorer compliance with treatment. These patients then are left at higher risk of negative outcomes, such as suicide attempts, sexual promiscuity, and alcohol and substance abuse.

A balanced approach with psychotherapy and drug prescriptions, particularly the SSRIs, might help reduce aggressive behavior, according to the authors. These agents have positive effects on the serotonergic dysfunction involved in aggressive behavior.

Actively Preventing Relapse in Patients with Bulimia Nervosa

Simply telling patients with bulimia nervosa who appear to have been successfully treated to come back if they have additional problems, or if they fear that they are developing such problems, may be an ineffective technique to prevent relapse, according to researchers at the University of North Dakota.

A recent multi-center study examined a strategy to prevent relapse among patients with bulimia nervosa (*Int J Eat Disord* 2004; 35: 549). Dr. James Mitchell

and colleagues studied patients who had initially achieved abstinence after having a course of cognitive behavioral therapy (CBT). The patients were told to re-contact the clinic to schedule additional visits if their symptoms recurred or if they feared symptoms would return. At the end of the CBT patients whose scores on the Eating Disorders Examination indicated they were no longer binge eating and purging, and thus who were considered to be successfully treated, were assigned randomly to follow-up only or to a crisis intervention model, in which the patient would receive additional visits if needed.

Results

None of the 30 subjects who relapsed during the follow-up period sought additional treatment visits. The authors believe that alternative strategies, such as scheduled return visits or phone calls to patients, should be considered as alternative relapse prevention strategies.

Helping Teachers Learn to Identify Eating Disorders

Secondary school teachers may be in a unique position to help identify students with eating disorders, but often they are unaware that such problems exist in their student population. Dr. Niva Piran and Erica A. Layton of the University of Toronto recently described a study in which they interviewed 10 teachers to determine their experiences with identifying and acting upon student eating disorders.

Two phases: identification and action

The teachers were interviewed about their experiences during a qualitative, transcribed interview. The process of identifying a student with an eating disorder was then broken down into two distinct phases: the identification phase and the action phase. Each phase then was analyzed to see what helped and what hindered teachers from identifying students with disordered eating.

Factors that helped teachers recognize students with eating disorders included a close student-teacher relationship, overt symptoms in students, the teacher's personal eating disorders issues, and a heightened awareness of eating disorders in general.

Factors that kept teachers from identifying students with eating disorders included a distant student-teacher relationship, hidden symptoms among students and the teacher's lack of general knowledge about eating disorders.

Few teachers referred students for help

When the researchers evaluated the action phase, or the actions the teacher took after identifying the problem, they learned that the only teachers who referred students for help were physical education teachers. The researchers surmised that the reason for this might be that physical education teaches felt more competent and comfortable handling such issues because they have more training and interest in health. And what kept the other teachers from referring students for help? The teachers reported that they believed that it would be inappropriate to intervene; they also had a fear of breaking trust with the student by mentioning the disorder. Others reported having a fear of doing the wrong thing, lack of confidence in their observations, lack of training, and lack of time.

The authors feel that teachers could benefit from special training to help them recognize eating disorders and then take appropriate action.

Partial Hospitalization for Treatment of Anorexia Nervosa

Due to economic factors, there is pressure to shorten hospital stays for all patients, including those with anorexia nervosa (AN). Patients with AN may be admitted for partial hospitalization, even though it is usually more difficult for them to gain weight in an outpatient setting.

Since normalization of weight is widely used as a criterion for recovery from AN, the cost per pound of weight gained rather than the cost per day of treatment is an important index of the cost-effectiveness of partial hospitalization, according to Angela S. Guarda, MD, of Johns Hopkins Hospital, Baltimore. At the annual meeting of the American Psychiatric Association, Dr. Guarda described the results of a study of partial versus longer-term hospitalization for treatment of a group of 62 anorexic patients. Her hospital's program includes an integrated step-down, inpatient-partial hospitalization design, with supervised housing, a behavioral protocol, and intensive group therapy.

The average weight gain among the 62 patients studied was more than 2 lb/week. The average cost per pound of weight gained among the patients who were treated initially as inpatients and then transitioned to partial hospitalization was significantly higher than for patients who had inpatient hospitalization. Overt eating disordered eating behavior did not affect inpatient cost per pound gained but did predict lower cost-effectiveness for partial hospitalization. Although partial hospitalization is cost-effective for treating behaviorally compliant AN patients, it is much more cost-effective for severely underweight or behaviorally disruptive patients to remain on an inpatient unit longer before being assigned to partial hospitalization.

Longer-term therapy for AN: more effective

In a second presentation, Arthur L. Robin, PhD, and Patricia Siegel, PhD of Birmingham, MI, reported that short-term therapy had only limited effectiveness among 37 female teens with restricting AN. The girls were assigned to 16 months of Behavioral Family Systems Therapy (BFST) or Ego Oriented Individual Therapy (EOIT). BFST consisted of family sessions focusing on a behavioral-weight gain program, cognitive restructuring, and improved family structure. EOIT included individual adolescent sessions focusing on dynamics that blocked eating; parents were seen separately.

The length of therapy distinctly affected the outcome. For example, 28% of the girls reached their target weights by 6 months, and 68% did so by 16 months. Twenty-eight percent of the girls resumed menstruation by 6 months, and 80% by 16 months. Eating habits, depression, and ego functioning did not improve before 16 months. Psychological variables did not improve until post-assessment follow-up.

QUESTIONS & ANSWERS

Gastric Surgery and Risky Eating Behavior

Q One of my patients recently had gastric bypass surgery and has lost a tremendous amount of weight. However, he still has some of his bad eating habits. Does this make a difference? (*L.C., Tampa*)

A What you are describing is, unfortuantely, not rare. According to a recent study, gastric bypass patients who have a variety of disturbed eating patterns may be at risk of returning to those old patterns after successful surgery (*Obes Surg* 2004;14:98). Binge eating is frequently linked to a poorer outcome after surgery, with weight regain. In this study, patients completed a self-report questionnaire before they had gastric bypass surgery, and then were followed up after surgery. Those who were identified as having high-risk eating behaviors were reinterviewed after they had surgery. Many high-risk patients reported they had lost control over their eating, and as a result were regaining weight. Some reported eating continuously throughout the day and evening, or "grazing," because they could no longer eat large amounts of food. This pattern emerged about 6 months after surgery. The author suggests that different forms of overeating need to be assessed in this population because former binge eaters may turn into "grazers" after gastric surgery. Recognizing risky eating behavior and intervening with education and therapy is essential for these at-risk patients.

Nibbles by Hunter

"Yes, I do hip replacement surgery, but that's for bones, not shape."

ON THE CALENDAR

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The Ages and Stages of Eating Disorders

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Outcome in Anorexic Inpatients at Discharge

Weight gain is a very important measure of initial successful treatment of anorexia nervosa and a criterion for discharge. According to the results of a recent study, the amount of weight gained may not be an accurate gauge of the pattern of weight gain after a patient is discharged.

Researchers at the Renfrew Center, Philadelphia, recently reported findings from a study of 214 women diagnosed with anorexia nervosa upon admission for residential treatment, then evaluated 3 months after discharge. The sample was trichotomized, based on change scores from intake to discharge and on outcome measures, including weight, Eating Attitudes Test (EAT)-diet and EAT-oral control subscales.

Dr. Maryelizabeth Forman and colleagues found that women who gained the most weight from intake to discharge experienced the most significant decline in weight at the 3-month follow-up examination. In contrast, women who gained the least amount of weight during the time from admission to discharge had the best improvement in weight gain at the 3-month follow-up. Thus, those who seemed to do better in treatment had a poorer result 3 months later.

As the researchers reported at the 2004 Annual International Conference on Eating Disorders in Orlando, their findings were consistent across both the diet and oral control subscales of the EAT-26.

IN THE NEXT ISSUE

Highlights of the 2004 International Conference on Eating Disorders

PLUS

- **Gay Men and Body Image**
- **Caloric Intake and Nutrition in Low-Weight and Weight-Restored Women with Anorexia Nervosa**
- **Respiridone Treatment for Teens with Anorexia Nervosa**
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