



## UPDATE

### Parents As the Main Agent of Change in Childhood Obesity

Working with parents alone may provide better results for treating obese children than including all family members, according to an Israeli study. Moria Golan, PhD, reported at the recent Eating Disorders Research Society meeting in Toronto that working directly with parents of obese children, compared with working only with an obese child or including parents and child together significantly improved the child's weight loss and parents' weight status as well. One hundred and fifty obese children from 100 families throughout Israel participated in the six-month project. Dr. Golan reported that omitting the obese child from the direct intervention and targeting the parents only with a health-promotion approach, emphasizing parenting style and practices, is a cost-effective and beneficial strategy for managing childhood obesity. She also reported that permissive parents had less success in helping their child lose weight and in losing weight themselves.

## The EDQLS: A New Instrument for Measuring Quality of Life

By Carol Adair, PhD and Gisele Marcoux, PhD • University of Calgary, Alberta, Canada, and Marlene Reimer, PhD University of Manitoba, Canada

Quality of life (QOL) is increasingly being recognized as an important outcome of treatment, yet eating disorders outcome measurement has often focused on reduction of symptoms rather than on functioning or quality of life. This may be caused by the fact that until recently no suitable instrument for measuring QOL has been available for people with eating disorders.

Where QOL has been measured, reports from clinicians suggest that generic QOL instruments developed for other (typically adult) patient populations seem to lack relevance (i.e., questionnaire items fail to reflect the developmental issues of adolescents and young adults), and patient response has also been found to be poor.

that it may be very useful in guiding individual treatment, evaluating services, and researching new treatments.

An initial pool of about 300 items was generated using extraction of QOL themes from the eating disorders literature, from patient and interviews with eating disorders professionals, and from first-person narratives from the Internet.\* The initial domains and items were validated in focus groups with patients, and then systematically pre-tested by patients, eating disorder professionals, and family members.

### Four qualifying factors

To be retained in the questionnaire initially selected items had to be rated highly on four principles:

- *Directionality* (the item was capable of showing change in a linear direction with treatment);
- *Universality* (the item captured behaviors or feelings across different types of eating disorders and across the range of ages of patients with eating disorders);
- *Wording/Ambiguity* (the item was clearly worded and understood without varying interpretations), and
- *General Likeability* (the item had resonance and general face validity).

Several stages of testing and refinement resulted in a final set of 40 items in the following 12 domains: cognitive functioning, education/vocation, family and close relationships, relationships with others, future/outlook,

*continued on page 2*

### A new QOL Instrument

Our group has developed and piloted a new QOL instrument – the Eating Disorders Quality of Life Scale (EDQLS), in collaboration with eating disorder professionals at five other sites. The EDQLS addresses areas that reflect aspects of life that are affected by eating disorders and that are likely to change with recovery (for example, leisure interests or relationships). It is written in age-appropriate language and covers content of relevance to adolescents and young adults with eating disorders. Preliminary results suggest

### ALSO IN THIS ISSUE

Adverse Childhood Experiences and Eating Disorders .....	2
Eating Disorders and Alcohol Abuse: Aggressive Treatment Is Best ..	3
Fluid Intake Among Patients with Eating Disorders .....	4
The Night Eating Syndrome: An Update .....	4
Laxative Abuse: Retailers Need More Educational Resources .....	5
A Mother and Child Bulimic Connection? .....	5
Review: <i>EDNOS: Eating Disorders Not Otherwise Specified</i> .....	5
Anorexia Nervosa: Predicting if Patients Will Accept Treatment .....	6
Early Weight Gain: a Positive Sign in AN Treatment .....	6
Purging Disorder: Another Form of Bulimia Nervosa? .....	7
Early Response to Desipramine Among Women with BN .....	7
BED: A Chronic or Temporary Condition? .....	7
Q & A: Are Eating Disorders and Addictions Related? .....	8
Competition for Mates or for Status? .....	8
Index to Volume 16, 2005 .....	Insert
Quiz for Continuing Education Credits .....	Insert

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## Adverse Childhood Experiences and Eating Disorders

Healthcare professionals working with pregnant women need to be aware of the high prevalence of underlying eating disorder symptoms and the possible association with a history of adverse experiences in childhood, according to the results of an ongoing study (*Br J Psychiatry* 2005;187:268).

The Avon Longitudinal Study of Parents and Children, also known as the “Children of the Nineties Project,” recruited 14,069 pregnant women in three districts in Avon, a city in southwest England, and then followed them with three questionnaires addressing parental mental health and childhood sexual abuse and experiences, including instances of unwanted sexual advances or exposure. R. Senior, MRCPsych, and colleagues used data from this study to explore early experiences recalled by pregnant mothers that were associated with lifetime and antenatal eating disorder symptoms.

### Early experiences did play a role

A number of early experiences significantly predicted lifetime eating disorder symptoms. Women who reported eating disorder symptoms were more likely to recall that one or more of their parents had mental health problems, including alcohol abuse and depression. The highest odds ratios were for parental cruelty (emotional or physical), and childhood sexual abuse. In contrast, happy memories throughout childhood and a stable family situation were associated with a lower rate of eating disorder symptoms. The death

of a parent and lower socioeconomic standing were not related to lifetime eating disorder symptoms. The most predictive variable was early sexual abuse.

Eating disorder symptoms reported during pregnancy, including self-induced vomiting, and laxative abuse to lose weight, were predicted by a similar set of early experiences, including parents with alcohol problems or depression, having emotionally or physically cruel parents, and having been sexually abused. Recalling parental alcoholism or mental health problems, depression or death, cruelty, divorce and early sexual abuse were all significant predictors of marked concern over shape and weight during pregnancy. Women who reported highly overprotective parents were also more likely to have marked concern over shape and weight. They were more likely to use laxatives and vomiting to control their weight during pregnancy. Early sexual abuse remained a significant independent predictor of lifetime eating disorder symptoms and greater-than-normal concern about shape and weight. Having a low level of social support also was a significant predictor of shape and weight concerns during pregnancy.

The authors note that maternal eating problems in the postnatal period can pose a particular risk to a developing child by interfering with healthy parenting and child growth. Thus, it is important to address early experiences that might be related to concerns about weight and shape.

*continued from page 1*

leisure, psychological health, emotional health, values and beliefs, physical health and eating issues. The EDQLS takes an average five minutes to complete and has undergone initial testing in individuals with eating disorders who are as young as 14 and as old as 44 years of age. Its reading level is measured at grades 5 to 7.

Pilot results are encouraging and were presented on November 28-30, 2005 at a conference in Banff, Alberta, Canada. Results have also been submitted for publication and for presentation at the International Eating Disorders Conference, to be held in Barcelona in June 2006. In addition, a field test and vali-

dation study is underway in 10 eating disorder clinics across Canada.

While the EDQLS will not be ready for general use until after results of field testing are in (expected mid-2006), eating disorder professionals are invited to provide their expert impressions on the face validity of the new instrument.

\*Some of the early developmental work is currently in press in *Qualitative Health Research*.

A copy of the EDQLS can be obtained by sending an e-mail request to Carol E. Adair (Co-Principal Investigator) at [ceadair@ucalgary.ca](mailto:ceadair@ucalgary.ca), or by visiting the EDQLS website: [www.med.ucalgary.ca/EDQLS](http://www.med.ucalgary.ca/EDQLS)

# Eating Disorders and Alcohol Abuse: Aggressive Treatment Is Best

Among all the mental disorders, both eating disorders and substance abuse disorders are associated with the highest risk of mortality. When both disorders coexist, the stage may be set for a particularly dangerous course.

Until recently, little had been written about the effects of one condition upon the other, according to Dr. Debra L. Franko and her colleagues at the Harvard Eating Disorders Center in Boston (*Int J Eat Disord* 2005; 38:200).

## Study design

In a prospective study, Dr. Franko and co-workers studied 136 women diagnosed with anorexia nervosa (AN) and 110 women diagnosed with bulimia nervosa (BN). The women were tested for signs of alcoholism, or alcohol use disorders (AUD) every 6 to 12 months for up to 9 years. After a brief telephone screening, individuals who met study criteria were scheduled for an in-person interview with a trained research assistant. The research assistants confirmed the present of full-syndrome eating disorders and assessed subjects for current or lifetime psychiatric disorders. Every six months thereafter, the women were assessed with the Eating Disorders with the Longitudinal Interval Follow-up Evaluation (LIFE-EAT-II); these interviews were conducted in person whenever possible. The LIFE-EAT II is a semi-structured interview that assesses eating disorders symptoms (such as binge eating, compulsive exercise, etc.), comorbid psychopathology, treatment received, and psychosocial functioning.

At each follow-up interview, the participants were also asked about how often they drank alcohol and any potential alcohol misuse since the previous interview. If a subject reported going through a period when she believed she drank too much or had a family member or others object to her drinking or was unable to stop drinking when they wanted since the last interview, she was assessed for AUD. The subject met the criteria for

AUD when she reported three or more of the symptoms (see Table 1) for at least 4 weeks.

## Alcoholism affected a quarter of subjects

When the study began, 42 (17%) of the women reported a history of AUD. Eleven of the women with a history of AUD before entering the study developed a new episode of AUD during the study. By 9 years of follow-up, 24 of those with no history at intake had developed AUD, resulting in a total of 66, or 27%, reporting a lifetime history of AUD. Of these 66 women, 33 had AN and 33 had BN.

Although AUD did not predict or influence recovery from symptoms of an eating disorder, a number of eating disorder symptoms did predict both the onset and recovery from an episode of AUD. Unique predictors

for AUD among women with AN were depression, overconcern with body image, and vomiting. Recovery from AUD was improved by group therapy and hospitalization for women with AN and by individual therapy and exercise for women with BN.

For patients with AN and BN, hospitalization shortened the time to recovery, suggesting that intensive treatment in a hospital setting is useful. The authors also found that both inpatient teams and outpatient clinicians could effectively treat alcohol problems in this group. Problems with alcohol did not appear to impede recovery from the eating disorder.

Because the combination of alcoholism and eating disorders appears to be potentially dangerous or even deadly, patients with both disorders should be treated aggressively, according to the authors.

**Table 1. Criteria for Alcohol Use Disorder**

1. Subject thinks she drinks too much.
2. Others complain about her drinking.
3. She admits she often can't stop drinking even when she wants to.
4. Frequent drinking before breakfast.
5. Frequently missed work, had impaired performance on the job or unable to take care of household responsibilities.
6. Job loss—drinking was the primary reason for this, according to the subject.
7. Frequently has difficulty with family members, friends, or associates because of drinking.
8. Divorce or separation primarily caused by drinking, according to the subject.
9. Alcoholic benders (on 3 or more occasions drank steadily for 3 or more days).
10. Physical violence associated with drinking on at least 2 occasions.
11. Traffic difficulties due to drinking (e.g., reckless driving, accidents, or speeding).
12. Picked up by police due to behavior associated with drinking (other than traffic difficulties, as above).
13. Frequent blackouts (memory loss for events that occurred while conscious during drinking episodes).
14. Frequent tremors most likely due to drinking.
15. Delirium tremens
16. Hallucinations after stopping drinking on at least 2 occasions.
17. Withdrawal seizures in a non-epileptic person, limited to periods when she stopped drinking.
18. Cirrhosis, gastritis, or pancreatitis attributed to alcohol, verified by a physician.
19. Polyneuropathy most likely due to drinking.
20. A diagnosis of Korsakoff syndrome (confusion and severe memory loss, especially for recent events; patients often make up stories to compensate for this).

# Fluid Intake Among Patients with Eating Disorders

Fluid intake and drinking behavior vary widely among patients with eating disorders, but few studies have specifically looked at this behavior. Some eating disorder patients may increase fluid intake in an attempt to weigh more and to depress hunger and appetite. Others may decrease fluid intake to avoid a feeling of fullness, abdominal discomfort and bloating, or to feel more in control.

A team at the University of Sydney, Australia, recently evaluated fluid intake among a group of eating disorders patients before the patients were admitted for inpatient treatment (*Int J Eat Disord* 2005;38:55). An experienced dietitian took a 7-day retrospective fluid intake history before patients were admitted. In face-to-face interviews, the dietitian prompted patients to recall and describe the frequency, type, and amounts of all fluids ingested during the past seven days.

Total fluid consumed each day was measured. This included all energy-free fluids (water, coffee with caffeine decaffeinated coffee, tea, herbal tea, and decaffeinated drinks, diet colas), energy-containing fluids (juice, milk-based products, including high-energy protein supplements, soft drinks, colas and soft drinks), and caffeine-containing fluids (colas, coffee, tea, and diet cola). Eighty-one patients participated in the study.

## Fluid intake: from a very little to a lot

Fluid intake varied widely—from as little as 250 ml to 6925 ml (nearly 7 L)/day. Most patients reported drinking no alcoholic beverages during the week before being admitted for treatment, and only 1 reported excessive alcohol consumption, in this case 25 standard-sized drinks a day. Age was moderately correlated with fluid intake; that is, the older the patient, the greater the fluid intake. Also, older patients were more likely to drink energy-free drinks than were younger patients. Body weight did not correlate with any of the fluid intake variables.

The most popular drinks during the 7 days before admission were water, diet cola, coffee, juice, and tea. Diet cola was the soft drink of choice. Those who binge-ate or who induced vomiting had a significantly higher caffeine intake from diet cola, coffee and tea, but not a significantly higher overall fluid intake than those who did not binge. Older patients and those with a lower body mass index drank more fluid than the other groups. It was unclear why these patients drank more than the other patients.

Among this sample, factors that affected the fluid intake of eating disorders patients included purging behavior and binge eating, which were associated with a higher intake of caffeinated beverages and excessive exercise. Age and body mass index did not predict total fluid intake. The Australian researchers state that fluid intake should be part of the clinical assessment of all eating disorder patients.

## The Night Eating Syndrome: An Update

The night eating syndrome, first described in 1955, is an eating disorder characterized by a delay in the circadian pattern of eating that disrupts normal sleep. Those with the syndrome eat a large proportion of their daily calories after their evening meal and wake up at night to eat. In the morning most have little or no appetite.

Most reports of the night eating syndrome have involved obese persons. However, a recent study reported that many night eaters were of normal weight (*Int J Eat Disord* 2004;35:217). This fortuitous discovery came from the use of a night eating syndrome website and questionnaires that showed remarkably similar responses from 40 obese persons and 40 of normal weight.

## Treatment with SSRIs

Dr. Albert J. Stunkard and colleagues at the Weight and Eating Disorders program at the University of Pennsylvania School of Medicine recently reported

that such patients might benefit from treatment with selective serotonin reuptake inhibitors (SSRIs) (*Appetite* 2005; 45:182). In his clinic, 23 night eaters were asked about any medications they felt had helped their condition—a total of 83 products were mentioned. These included antidepressants, hypnotics, and herbal preparations. Only one agent showed consistent effectiveness—phenfluramine and phentermine ('fen-phen').

Seventeen of the 23 night eaters then underwent an open-label trial over 12 weeks with the SSRI sertraline. Twelve were women with a mean age of 46 years and a mean body mass index (BMI) of 39.3 and 5 were men with a mean age of 50.0 and a mean BMI of 31. All the men and women in the trial showed frequent nocturnal arousals with food intake, evening hyperphagia and morning anorexia.

The subjects received 50 mg/day of sertraline for the first 2 weeks, after which the dosage was increased, as tolerated, to a maximum of 200 mg/day. The average daily dose at the end of the 12-week trial was 188 mg. The participants were seen every other week for a 30-minute follow-up visit.

## Nocturnal awakenings, caloric intake, and ingestions were reduced

Twelve of the 17 men and women completed the study. By week 12, four primary outcome measures showed highly significant improvement. The number of awakenings per night fell from 2.0 per night to 0.8; nocturnal ingestions fell from 1.5 per night to 0.5 per night, and caloric intake after supper fell from 51.6% to 25.7%. The Clinical Global Impression of Improvement fell from 4% to 2.6%.

Three subjects discontinued treatment because of excess sleepiness or increased anxiety, and one dropped out because of hypomania. One was lost to follow-up. The three who developed sleepiness or anxiety had their dosage reduced after the side effects appeared and discontinued it at a dosage of 37.5 mg/day, suggesting a special sensitivity to sertraline.

Five subjects fully remitted and three responded to the medication. Were the beneficial effects derived solely from the drug's antidepressant action? Ac-

to the authors, the correlation between the improvement in measures of night eating correlated nonsignificantly with the improvement of depression on the Beck Depression Inventory.

Thus, the authors feel that the night-eating syndrome may be helped by pharmacotherapy, particularly with serotonin-enhancing medications. A double-blind trial of sertraline is currently underway.

## A Mother and Child Bulimic Connection?

Among preadolescent and adolescent girls, having a mother with a history of an eating disorder increases the risk that the girls will also develop eating disorders. However, other modifiable factors may be of as much importance, according to a multi-site study.

Alison E. Field, ScD, and colleagues used data from 5,897 girls and 4,491 boys 9 to 14 years of age who are participants in the ongoing Growing Up Today Study, and who were followed for up to 5 years. Subjects in the study live throughout the U.S., and all have mothers who are registered nurses. The study, based on self-report questionnaires, is being conducted by researchers at Children's Hospital, Brigham and Women's Hospital, Harvard Medical School, and Harvard School of Public Health, all in Boston; Wesleyan University, Middletown, CT; and Stanford School of Medicine, Palo Alto, CA.

### What the study has shown so far

As Dr. Field reported at the Eating Disorders Research Society meeting in Toronto in September, during the 5 years of follow-up 7.1% of the females and 1.1% of the males started to binge eat or purge (vomiting or using laxatives) at least once a week to control their weight. Approximately 4% of the mothers reported a history of an eating disorder.

Boys and girls whose mothers reported having a history of an eating disorder were more likely than their peers to start to binge eat or purge at least weekly. Despite this, importance of thinness to their peers and fathers and media influences were found to be equally important risk factors, at least among the girls.

## EDNOS: Eating Disorders Not Otherwise Specified: Scientific and Clinical Perspectives on the Other Eating Disorders

(Edited by Claes Norring and Bob Palmer. New York: Routledge, 2005; 338 pages; \$52.95)

Studies suggest that as many as 50% of patients with eating disorders seen in specialty treatment programs are most accurately diagnosed as having an "Eating Disorder Not Otherwise Specified," currently labeled "EDNOS," rather than anorexia nervosa or bulimia nervosa per se. In this first-ever volume totally dedicated to the EDNOS collection, Drs. Norring and Palmer, distinguished European eating disorders experts, have brought together 29 international authorities to address multiple aspects of this heterogeneous group. As befits such a volume, to help frame the field the volume starts with several good chapters that attend to issues of classification, typology, and the atypical eating disorders. Clinicians and administrators will find the discussions of atypical eating disorders to be particularly useful. A variety of lumping-together and splitting-apart techniques, using advanced statistical methods, are used to supplement the old-fashioned and still useful methods of careful clinical description of odd and unusual cases. As you would expect, binge eating disorder, still subsumed under EDNOS in the DSM-IV, figures prominently here, and is well considered in several chapters, by in relation to course and obesity.

Among other clinical syndromes striving for independent recognition, we are informed about such things as anorexia athletica; non-purging bulimia nervosa; food avoidance emotional disorder, and the night eating syndrome. Chapters elucidate attempts to understand the nature, origins and pathogenesis of EDNOS syndromes from a variety of perspectives. These include biology, genetics (including twin studies), cross-cultural, psychoanalytic, developmental, and neurodevelopmental perspectives. Eating disorders in children and in athletes and in relation to diabetes are nicely reviewed as not quite falling within current diagnostic boundaries. Finally, among many excellent chapters, I was particularly taken with a final chapter that provocatively discusses the nature of diagnosis, including why we diagnose and the psychology of diagnoses, including a good discussion of "fuzzy sets" – the sort of mathematics that may move these fields to the next conceptual level, away from simple categories.

To sum up, EDNOS has long deserved the special attention given to it in this welcome volume. Those who'd like to bring the important and mixed group of clinical syndromes and disorders now hidden under the EDNOS umbrella into proper perspective would do well to read this volume.

–J.Y.

## Laxative Abuse: Retailers Need More Educational Resources

A Great Britain study explored retailers' services and policies regarding laxatives, and assessed the issue of laxative abuse in the context of eating disorders. As Dr. Rachel Bryant-Waugh reported at the International Conference on Eating Disorders in Montreal, 53 retailers reported stocking an average of 12 laxative products, most of which were senna-based preparations.

Sales practices varied widely; however, most retailers had at least one standard practice in place to limit or to monitor laxative sales. The most common were age restrictions and monitoring the amount of laxatives sold to an individual customer. The most common way retailers detected abuse were frequency of visits and the purchase of large quantities. Most also reported

that they could be alerted to abuse by the customer's physical appearance. Cases of suspected abuse were usually referred to the head pharmacist/store manager and misuse led to restricting sales rather than offering any guidance about abuse.

Staff training was variable and few employees had any information about local support services for individuals found to be abusing laxatives. Most retailers agreed that they have an important role to play in addressing laxative misuse and were willing to work with eating disorders services. However, they also pointed out the need for more information and resources to help them inform, advise, and ultimately help customers suspected of misusing laxatives.

# Anorexia Nervosa: Predicting If Patients Will Accept Treatment

Anorexia nervosa is still one of the most difficult psychiatric disorders to treat, as evidenced by the fact that despite many advances, treatment is about as successful today as it was 50 years ago.

According to Dr. Katherine Halmi and colleagues (*Arch Gen Psychiatry* 2005; 62:776), few controlled studies of the course of treatment have been done because of the nature of AN itself. That is, the disorder is relatively rare, so it is difficult to get large enough numbers of cases at any one center. In addition, patients with AN resist treatment and are at best ambivalent about it. Finally, medical complications often lead to withdrawal from treatment protocols.

Dr. Halmi, at Cornell University, and colleagues at Stanford University and the University of Minnesota, designed a randomized prospective study of 122 patients from 14 to 50 years of age with DSM-IV criteria for AN to evaluate the factors that can lead to nonacceptance and noncompletion of treatment. The patients were randomly assigned to one of three treatments: cognitive behavioral therapy (CBT), fluoxetine, or a combination of the two, for one year.

CBT sessions were scheduled twice weekly for the first month, once weekly during months 2-6, twice monthly for months 7-9, and once a month for months 10 to 12. The CBT was a manual-based intervention developed specially for this protocol. Fifteen-minute medical management sessions were conducted by a psychiatrist after the therapy session weekly for the first month. These sessions were then scheduled twice a month through the fourth month and then monthly.

Patients in the fluoxetine treatment group received the medication during the medical management session. Within 6 weeks, all these patients were receiving the maximum dose, 60 mg/day. After 6 weeks, they continued taking the maximum dosage they could tolerate.

About a third of the participants had previously been hospitalized and two-thirds had previous treatment as outpatients. More than half engaged

in purging. The mean body mass index (BMI) was 17.8 kg/m<sup>2</sup>.

## Who dropped out or withdrew?

The dropout and withdrawal rates were substantial, according to the authors. Twenty-one participants, or 17%, were withdrawn from the study, mainly due to treatment failure. Other reasons included pregnancy (2 patients) and intolerable side effects of the medication (3 patients).

Among the 101 remaining patients, 56, or 55%, dropped out. The main reason given was dissatisfaction with some aspect of the treatment (68%). An additional 11 subjects, or 20%, dropped out very early in treatment; 4 were withdrawn by their families, and 2 (4%) dropped out later in treatment—all without giving a reason.

The strongest predictor of treatment acceptance was the type of treatment. Eighty-nine of the original 122 study participants were treatment acceptors. Of these, 45 or 51% completed treatment. The only predictor of treatment completion was self-esteem. A low score on the Rosenberg Self-Esteem Scale led to a 40% completion rate, whereas a high self-esteem score was associated with an 80% treatment completion rate. The type of treatment was not a significant predictor of treatment completion among those who accepted treatment.

The very low rate of acceptance in the medication treatment group does not seem to pertain when medication is given together with some form of psychotherapy. As Dr. Halmi noted, this suggests that medication alone cannot be an effective treatment for anorexia nervosa if only because most anorectic patients will not accept such treatment.

## Overcoming high dropout rates

Is there any way to overcome these high dropout rates? The authors note that it became clear that medication alone is not a viable treatment for such patients. At one of the three study sites, for example, 165 potential subjects were screened, 16 were randomized to medication and only 1 completed that treatment. Also, one major reason for

dropping out of the treatment group was medical difficulties. Therefore, it is necessary to develop new protocols that include dealing with such difficulties without dropping patients from the protocol to which they have been assigned.

Finally, according to the authors, in the groups that received psychotherapy, patients with high obsessive preoccupation tended to have relatively high acceptance rates for treatment involving psychotherapy. Those with high self-esteem were more likely to complete treatment than those with low self-esteem.

It might be possible that devising different treatment protocols for patients with AN that take into consideration such baseline characteristics might alleviate the problem of having a patient initially agree to treatment and then drop out. According to the authors, remedies need to be identified that will improve acceptance of treatment and reduce dropout among patients with AN who have low obsessive preoccupation and low self-esteem.

## Early Weight Gain: a Positive Sign in AN Treatment

According to Dr. Marion P. Olmstead of Toronto General Hospital, there is growing evidence that early response to treatment strongly predicts final response to that treatment. Eighty-six patients with diagnoses of anorexia nervosa (AN) reinforced this theory.

The patients were enrolled in a day hospital program for at least 6 weeks. Their mean age was 33.1 years, and the mean duration of illness was 11.1 years. The mean BMI was 15.9.

### Weight gain during the first 6 weeks predicted outcome

Weight gain during the first 6 weeks of treatment was significantly associated with outcome. As Dr. Olmstead reported at the Eating Disorders Research Society's annual meeting in Toronto, planned comparisons showed that the poor outcome group, those who were slow to gain weight at the outset of treatment, differed significantly from the other groups.

# Purging Disorder: Another Form of Bulimia Nervosa?

Purging disorder (PD) is an eating disorder reported among normal-weight individuals who repeatedly purge without objective binge episodes. This disorder falls loosely into the category of an eating disorder not otherwise specified, or EDNOS, but has some characteristics of bulimia nervosa (BN).

Dr. Pamela Keel and her associates designed a study to examine the clinical significance and distinctiveness of purging disorder by comparing three groups of women, including women with DSM-IV bulimia nervosa (BN, purging subtype), women with PD who would have met DSM-IV criteria for BN purging subtype except for the absence of large binge episodes, and non-eating disordered controls (*Int J Eat Disord*, 2005:191). The study group included 111 women aged 18-45 years, who had a body mass index between 19 and 25 kg/m<sup>2</sup>, and who were recruited from the community.

The participants completed questionnaires and face-to-face structured clinical interviews at baseline. Follow-up assessments occurred approximately 6 months later and included the Eating Disorders Examination (EDE) interview and all baseline self-report questionnaires.

## Study results

Compared with women in the control group, women with PD seemed significantly impaired on measures of eating pathology, general psychopathology, and impulsiveness/personality disorders. Women with PD did not differ significantly from women with BN on measures of eating disorder severity, body image disturbance, or dietary restraint.

The differences that did emerge between PD and BN may help explain the disparity in the amount of food consumed during self-reported binge eating episodes as well as the frequency of binge-purge episodes. Women with BN reported greater disinhibition around food and greater hunger compared with women with PD. Previous studies have suggested that binge eating episodes in BN are associated with a reduced satiety

response mediated through blunted serotonin (*Arch Gen Psychiatry* 1997; 54:529) and cholecystokinin function (*Am J Clin Nutr* 1997; 65:114). These two systems may provide clues to better understanding differences between PD and BN.

## PD: Not more severe than BN

When the authors compared mean depression and anxiety scores, the findings varied, suggesting that differences may change over time. For example, depression and anxiety were significantly lower in the PD group in the current study than in the PD group in a previous study by the authors.

PD clearly occurs among individuals with no history of BN, and there is no indication that PD represents a more severe eating disorder than, or a more ominous form of, BN. Although some might view PD as a less severe disorder compared with BN (due to differences in hunger, disinhibition, and binge/purge frequency), the authors note that it is merely a matter of a better understanding of the pathology associated with BN.

Individuals with PD are characterized by a tendency to become locked into negatively reinforced behaviors. Similar to compulsions in obsessive-compulsive disorder, purging in PD may be maintained by a strong need to reduce anxiety and the threat of unwanted outcomes, such as weight gain.

## BED: A Chronic or Temporary Condition?

Results of some studies have suggested that binge eating disorder (BED) may be only a temporary, nonspecific pattern of abnormal eating that will remit after a short time, such as 1 to 5 years. Others, studying different populations, suggest that BED may be a more chronic and stable disorder, like bulimia nervosa (BN).

James I. Hudson, MD, ScD, of Harvard Medical School/McLean Hospital, Belmont, NY, and researchers at Columbia University, and the universities of North Carolina, Minnesota, and Cincinnati,

sought to settle these conflicting findings by examining data from a family interview study in which they interviewed 888 first-degree relatives of 300 overweight or obese probands (150 had current or past diagnoses of BED and 150 had no history of an eating disorder) recruited from the community. They then compared the total lifetime duration of illness among relatives with lifetime diagnoses of BED (131), BN (17), and AN (18).

## The duration of BED was longer than that of AN or BN

As Dr. Hudson reported at the Eating Disorders Research Society meeting in Toronto at the end of September, the mean duration of BED was 14.4 years—significantly longer than either BN (5.8 years) or AN (5.9 years). The authors suggest that BED is at least as chronic as the well-validated disorders AN and BN, and thus probably represents a stable syndrome.

## Early Response to Desipramine Among Women with BN

Many studies have shown that antidepressants are very effective for treating patients with bulimia nervosa (BN). B. Timothy Walsh, MD and colleagues at Columbia University, New York City, recently reported finding preliminary evidence that patients with BN who will not respond to treatment with antidepressants can be identified early in treatment (*Int J Eat Disord* 27: prepublication abstract).

The researchers based their findings upon data from two previously published studies of the tricyclic antidepressant desipramine. Seventy-seven women with BN were included in the analysis. Receiver operating characteristic (ROC) curves were constructed to examine the relationship between the percentage of reduction in symptoms at the end of each week and failure to respond to antidepressant medication at the end of the study. According to the authors, patients with BN who did not respond to antidepressants could be reliably identified within the first two weeks of treatment.

## QUESTIONS & ANSWERS

### To What Extent Do Clinicians Think Eating Disorders and Addictions Are Related?

**Q** I've heard that eating disorders are just another form of addiction, like substance abuse. Is this true? (M.L., Cincinnati)

**A** Although much of the public believes eating disorders share many similarities with addictive disorders and might actually be addictions themselves, so far little evidence has been found to prove this. An interesting sidelight to this comes from a recent Canadian study that surveyed psychotherapists in Canada to see if they used addiction-based therapy for patients with eating disorders. As Kristin M. von Ranson, PhD, and a team at the University of Calgary reported at the Eating Disorders Research Society meeting in September, 26% of therapists often or always used addictions-based therapies for patients with eating disorders, and another 15% referred clients to adjunctive addictions-based eating disorders treatment. This meant that 42% of therapists used or permitted addictions-based treatments for patients. The authors also systematically surveyed English-language websites describing eating-disorders-focused treatment studies. She found that 30.5% of these unique eating disorders websites used

an addictions-based approach as part of or all of the treatment. However, these clinicians were not specifically eating disorders specialists. It's likely that a much smaller percentage of clinicians specializing in eating disorders would link these disorders with the addictive disorders. But this remains to be studied.

### Competition for Mates or for Status?

In a recent study at the University of Arizona, Tucson, Dr. L. M. Faer and colleagues sought to answer the following question: Do eating disorders among women arise because of competition for mates or status? (*Psychol Psychother* 2005; 78:397).

The researchers predicted that female intrasexual competition (ISC) for mates would be the strongest predictor of bulimia; in contrast, female ISC for status would be the strongest predictor of anorexia nervosa. A group of 202 undergraduate women participated in the study. The women completed numerous measures, including the General Competitiveness Scale and the Eating Disorders Inventory.

The results demonstrated that ISC for mates was ultimately the driving factor that contributed to female competition for status, general competitiveness, perfectionism, body dissatisfaction, drive for thinness, and both anorexia and bulimia. Contrary to the authors' initial expectations, the results supported a mostly spurious causal relationship between female competition for status and anorexia, with the only indirect causal effect being the influence of perfectionism, which was uniquely linked to anorexia and not to bulimia.

#### Nibbles by Hunter

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#### CLINICAL PORTRAITS



OBSESSIVE COMPULSIVE



OBSESSIVE REPULSIVE

## IN THE NEXT ISSUE

### Rethinking the Definition of Anorexia Nervosa

By Arnold Andersen, MD

Here is one New Year's resolution: The current DSM definition of anorexia nervosa is badly in need of updating. Here are some thoughtful and helpful suggestions.

#### PLUS

- **Resting Tachycardia: a Helpful Warning Sign in Anorexia Nervosa**
- **Weight Suppression and Its Effect on Bulimia Nervosa**
- **Anorexia Nervosa and Behavior Traits**
- **AN: From Renal Failure to Successful Weight Gain**

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## Continuing Education Quiz for Eating Disorders Review

November/December 2005 - Volume 16 - No. 6

You are eligible to receive one (1) Continuing Education (CE) credit by completing this quiz based on this issue of Eating Disorders Review (80% correct for a pass). INSTRUCTIONS: Circle the best answer to each of the following questions and return the completed test with a check for \$25 (payable to PER) to PER at PO Box 2196, Keystone Heights, FL 32656.

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Your CE credits will be documented and you will be sent a letter and certificate of completion. CE credits can be used in support of your license renewal, to maintain your managed care board memberships, to obtain discounts on your professional liability insurance policy, and to document your commitment to ongoing professional development. Learning Objectives: 1) Increase your knowledge regarding recent research developments concerning eating disorders, and 2) Enhance your clinical knowledge regarding disordered eating.

- 
1. According to recent research by Moria Golan, the most effective way to treat obese children may be by working with
    - a. them alone
    - b. their parents alone
    - c. them and their parents jointly
    - d. none of the above
  2. According to the Avon Longitudinal Study of Parents and Children, which of the following factors were related to marked concern over shape and weight during pregnancy
    - a. recalling parental alcoholism
    - b. parental divorce
    - c. early sexual abuse
    - d. all of the above
  3. In a prospective study by Dr. Franko et al., what percentage of the sample of eating disordered participants also had a history of alcohol use disorders
    - a. 10%
    - b. about one-quarter
    - c. just over half
    - d. nearly three-quarters
  4. According to a team of researchers from the University of Sydney, the most popular drinks for eating disordered patients in their study prior to intake included
    - a. water
    - b. diet cola
    - c. coffe
    - d. all of the above
  5. In the University of Sydney study, older patients and those with lower body mass index drank \_\_\_\_ fluid than the other groups.
    - a. more
    - b. less

*(continued on other side)*

6. In a study of the effects of SSRIs on night eating syndrome, researchers found positive changes in which symptoms
  - a. number of awakenings per night
  - b. calorie intake after supper
  - c. the number of nocturnal ingestions
  - d. all of the above
  
7. In a large scale study of nearly 10,000 girls and boys, researchers have found that over a 5-year period, roughly \_\_\_\_ of the girls and \_\_\_\_ of the boys started to binge eat or purge.
  - a. 7%; 1%
  - b. 12%; 4%
  - c. 23%; 11%
  - d. none of the above
  
8. Studies suggest that as many as \_\_\_\_ of patients with eating disorders seen in specialty treatment programs are most accurately diagnosed as Eating Disorders Not Otherwise Specified (EDNOS).
  - a. 10%
  - b. 25%
  - c. 50%
  - d. 75%
  
9. In a study of whether anorexic patients will accept treatment or not, researchers noted that \_\_\_\_ percent of those with a low self-esteem score completed treatment, compared to \_\_\_\_ percent with a high self-esteem score.
  - a. 10%; 75%
  - b. 40%; 80%
  - c. 80%; 40%
  - d. 20%; 60%
  
10. In a study of binge eating disorder (BED), Hudson and his colleagues found that the mean duration of the disorder was \_\_\_\_ years.
  - a. 4.3
  - b. 5.9
  - c. 9.8
  - d. 14.4

---

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Evaluation: Overall, this issue of *Eating Disorders Review*: (circle appropriate response)

Provided informative updates	5	4	3	2	1	Was not informative
Expanded my knowledge	5	4	3	2	1	Did not expand my knowledge
Provided useful resources	5	4	3	2	1	Did not provide useful resources
Was appropriate for my training level	5	4	3	2	1	Was not appropriate