

EATING DISORDERS REVIEW

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UPDATE

Is Exercise Harmful During Treatment for Bulimia Nervosa?

It is still debatable whether patients with bulimia nervosa (BN) should be allowed to exercise during intensive treatment. One theory holds that these patients should not exercise because they cannot separate exercise from weight and shape concerns, and thus exercise will only perpetuate the binge-purge cycle. Others believe that moderate exercise may not interfere with treatment and may even be helpful in the recovery process. Traci McFarlane, PhD, and colleagues at Toronto General Hospital and the University of Toronto recently reported the results of their study of a series of BN patients admitted to the day hospital program at Toronto General Hospital. Preliminary results showed no differences in frequency of binge eating at the end of treatment according to exercise status. However, patients who exercised while in the day hospital engaged in significantly more vomiting than those who did not exercise. These results suggest that engaging in any exercise while in intensive treatment for BN may signal a stronger attachment to the illness and to weight and shape control. The authors also believe this suggests that BN patients should be encouraged to abstain from exercise until their symptoms are under control.

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Revising the Diagnosis of Anorexia Nervosa Will Improve Patient Care

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Anorexia nervosa (AN), the oldest eating disorders subtype, was first described centuries ago. Its historical legacy has significant positives and negatives. The positives include improved diagnosis and research. The primary negative is hesitancy about changing historical thinking about AN, even though evidence-based studies suggest this is timely and imperative for improving patient care. Why have there been complexities in the diagnosis of AN?

Agreeing Upon a Definition for AN

An agreement on a definition of AN comes first. AN is: (1) *a disorder of abnormal eating behavior*, (2) driven primarily by the *internalization of the overvalued sociocultural belief* in the benefits of slimming (predominantly among females) or shape change (predominantly among males), (3) sufficiently sustained in duration and severity to cause *significant signs and symptoms of medical starvation as well as psychological and social change*.

It is important to understand the psychopathology of “overvalued beliefs.” They are: (1) widely held sociocultural beliefs, (2) given ruling passion in small group of individuals, often during crucial developmental years, (3) leading to risky or dangerous behaviors.

AN is both a *strategy* to deal with emotional distress from a variety of sources (for example, “existential fears of maturation,” depressive/anxious

mood, family functioning, decreased self-esteem, social acceptance, etc.), and an *illness* that has a life of its own once it is established. In addition, it has perhaps the highest premature mortality (12% to 19%) of any psychiatric disorder. AN is not a subset of another disorder, such as obsessive-compulsive disorder or psychosis, or major depressive illness, although it usually has from two to four “companion” comorbid disorders, some secondary to AN, some primary to it.

Its hallmark psychopathological findings are: a morbid fear of fatness with a relentless drive for thinness, with frequent but not invariable distortion of body image. Many of its features, such as preoccupation with thoughts of food, emotional flattening or irritability, social isolation, and decreased sexual drive, are consequences of starvation, not part of the psychopathology of AN. These features have been reproduced in experimental starvation studies.

The high frequency of onset of AN during adolescence has primarily to do with the fact that the core challenge of adolescence is forming a personal identity, and slimming/shape change in this country are unfortunately very effective, albeit short-term, pseudo-solutions to forming a personal identity. In other words, just be thin and you will feel better about yourself; you can control something completely when everything is changing in ways you didn't ask for; you get more attention; and you have a method to deal with

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crummy moods. Unfortunately, AN is a good enough pseudo-solution to seem to solve all the issues it is asked to solve. There are no dumb reasons for developing AN.

Getting the Diagnosis Right

Although AN has been described as rare, it is as common as schizophrenia or childhood onset of Type I diabetes. It is not a benign disorder, although it is highly treatable when done well. All of these are reasons to get the diagnosis right. The term “diagnosis” means “thorough knowledge.”

What kinds of knowledge are conferred by accurate diagnosis? An accurate diagnosis confers knowledge about: (1) what treatments to use; (2) what the future holds (*pro-gnosis*, “future knowledge”). In the ancient world, doctors were paid to tell a parent the probable outcome (prognosis) of an injured child, even when treatments were not effective. So why is there concern about the diagnosis of AN?

First, the historical nature of AN seems to make clinicians reluctant to make changes, even as evidence accumulates. AN has long been associated with (a) being female—even though the first cases involved a male and a female; and (b) amenorrhea (having been classified in the endocrine section of texts for more than 50 years).

At least two studies have demonstrated that amenorrhea is irrelevant to the diagnosis of AN. Patients meeting the core AN criteria (self-starvation, overvalued belief in the importance of slimness, sustained functional impairment medically, psychologically, and socially), whether or not they have a light menstrual bleed or none have the same clinical picture, the same natural course of illness, and the same response to treatment. In addition, requiring amenorrhea for the diagnosis is gender-biased. In the *ICD-10*, the diagnostic classification used by most of the world, uses the phrase “abnormality of reproductive hormone functioning,” suggesting changes in estrogen or testosterone qualify as medical signs of AN. This is a better but still overly restricted appreciation of the global starvation changes that occur with AN. Requiring

amenorrhea in the diagnosis of AN also ignores the data that some women lose periods soon after starting to diet, and some at very low weight have continued menstrual function. So, out with amenorrhea!

Misreading the DSM-IV

There is a slavish misreading of the *DSM-IV*'s supposed criterion of requiring weight less than 85% of norms for age and height for the diagnosis of AN. Normal weight, like height, is bell-curved in its distribution. A woman who is healthy at a self-regulating weight of, for example, 125% of the statistical average, and who diets, may have all the medical, psychological, and social symptoms of AN at 90% of “normal” or “healthy” weight, all of which are averages, not mandates. A straightforward reading of the *DSM-IV* is frustratingly ignored. The use of the 85% level is said to be *exempli gratia*, or an example. It is unbelievable how rigidly insurance companies, clinicians, and the media interpret this level.

Many mischievous as well as serious patient-unfriendly results occur when insistence on amenorrhea and a weight less than 85% of an average are required as part of the diagnosis of AN. The huge number of so-called “atypical” cases of eating disorders are, in fact, 75% of the time, AN misdiagnosed by relying on disproved or archaic criteria. Female patients are told if they have menstrual function and/or final diet-induced weight greater than 85% that they do not have AN, but rather have an “atypical eating disorder.” This confuses clinicians (“How do you treat atypical cases?”), causes frequent denial of health insurance payment for diagnosis evaluation or treatment (“We only reimburse AN and bulimia nervosa; also, atypical cases are not that serious.”). These things shouldn't happen, but they do time and time again.

Resistance to Change

In the real world, there are some awkward factors to deal with in understanding resistance to change in diagnostic criteria. Some resistance to change comes from researchers invested in keeping overly narrow criteria because of the possible need to change

diagnoses in research studies; emotional investments in archaic criteria, albeit out of date, are at times a personal reality. Politics as well as science affect the criteria in differing degrees (for example, diagnostic categories that had a brief half-life in previous *Diagnostic and Statistical Manual* editions).

More and more disorders are appreciated as being spectrum disorders, with a change from single rigid category on the dimension (high blood pressure vs. no high blood pressure) to a spectrum of severity. Now, a person with pre-hypertension is treated with the same vigor and method as the old “full” hypertensive.

Likewise, if a patient has the core features of AN: (1) self-induced starvation; (2) psychopathology of an overvalued belief in the benefits of slimming or shape change; (3) duration and severity of disorder sufficient to suffer functional impairment medically, psychologically, and socially, they have AN and need to be diagnosed as such, and treated as such.

Asthmatic patients are not told to go home and become more severely asthmatic before they qualify for treatment. Likewise, AN patients do not stop having AN because they exceed 85% of their normal weight or at normal weight, any more than a hypertensive or diabetic patient loses his diagnosis because medical treatment produces normal blood pressure or normal glucose levels. If, after five years there are no signs of AN (“normative cultural distress,” i.e., lip service to “dieting is normal”), then AN, like cancer, can be considered probably cured.

Thankfully, a “transdiagnostic” approach to AN at any level of severity, and whether or not they meet any current state-of-the-art evolving diagnostic criteria (*DSM-IV* or *ICD-10*), has been shown to lead to clinical improvement in the large majority of patients if applied integratively and for long enough to “work the disorder out of a job.” The myths of AN being always chronic, always severe, hard to treat, difficult to diagnose, etc., are all completely untrue. These myths have all the features of disorders clinicians most like to treat: (1) serious enough to absolutely require treatment; (2) responsive enough to

New Bulimia Nervosa Website Is Launched

In recognition of National Eating Disorders Awareness Week, ECRI (formerly known as the Emergency Care Research Institute) recently unveiled a new informational website for family and friends of patients with bulimia nervosa.

The website, www.bulimiaguide.org, is a comprehensive-evidence-based resource. The website offers a comparison of the effectiveness of treatments for bulimia nervosa based on their the results of an in-depth scientific analysis of all the available clinical research. It also provides families and patients with in-depth information about navigating the health insurance maze and how to maximize their insurance benefits.

Some of the features offered on the website include:

1. *Bulimia Nervosa Resource Guide for Family and Friends* (a 75-page printable guide);
2. Summary of *Bulimia Nervosa: A Resource Guide for Family and Friends* (a 12-page summary printable guide);
3. *Efficacy of Treatments for Bulimia Nervosa* (a 650-page evidence report);
4. Summary of *Efficacy of Treatments for Bulimia Nervosa* (16 pages);
5. A full-color, 11 x 17-inch full-color poster about the website and a 12-page summary of the guide;
6. A searchable directory of residential facilities that treat bulimia nervosa;
7. Detailed information on strategies for maximizing health insurance benefits;
8. A list of ongoing clinical trials on bulimia nervosa;
9. A review of state mental health parity laws and mandates affecting coverage of care for eating disorders; and
10. A catalog of current health insurance coverage policies for bulimia nervosa.

Dr. Pauline Powers, past president of the Academy for Eating Disorders, and *EDR* Editorial Advisory Board member, notes, “This outstanding website provides a wealth of information for patients with bulimia nervosa and their families. It is often difficult to understand the symptoms of an eating disorder and many people do not recognize how dangerous bulimia can be. The website outlines what is known about the causes of bulimia nervosa, describes the physiological complications that can occur and provides a detailed evaluation of the treatments that have been found to be useful.”

ECRI is a nonprofit health services research agency with offices in North America, Europe, and Southeast Asia.

have a high likelihood of “cure,” “remission,” not just improvement (up to 76% in the best-outcome series); (3) challenging enough in research and treatment in both the psychosocial and biomedical areas to provoke new research efforts.

All the answers about AN are not in. But a simpler, clearer approach to diagnosis will benefit many of these patients. As with appendicitis, a clinician cannot treat what is not first accurately diagnosed. A quiet, persistent, non-inflammatory insistence on recognizing AN as AN will benefit patients, and eventually the diagnostic criteria will come around to recognizing the criteria that are evidence-based and proven, and which need to be updated.

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Some AN Patients with Childhood Sexual Abuse May Require Special Treatment

Patients with anorexia nervosa (AN) of the binge-purge subtype and a history of childhood sexual abuse may need more intensive treatment for their eating disorder than patients without a history of sexual abuse. In addition, these patients may require treatment aimed specifically at addressing the effects of sexual abuse. These were two of the findings of a recent study by a team of clinicians in Toronto, Canada (*Child Abuse & Neglect* 2006; 30:257).

Dr. Jacqueline C. Carter and her colleagues assessed 77 consecutive patients with anorexia nervosa who were admitted to an inpatient eating disorders unit between 2000 and 2005. This is an intensive group therapy program aimed primarily at normalizing eating and restoring body mass index (BMI; kg/m²) to 20. Admissions are voluntary, and patients may leave the program at any time. The staff can also discharge patients when there is lack of progress or with repeated violations of program rules—for example, purging.

The 95 participants were assessed on admission to the unit with the Eating Disorder Examination (EDE), the self-report version of the EDE (EDE-Q4), the Beck Depression Inventory, the Rosenberg Self-esteem Scale, and the Brief Symptom Inventory. Interpersonal function was assessed with the Inventory of Interpersonal Problems, which measures distress from interpersonal sources—its six subscales measure assertiveness, sociability, intimacy, submissiveness, responsibility and control.

Childhood sexual abuse was defined as any unwanted sexual experience involving physical contact, including sexual touching and sexual intercourse that occurred before age 18 and before the onset of the eating disorder.

Nearly half had been abused

Eighteen of the 95 patients were excluded from the study because of abuse after age 18 or because the sexual abuse occurred after their eating disorder developed. Thirty-seven, or 48%, of the remaining 77 patients reported a history of sexual abuse during childhood. Eighty-four percent reported more than

one episode of sexual abuse, usually by the same perpetrator, and 16% reported a single episode. The average age at which it occurred was 10.1 years. More than half (19 or 51.4%) were sexually abused by a family member or personal acquaintance; 16.2% by a boyfriend, 18.9% by an immediate family member, 5.4% by a stranger, and 8.1% by a teacher or doctor, for example.

Comorbidity was greater among the abused women

Compared with subjects who did not report a history of sexual abuse during childhood, patients with a history of sexual abuse had greater psychiatric comorbidity, including higher levels of depression and anxiety, lower self-esteem, more interpersonal problems and more severe obsessive-compulsive symptoms. Those with a sexual abuse history had significantly higher mean EDE-Q Global scores, indicating more severe eating disorder psychopathology.

Premature discharge from treatment

Contrary to the authors' predictions, the mean time of discharge for those with a history of childhood sexual abuse was not significantly different from that for patients without a history of abuse. The proportion of patients dropping out prematurely also did not differ significantly between the group with a history of sexual abuse (43%) and those without such a history (57%).

The impact of AN subtype

Significantly more patients with a history of childhood sexual abuse had the binge-purge subtype of AN (54%), compared with the restricting subtype of AN (46%). Most patients with AN-binge-purge subtype (65%) had a history of childhood abuse, while less than half (37%) of AN-restrictor patients reported such experiences. The binge-purge subgroup terminated earlier and at a faster rate.

Purging more likely among those with a history of abuse

The authors noted that their results support previous research showing that patients with AN who report a history

of sexual abuse were more likely to use purging behaviors (such as self-induced vomiting or misuse of laxatives) compared with patients without a history of sexual abuse. One possible explanation is that the effects of childhood sexual abuse may interact with personality characteristics present in AN patients with the binge-purge subtype versus those with the restricting subtype of AN. For example, the tendency of the AN binge-purge type subgroup to show greater mood lability and more impulsive behavior may be intensified by the aftermath of childhood sexual abuse. Because purging behaviors may help modulate negative internal states, individuals with a history of childhood sexual abuse who develop an eating disorder may be more likely to develop purging behaviors, possibly as a way of coping with the negative emotional effects of the abuse. In addition, sexual abuse during childhood may interfere with development of self-regulation and social functioning.

Routine screening for abuse is suggested

According to Dr. Carter and colleagues, it is not clear whether treatment for the abuse should take place before, after, or concurrently with treatment for an eating disorder. Also, since childhood sexual abuse is so common in this population and often is not disclosed by patients, it may be important to routinely screen patients for a history of sexual abuse.

FEEDBACK continued from Back Page

a specially designed feedback form administered halfway through treatment; (3) with computerized feedback about bulimic and other symptoms, such as anxiety, depression, and interpersonal functioning, repeated at intervals throughout treatment and follow-up.

Adding feedback to CBT didn't have any effect on patients signing up for or dropping out of treatment. However, it did improve outcome by reducing self-induced vomiting and dietary restriction. Thus, the authors suggest that repeated personalized feedback can improve outcome when paired with CBT self-help programs.

Media Influences and Body Dissatisfaction in Young Women

By Walter Vandereycken, MD, PhD
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Epidemiologic data strongly suggest that the influence of society and culture is putting young female adolescents at risk for developing an eating disorder. However, this effect is complex and multifactorial, including social transition (e.g., migration, urbanization), peer pressure (social comparison and teasing), and exposure to Western media.¹

British researchers have focused on a combination of two important factors in adolescents: media influences and social comparison.² Unlike males and older females, girls between 14 and 17 years of age were found to show a relationship between increased body consciousness and the worship of a celebrity whose figure they admired. Perhaps this reflects an interactional cycle: worship of a celebrity with an idealized body shape may lead to poor body image (and/or low self-esteem), and body dissatisfaction may create a stronger interest in celebrities because of their admired physical appearance. If this admiration is then linked to a thin body ideal, the step toward slimming behaviors is to be expected.

The mass media strongly influence how adolescents see themselves and others. But there are many differences in responses to the media in youngsters of various sociocultural backgrounds.³ When exposed to thin models, females at risk for an eating disorder are more likely to endorse thinness/restricting expectancies.

Another study has shown that media-portrayed idealized images may detrimentally affect the body image of young women when they show some vulnerability, such as appearance anxiety or body shame.⁴ Media exposure to attractive but realistic (average-weight) models appears to lessen this relationship.⁵

Better media literacy is one key

From a preventive viewpoint, many people therefore wish that celebrities and models had a more “realistic” shape. But so far that remains a bit utopian. In the meantime, it is a more realistic preventive action to help adolescents become more active and critical viewers of the media. In schools, for example, one could make use of interventions that address media consumption. Enhancing media literacy, the ability to view the media critically and to understand media messages is a potentially successful way to counter the impact of the media.⁶

Wishing that celebrities and models had a more “realistic” shape remains a bit utopian.

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Using the EAT-26 to Screen Nonclinical Populations

A team of Italian researchers recently found that the shorter version of the Eating Attitudes Test, the EAT-26, was useful for detecting subjects at high risk of binge eating disorder (BED) and eating disorders not otherwise specified (EDNOS) when given in a non-clinical setting (*Int J Obesity* January 2006). They also reported that a cutoff point different from that generally given in the medical literature was more effective for uncovering patients at risk of eating disorders.

Dr. B. Orbitello and colleagues at the University of Udine, Udine, Italy used the Eating Attitudes Test-26 (EAT-26) to screen a group of obese patients from the general community for possible eating disorders. Their subjects were 835 men and women seeking treatment and nutritional advice for obesity for the first time. The final group included 231 subjects (39 males, 192 females) with a mean body mass index of 32.5 kg/m².

The researchers theorized that a cutoff point different from that used in clinical populations (usually 20) would be more effective in a nonclinical setting. Dr. Orbitello reported that 250 subjects from the original group were also randomly selected and given the *Semistructured Clinical Interview for DSM-IV* (SCID, version 2.0).

What the tests showed

Logistic regression analysis pinpointed three EAT-26 subscales that were especially helpful. High dieting (D) or Bulimia (B) subscale scores indicated risk for EDNOS or bulimia nervosa (BN) cases; on the other hand, a high Oral Control (O) subscale score represented a protecting factor for BED. The researchers note that the standard EAT-26 cutoff score of 20 suggested in the literature will not be effective for detecting AN and BN among community and non-clinical groups. Instead, they propose a lower cutoff score of 11. Using the lower score cutoff led to a 31.9% reduction in the false-negative rate.

Monitoring Weight Daily Can Combat Weight Gain

Most commercial weight-loss programs discourage clients from weighing themselves daily because many factors, including normal fluid fluctuations, can influence the numbers on the scale. For example, Weight Watchers suggests members weigh only once a week to monitor weight and to maintain weight loss.

The freshman year of college is a notorious time for weight gain, particularly among college women. Cornell researchers recently sought to show that freshmen women might be able to avoid this weight gain by weighing themselves daily and having regular feedback from a professional staff (*Int J Obesity* January 31, 2006).

Dr. D. A. Levitsky and colleagues from the Division of Nutritional Sciences at Cornell University designed two independent studies. In the first, the researchers used an algorithmic method called the tissue monitoring system (TMS) to estimate changes in body tissue mass from changes in daily body weight. The TMS algorithm is used to estimate changes in body tissue mass from changes in daily body weight. With this method, fluctuations in body weight, are averaged over 7 days, giving a more accurate estimate of change in the weight of total body tissue.

The study group included 34 female freshmen between 18 and 21 years of age. The women were randomly assigned to an experimental or control group. All women were told that the study was about freshman weight gain and were given basic nutritional advice to eat three meals a day and to avoid snacking.

Women in the experimental group were given an analog bathroom scale and were advised to weigh themselves each morning immediately after arising from bed and before voiding. They then e-mailed their daily weight to the researchers. At the end of seven days, the staff e-mailed back a chart showing the day-by-day weights. A control group was weighed at the beginning and end of the semester, but had no contact with the staff between the 2 weigh-ins.

At the end of 10 weeks, the control group had gained a mean of 3.1 kg., while the experimental group gained less than 1 kg.

A second study with feedback

In the second study, 41 female freshmen 18 years of age or older were recruited through on-campus posters and introductory classes. Mean body weight was 62.0 kg. Participants were assigned to either a control group (24) or an experimental group (17). The purpose of the second study was to see if teaching portion sizes would have an impact on weight gain.

Each member of the experimental group received an analog scale and was instructed to weigh herself immediately after arising from bed and before voiding, similar to the previous study. They then e-mailed their daily weight to the research staff, who then entered it into a Microsoft Excel spreadsheet. In this study, each student received a value for the number of calories they needed to decrease to maintain a constant weight. After several days of data, the current body mass was estimated. The difference between the initial body mass and the current body mass was recalculated every day using the last seven points. The calculated level was then sent to each participant in an e-mail each day, accompanied by the following message: "In order to maintain the weight of your first seven days, you should___(increase/decrease) your intake by___calories." The control group was not contacted again until the last week of the semester. At this point, 10 weeks after the initial meeting, participants were reweighed wearing light clothing and no shoes.

The untreated control group gained an average of 2.0 ± 0.65 kg, whereas the experimental group lost a mean of 0.82 ± 0.56 kg. The difference in weight gain between the two groups was statistically significant.

The results of the second study echoed the findings of the original study: freshmen women gain a significant amount of weight during their first semester at college, and providing

these freshmen with information about their weight has an impact upon weight gain. On the average, adults who were provided feedback about their weight with the TMS gained less weight during the semester. According to the authors, both methods used in the first and second experiment was equally helpful in preventing weight gain during the 10-week semester.

Does frequent weighing lead to eating disorders?

The authors also addressed the issue of daily weighing as a precursor to developing an eating disorder. They cited a recent review by the National Task Force on the Prevention and Treatment of Obesity, which concluded that concerns that dieting individuals might develop psychological dysfunction in overweight and obese adults are not generally supported by empirical studies, and that knowledge of one's tissue weight (as opposed to scale weight) may actually help prevent an eating

Body Image Concerns Among Male Adolescents with AN

In what is believed to be the first study of the perception of body image and eating attitudes among male teenagers with anorexia nervosa (AN), Araceli Gila, PhD and co-workers at the University of Barcelona found distinct differences between male patients with AN and control subjects from the general population (*J Adolescent Health* 2005; 36: 221).

The patient group was made up of 30 boys and male adolescents aged 11 to 18 who fulfilled the *DSM-IV* diagnostic criteria for AN. The comparison group was made up of 421 boys of similar social and cultural backgrounds from the general population attending nine different schools. They were also 11 to 18 years of age.

The Subjective Body Dimensions Apparatus (SBDA) is a cylindrical pole 190 cm high supported by a base. The pole has several holders to support small sticks that represent different parts of the body—shoulders, waist, thorax, hips, thighs, and calves. On both sides

of the sticks are several rings with a string passing through them, which can adjust the position of the sticks, changing the overall silhouette. A researcher works with the subject to develop a body image that is equivalent to one that would be seen in a full-length mirror, and the final subjective image is compared with the real silhouette. Eating attitudes were evaluated with the Eating Attitudes Test in the 26-question version (EAT-26). The Eating Disorders Inventory (EDI) was also administered to 19 anorexic patients and 200 boys from the comparison group.

The mean age of the two groups was similar but there were statistically significant differences in height, weight, body mass index (BMI, kg/m²) and total EAT-26 score. In the EDI scales, on the Body Dissatisfaction scale showed statistically significant differences between the two groups. Among anorexic patients, the correlation between BMI and the EAT score was particularly high and negative. The Drive for Thinness scale had a high and positive correlation with the EAT score and a high but negative correlation with age.

Both groups overestimated body size

Male teens from the general population overestimated all parts of their bodies, especially the thorax, waist, and hips. However, the overestimations by the anorexic patients were greater in most measures than those of the controls. The differences between the groups in shoulders, hips, and thighs were statistically significant. The fact that male adolescents overestimate some parts of the body more than others may indicate that they are concerned with specific areas of the body. The authors noted that the global percentage of overestimation in boys (14.8%) did not differ greatly from that found in girls from the general population using the same technique (11.5%).

Thus, anorexic boys overestimate certain parts of their bodies more than do boys from the general population and have higher mean scores on the EAT-26 and some EDI scales such as Body Dissatisfaction. Other EDI scales do not differentiate between male anorexic patients and persons from the general population, suggesting to the authors

Assessment of Eating Disorders

Edited by James E. Mitchell and Carol B. Peterson. New York: Guilford Press, 2005; 242 pages, \$35

In this nicely edited, concise volume, Drs. Mitchell and Peterson have brought together leaders in the field, primarily from the outstanding research groups at the universities of North Dakota and Minnesota, as well as several other major universities, to contribute crisp summaries on all aspects of the assessment of eating disorders. After preliminary chapters on diagnostic and classification issues, Dr. Peterson offers an excellent discussion on conducting the diagnostic interview. Dialogued vignettes show how some of the suggested points are best framed in conversation with patients. These chapters are followed by Dr. Mitchell's presentation on developing a standardized database for patients with eating disorders, which includes in its entirety a copy of his excellent *Eating Disorders Questionnaire (EDQ)*, version 9.0, a project he and his group have been working on for years. In routine clinical practice, patients complete the *EDQ* prior to their initial visit. The clinician and patient then review the patient's responses to clarify and amplify key areas.

Subsequent chapters cover the pros and cons of various structured interviews and self-report measures. These sections will be useful for researchers as well as those with treatment programs seeking to collect data in a systematic fashion. Briefly reviewed are

that some of the aspects evaluated by this inventory may not be adequate for assessing relevant characteristics of AN in males.

Motivational Enhancement Therapy for Binge Eaters

Motivational enhancement therapy, or MET, is designed to help clients make changes by developing their own motivation and a personal plan for change. It is frequently used with patients with alcohol and substance abuse problems.

Using a single 1-hour session of motivational enhancement therapy (MET) has been found to increase readiness to change, improve the efficacy of self-help treatment for binge eaters and to improve compliance with a self-help

specific strategies for the medical workup, nutritional assessment by registered dietitians, assessing families, and, using a variety of techniques, the assessment of body image disturbances. In a somewhat unique presentation of "ecological momentary assessment," a research group exploring these modalities describes how they use these techniques to acquire information "in the field." The group explains how they stimulate patients' responses by means of personal digital assistants, or PDAs, pagers, and wrist alarms. The patients can record exactly what they've been doing and what has been transpiring at that point in time with respect to behaviors and thoughts associated with eating disorders and associated phenomena under observation. These methods not only offer in-vivo research measures, but also ultimately promise potential new avenues for intervention.

In a final chapter, on treatment planning, Dr. Mitchell proposes a series of specific intervention strategies by means of helpful algorithms that readers of all stripes will value.

Although virtually all clinicians working with eating disorder patients conduct assessments as part of their core operations, this book can bring new thinking to experts as well as novices about state-of-the-art approaches to these crucial aspects of our activities.

— J.Y.

manual (*Psychol Addict Behav* 2006; 20:44).

Participants with bulimia nervosa or binge eating disorder were randomly assigned to either attend a 1-hr. MET session prior to receiving the self-help manual (45 patients) or to receive a self-help manual only (45 patients). The participants were followed for 4 months and self-reported eating disorder outcome and compliance were assessed.

Dr. E. C. Dunn and co-workers at the University of Washington found that the MET intervention resulted in increased readiness to change for binge eating compared with the self-help-only group. However, few differences were found between the MET group and the SH group for changes in eating attitudes and frequency of binge eating and compensatory behaviors.

QUESTIONS & ANSWERS

Hyperactivity Among Anorexia Nervosa Patients

QI'm curious to know why some patients with anorexia nervosa (AN) develop marked behavioral hyperactivity, as in excessive motor movements and compulsive exercise, whereas others are much less inclined to be so physically active. (S.T., Seattle)

AThe phenomenon you describe is well known clinically, and in various series hyperactivity has been reported in 31% to 80% of patients with AN. However, although some recent findings offer grounds for interesting speculations, little is known about the specific mechanisms that differentiate hyperactive from non-hyperactive patients with AN.

In patients with AN, levels of hyperactivity as well as inner and outer restlessness have been correlated with hypoleptinemia. These associations are stronger than simple associations between low BMI and hyperactivity (*Biol Psychiatry* 2005; Dec 22; [Epub ahead of print]). But clearly, these observations say nothing about cause and effect; they simply describe temporal associations.

However, along these lines, in animal studies of semi-starvation-induced anorexia, hyperactivity increases. And, when these animals are given leptin, their semi-starvation-induced hyperactivity decreases (*Mol Psychiatry* 2000; 5(5):476). Leptin has also been noted to decrease anxiety-related movements

in leptin-deficient ob/ob mice. To my knowledge, no observations have yet been published on the potential effects of leptin on hyperactivity in human AN.

So, it's possible that hypoleptinemia may contribute to hyperactivity in patients with anorexia nervosa. But we don't know for sure, and many other processes are undoubtedly involved as well. Coincidentally, recent research based on the hypotheses that hyperactivity in AN might be related to upregulated arginine vasopressin or enhanced pituitary sensitivity to arginine vasopressin failed to show evidence for these associations (*J Psychiatr Res* 2006 Jan 30; [Epub ahead of print]).

-J.Y.

Personalized Feedback Enhances CBT for Bulimia Nervosa

Feedback has long been a part of psychosocial and health behavior interventions. Now computerized assessment and treatment tools are making it even more effective, according to a group of London researchers.

Janet Treasure, MD and colleagues at the Institute of Psychiatry, London, have reported that adding repeated personalized feedback to guided self-help cognitive behavioral therapy (CBT) improves treatment outcome for patients with bulimia nervosa, or BN (*Br J Clin Psychol* 2006; 45:111). In this randomized control study, 61 patients with DSM-IV-defined BN were randomly chosen to receive 14 sessions of CBT guided self-care, with or without

personalized feedback on current physical and psychological status, risk and problems, and other variables that might help or hinder change.

The patients received feedback in a number of ways: (1) with personalized letters sent after patients were first evaluated and at the end of treatment; (2) with

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Nibbles by Hunter

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IN THE NEXT ISSUE

A Review of the Health and Human Services Report on Therapy for Anorexia Nervosa

The Health and Human Services' Agency for Healthcare Research and Quality recently released a report finding no effective medications for anorexia nervosa and a few behavioral therapies that might have limited benefits.

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