

EATING DISORDERS REVIEW

Current Clinical Information for the Professional Treating Eating Disorders



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UPDATE

Rate of Eating Does Not Affect Binge Size in Bulimia Nervosa

One characteristic of bulimia nervosa (BN) is rapid eating, especially during an eating binge. In a recent controlled study at Columbia University, researchers found that binge size was not affected by eating rate among women with BN. In contrast, eating more rapidly did significantly increase the amount of intake among a group of healthy controls. Fifteen women with BN and 16 healthy control women were instructed to "binge eat" just before they consumed an *ad libitum* yogurt shake. All subjects ate two meals, one delivered at a fast rate (140 g/minute) and one at a slow rate (70 g/minute). Patients with BN ate significantly more than controls at both the rapid and slow meals. Women with BN ate a mean of 305 g more food than controls, whether they ate at a slow or fast pace. Ellen Zimmerli, PhD and her colleagues at Columbia University note that their results may have implications for current treatment approaches for patients with BN. That is, the behavioral strategy of training patients with BN to eat at a slow, constant rate may be ineffective. The researchers presented their findings at the International Conference on Eating Disorders in Barcelona, Spain, in June.

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Some Highlights of the 2006 AED Meeting in Barcelona

Taking a Global Approach to Eating Disorders

By Mary K. Stein
Managing Editor

The International Conference on Eating Disorders, held in Barcelona, Spain June 7-10, underscored the contrast between the vast advances being made in eating disorders research and treatment and the worldwide challenges of underfunding for treatment, high costs for care, and misconceptions about the seriousness of eating disorders among the general public.

A Worldwide Effort to Increase Awareness

In her keynote address, "Reducing the Burden of Suffering in Eating Disorders: Toward a Global Perspective," Dr. Ruth Striegel-Moore, professor of psychology at Wesleyan University, Middletown, CT, challenged eating disorders experts to come together as a world community to improve awareness and treatment of eating disorders. She praised the progress being made, including an explosion of research, growth in the number of scientific journals, and the rise in the number of professional advocacy groups. Dr. Striegel-Moore also saluted the men and women who developed

the Worldwide Charter for Action on Eating Disorders [for a copy of the Charter, see: <http://www.edauk.com/acrobat/charter.pdf>], which outlines the rights and expectations for people with eating disorders and their families.

Eating disorders are the source of serious personal suffering and pose major burdens to society, she said, adding that scientific ad-

vances show that harnessing technology can improve treatment. Despite the advances, however, she noted that eating disorders remain under-researched and undertreated. "Eating disorders intensely and profoundly affect families not only due to the risks passed on through genetics but also because of financial burdens on the family. They pose enormous burdens for society, and a severe threat to health and well-being," she said.

Limitations and Narrow Diagnostic Criteria

According to Dr. Striegel-Moore, eating disorders are often under-diagnosed worldwide because most studies include only adults and only European and U.S. groups. In addition, narrow diagnostic criteria lead to underestimates of the number of eating disorders in the community. As a result of the inability to provide an accurate number of people affected, government officials feel eating disorders are not an important health risk. For example, she pointed out that at first the Healthy People 2010 initiative omitted eating disorders, which could seriously affect funding for research and treatment. At this point, the only goal related to eating disorders in the initiative is reducing recurrence. There is no mention of prevention of eating disorders.

On the positive side, she said, there is hope with projects such as the international database being developed by Dr. Jim Mitchell of the Neuropsychiatric Institute, Fargo, ND. To further reduce

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the burden, Dr. Striegel-Moore urged the audience to agree upon a common core assessment category and validated diagnostic instruments, as well as focusing on shortening the duration of eating disorders. "Prevention does work to reduce risk," she said, adding, "We need to be very tuned in to early response to treatment and to use treatments that work." "If it doesn't work, reconsider," she stressed.

Broader outreach and screening methods will also help, she said, including use of pro-recovery websites, which can help in case-finding and coordinating screening across the world. She also called for a "reality check," to recognize the disconnect between the evidence base and what actually happens in clinical care. Even in countries with low barriers to care, people with eating disorders underutilize services available to them, she said.

Fighting Stigma

Dr. Striegel-Moore noted that stigma is one of the greatest burdens to getting treatment for an eating disorder. Eating disorders are often trivialized or even ridiculed, she said, and some laypeople view disorders such as anorexia nervosa (AN) as a "slimming disease" that one can easily change. Others believe that AN is self-induced or just a way to get attention. Still others think eating disorders are caused by lack of self-discipline or inadequate parenting, discounting the importance of genetics or biological variables.

The stigma of having an eating disorder also reduces self-esteem and worsens suffering for patients, delays seeking help, and reduces needed support from families and friends, and therapeutic effectiveness, she added. To combat the stigma of an eating disorder, she noted that it is important to understand it in light of the cultural objectification of the female ideal.

Finally, Dr. Striegel-Moore challenged the audience members to help reduce the burden of eating disorders by getting involved with eating disorders organizations, advocating with elective officials, and donating time and money to improve awareness of eating disorders.

Plenary Session I: When Nature Meets Nurture

Three experts outlined ways in which genetics and environment may interact to influence behaviors and the risk of eating disorders in differing age groups.

Gene-environmental interactions

Avshalom Caspi, PhD, professor of personality development at King's College, London, and a pioneering genetics researcher, described some of the challenges and strategies for using information gained from gene environment interaction (GxE). Such interactions occur when the outcome of exposure to an environmental pathogen is conditional upon a person's genotype. This very new area of science has already been used to explore schizophrenia, responses to cannabis and other types of substance abuse, and has been applied in many experimental animal studies. One day it might help why some individuals develop eating disorders while others do not, he said.

According to Dr. Caspi, better understanding of genetic susceptibility to environmental factors will be helpful for understanding why some individuals react to environmental stressors and why their genetic makeup makes them susceptible. He praised the science of imaging genomics, which combines brain imagining and human genome identification.

Dr. Caspi also proposed a novel study design that would use environmental pathogens as research tools in gene-hunting. Dr. Caspi noted that one day, as research continues, "We may be able to understand how an environmental factor external to an individual is able to access the neurobiological system and alter its elements to cause psychopathology."

Puberty and genetic activation of eating disorders

Dr. Kelly Klump, associate professor of psychology at Michigan State University, and President-elect of the Academy of Eating Disorders, told the audience that puberty is a critical period for the activation of genes that make some persons susceptible to developing an eating disorder. She also explained how

recent studies have shown that ovarian hormones may have important links to the development of eating disorders. Better understanding of the ways developmental changes in genetic influences might highlight neurobiological systems involved in the development of eating disorders.

Dr. Klump described two studies using the data from the Minnesota Twin study, which included 1200 female twins and their parents, which have examined genetic and environmental factors involved in the etiology of eating disorders. "Adolescence may be a critical time for the emergence of genetic influences on eating disorders," she said.

The first study involved two groups, 11-year-old and 17-year-old twins. At age 11, genetic influences accounted for 0% of the variability of eating disorder symptoms, while environmental influences made up 100% of variability of eating disorder symptoms. Among the 17-year-olds, however, genetic influences made up 60% of the variability of eating disorder symptoms and 40% of the environmental influences.

In a second study of 11-, 14-, and 17-year old twins, similar patterns emerged: at age 11, genetics accounted for 0% of variability of eating disorder symptoms, but by age 14, the correlation of symptoms to genetics was very similar among the 14-year-olds and the 17-year-olds. According to Dr. Klump, a dramatic change in risk of eating disorder symptoms was seen in mid-adolescence—which was a sign of an activation of a genetic effect on eating disorder symptoms. "It was as if the genes began to turn on," she said, and the common event in both groups was puberty. Before puberty, genetic effects accounted for no eating disorder symptoms, but by puberty this rose to 50%. Further evaluation pointed to the effect of ovarian hormones on this activation (see also article on page 5). In animal studies, Dr. Klump noted, ovarian hormones have a direct effect on ingestion of food.

Dr. Klump stressed that as exciting as the findings of the genetic and environmental clues are, the developmental shifts and the effects of ovarian hormones are only a single part of the

very complex puzzle of the etiology of eating disorders.

Maternal eating disorders and the postnatal period

Dr. Alan Stein, professor of child and adolescent psychiatry at the University of Oxford, noted that maternal eating disorders have a powerful impact upon developing children, even from the first week of life. A mother's behaviors, emotions, and cognitions can affect the child, who can distinguish the mother's voice as early as one week of age.

The postnatal period may be particularly difficult for women with eating disorders because of overconcern about body shape and weight, he said. Adverse experiences during this time can affect a child's later development, Dr. Stein explained. In studies of bulimic mothers and control subjects, mothers with eating disorders were found to be more intrusive, more critical and the cause of more mother-infant conflicts than were controls.

Dr. Stein described an intervention technique in which videotaping feeding sessions helped to demonstrate maternal problems with feeding and interacting with infants. One of the clues that suggested maternal-infant conflict was the mother's inability to correctly interpret her infant's feeding cues. A second finding was the mother's struggle or refusal to allow her infant age-appropriate autonomy over food and self-feeding. At five years, the conflict between child and mother remained. Dr. Stein added that mothers with eating disorders had subtle difficulties with interacting with their children. By 10 years, the children had more concerns about their shape and weight than did children of mothers who did not have eating disorders.

What can clinicians do? Treating the parent's eating disorder alone is not enough and does not reduce the risk to the child, said Dr. Stein. To intervene earlier, parents need to become aware of their negative patterns. Dr. Stein recommends a positive approach to changing such patterns, first with in-home visits to evaluate the situation. Often simple education about what the infant is doing is enough. One area is failure to pick up on the infant's cues—this can be a problem as simple as a mother

feeding the infant ahead of her own meal, being hungry and unconsciously transferring her own feelings of hunger upon the infant. Another is interpreting an infant's slow eating and swallowing as refusal to eat.

With video feedback, the mother can often see negative or potentially harmful patterns she would never have otherwise suspected. The focus begins with the child, not the parent, highlighting what the baby is doing. Then, attention can gently turn to the mother's responses to the baby and, according to Dr. Stein, subsequent sessions can then address conflicts, self-feeding issues, and work with cognitions, using guided self-help CDs.

(In the next issue, more from the conference, including "Diagnosing Eating Disorders: A Constructive or Constrictive Enterprise?" and "Eating Disorder Treatment Guidelines.")

Charting the Course of Body Dysmorphic Disorder

Body dysmorphic disorder (BDD), is a distressing, often impairing, preoccupation with a slight or imagined defect in one's physical appearance. Until recently, little was known about the course of BDD. In what is believed to be the first prospective follow-up study of BDD patients, researchers at Brown Medical School have found that BDD tends to be chronic (*Am J Psychiatry* 2006; 163:907).

Katherine A. Phillips, MD and colleagues obtained data with the Longitudinal Interval Follow-up Evaluation on weekly BDD symptom status and treatment received over a year for 183 subjects. The subjects were comprehensively evaluated at intake with self-reports and other measures.

Outcome: Higher-than-Expected Relapse Rates

A total of 154 subjects (84%) reported receiving mental health treatment during the one year of follow-up, but only (47.5%) reported receiving treatment specifically for their BDD symptoms. Only 16% reported having an optimally adequate experience with psychotropic medications. Only 9% reported full remission from BDD symptoms, and 15% of these subsequently relapsed. Gender and ethnicity did not predict remission.

Olympic Committee Releases New Position on the Female Athlete Triad

The female athlete triad includes the interrelated problems of disordered eating, amenorrhea, and osteoporosis. The International Olympic Committee's Medical Commission (IOMC) recently posted a position stand on the female athlete triad on the Olympic Committee's web site (http://multimedia.olympic.org/pdf/en_report_917.pdf).

Drs. Roberta Trattner Sherman and Ron A. Thompson offered a case study to demonstrate the special issues that arise when treating an athlete with disordered eating and how the recommendations in the IOMC Position Stand on the Female Athlete Triad can be used to effectively manage such issues (*Int J Eat Disord* 2006; 39:192).

According to the authors, disordered eating by athletes typically involves a willful attempt to create a negative energy balance. Part of this is based on the premise that a thinner or leaner body can lead to enhanced performance, such as in distance running or lightweight rowing. Athletes may also believe that being thinner may help them get a better score in sports where they are heavily judged by body size and appearance, such as diving, figure skating, or gymnastics.

Tirade over the Triad: A Case Study

A 19-year-old female collegiate long-distance runner visited the athletic department physician just before a conference meet because her training was not going well. After he had examined her, the physician referred her for an evaluation for a possible eating disorder. The athlete had been amenorrheic for more than 8 months and weighed 102 lb at 5 ft, 5 in (body mass index:17.0 kg/m²). Dual-energy x-ray absorptiometry scanning (DEXA) yielded a score in the normal range. The athlete was told that until she was further evaluated and medically cleared, she would be considered injured and would not be allowed to train or to compete. She reluctantly agreed to be evaluated for an eating disorder.

The authors point out that the term "triad" should not be interpreted to mean that all three components of the female athlete triad must be present to warrant intervention or assessment.

The IOC now emphasizes the athlete's health rather than weight or body composition.

The IOMC position statement also emphasizes that the presence of any one of the components indicates the need to assess the athlete for the presence of the other two.

The athlete was furious that she was being "forced" to submit to treatment. Her feelings were acknowledged and she was informed that the rules about competing and participating in her sport were in place to protect her. However, she denied that she had an eating problem and reported that her daily caloric intake was from 2000 to 2500 kcal. A weekly food log she was forced to keep indicated a daily intake closer to half that amount, even while she was typically running 50 to 60 miles a week in addition to participating in weight training. Further investigation revealed that she did other running and calisthenics, and had been treated for an eating disorder three years earlier in high school, when her weight fell to 99 lb (BMI: 16.5).

Based on restrictive eating, amenorrhea, body image disturbance and weight at the time of her evaluation, she was diagnosed with anorexia nervosa. However, she was told that she could begin training and competing when she was able to increase her caloric intake and restore her weight. She still angrily stated that she did not need treatment and could increase her caloric intake and gain weight without treatment.

It appeared to be a standoff until the psychologist told her that she could see a dietitian, but had to follow the dietitian's plan. The athlete returned to the psychologist and angrily said she would not work with the dietitian.

The psychologist arranged a meeting with the athlete, psychologist, coach,

physician, dietitian, and athletic trainer. After all parties expressed their opinions and concerns, the coach held firm and agreed that the athlete needed to enter treatment and could not train or compete until her treatment providers agreed that it was appropriate.

This case illustrated the IOMC position, which recommends referral to a dietitian for any symptomatic or at-risk athlete, particularly one who resists treatment. As the authors note, the referral to a dietitian is meant to be diagnostic. That is, the athlete is presented with a meal plan designed by the dietitian to meet the athlete's nutritional needs for health and performance. If, as in this case, the athlete is unwilling or unable to follow the plan, she is referred back for treatment. The case also showed how healthcare professionals worked with the athlete and the coach in a "sports family" session. The coach was not involved in any decisions about the athlete's weight, just as is suggested by the IOC.

Outcome

After 4 months of treatment, the athlete's menstrual cycle returned but was light and short. The athlete was adamant about returning to training; however, she was informed that she needed to increase her intake by an additional 200 to 300 kcal/day to regain normal menstruation. She was allowed to begin slowly with short, moderate runs, and daily caloric intake was slowly increased. As she gradually gained weight, she was able to return to training.

The new position of the IMOC places the emphasis on the athlete's health rather than on weight or body composition. In addition, it recommends a process for managing an athlete who refuses a referral for evaluation or treatment or refuses to comply with treatment recommendations.

This process can be helpful to the athlete in several ways, according to Drs. Sherman and Thompson. It relies on the belief that participating in sports

is so important to an athlete that he or she can be motivated to seek treatment by withholding or reinstating sport participation. When athletes are told they cannot compete or train given their health status, some view it as punishment. To counteract this, according to the authors, athletes should be told that they are regarded as injured, and injured athletes must be evaluated to determine the extent of injury as well as the potential risk if they train or compete while injured.

(See page 8 for more on the triad.)

Better Defining 'Excessive Exercise'

According to the 4th edition of the Diagnostic and Statistical Manual (DSM-IV), exercise becomes "excessive" when it significantly interferes with important activities, or occurs at inappropriate times or in inappropriate settings, or when the athlete keeps exercising in spite of injury or other medical complications.

Jonathan Mond and other researchers at the Neuropsychiatric Research Institute, Fargo, ND, recently hypothesized that people who exercise only for weight or shape reasons might have levels of eating disorder psychopathology rivaling those of people with eating disorders (*Int J Eat Disord* 2006;39:147). Their research was conducted as part of the Health and Well-Being of Female ACT Residents Study, a large-scale Australian epidemiologic study of disability associated with bulimic-type eating disorders among young adult women in the community.

Study Format

First, self-report questionnaires were given to 10,000 women 18 to 42 years of age. The questionnaires included measures of eating disorder psychopathology, health-related quality of life, questions about general psychological distress, and exercise behavior, as well as other social and demographic information.

The final study group included 3,472 women who had exercised at least once a week over the past 4 weeks. The women were asked to indicate how of-

ten they exercised mildly, moderately, and rigorously. Next, they completed the Eating Disorder Examination Questionnaire (EDE-Q), and the Medical Outcomes Study Short-Form Disability Scale (SF-12), a 12-item measure of perceived impairment in everyday functioning. Finally, they filled out the Commitment to Exercise Scale (CES), an 8-item measure designed to address obligatory exercise.

Two Variables were Identified

As predicted, the degree of guilt experienced when exercise was postponed and the extent to which an individual exercised to lose weight or change body shape were the two variables most strongly associated with higher levels of eating disorder psychopathology and reduced quality of life. There was also a link between frequency of rigorous exercise and the women's perception of their physical health.

About 9% (322) of the women in the study group reported exercising only to lose weight or to improve their shape, and 3.9% (136) reported intense guilt after postponing exercise. One hundred and nineteen (3.3%) of the women reported experiencing both of these behaviors.

The best predictor of eating disorder psychopathology was found in the CES item, "I feel guilty after missing an exercise session." Results of an earlier study by Ackard et al (*Eat Disord* 2002; 10:31) found that emotional attachment to exercise, particularly negative emotion associated with missing an exercise session, correlated most highly with subscales of the Eating Disorders Inventory.

Notably, the items of the CES that corresponded most closely to the definition of excessive exercise given in the DSM-IV ("Do you exercise even when you have sustained an exercise-related injury?" and "Are there times when you turn down an invitation to an interesting social event because it interferes with your exercise schedule?") were not associated with higher levels of eating disorder psychopathology.

Thus, the portion of the DSM-IV that specifies symptoms of excessive exercise may need to be revisited and modified in the next revision, the DSM-V.

How Ovarian Hormones May Affect Binge Eating in BN

Decreases in estradiol (E_2) and increases in progesterone (PRO) may intensify binge eating, according to the results of a study of ovarian hormones and binge eating in bulimia nervosa (BN). As reported by Drs. Pamela Keel, Crystal Edler, and Susan Lipson at the AED Conference, symptom fluctuations in BN are related to menstrual cycle phase, and ovarian hormone function is a prime candidate for unraveling the neurobiological mechanisms of binge eating.

A Small Controlled Study

The researchers examined daily changes in ovarian hormones and binge eating in two groups: 9 women with DSM-IV-diagnosed BN and 9 regularly menstruating controls without BN. Women in both groups collected saliva samples and recorded their moods and bulimic symptoms for 35 days. E_2 and PRO were measured by radioimmunoassay.

Women with BN reported higher levels of depression, impulsivity, restraint, disinhibition, and hunger compared with controls. However, mean E_2 and PRO levels did not differ between the two groups. The same proportion of controls and BN patients failed to show a preovulatory E_2 peak, indicative of disrupted hormonal cycles. The researchers used within-subject analyses of associations between ovarian hormones and binge eating separately for women with BN with expected hormone profiles (BN-E) and those with disrupted hormone levels (BN-D).

Fluctuations Noted among BN Patients

Significant positive associations between daily fluctuations in negative affect and binge frequency were found in BN-E and BN-D groups, and both groups showed a significant positive association between PRO and binge frequency (controlling for E_2 and mood). A significant negative association between E_2 and binge frequency (controlling for PRO and mood) occurred only in the BN-E group.

In women with predictable hormone profiles, cyclical changes in ovarian hormones are dictated by the female reproductive system and can't be attributed to the presence or absence of disordered eating. The authors' results are consistent with those reported from experimental animal studies and suggest that decreases in E_2 and increases in PRO may drive increases in binge eating in women with BN.

New APA Eating Disorder Treatment Guideline

At a plenary session at the ICED meeting in Barcelona, Dr. Joel Yager, professor at the University of New Mexico and *EDR's* Medical Editor, outlined the third revision of the American Psychiatric Association (APA) Practice Guideline for the Treatment of Eating Disorders.

As Dr. Yager told the audience, the 2006 APA practice guideline is the result of extensive literature reviews, updated evidence-based research and feedback from psychiatrists, internists, pediatricians, psychologists, registered dietitians, social workers, and other professionals involved in the assessment and treatment of patients with eating disorders. The committee also drew upon feedback from a large international group of clinical researchers, and considered guidelines of the British National Institute for Clinical Excellence (NICE), Australia and New Zealand, and the Society for Adolescent Medicine. As an indication of the type of clinical input that went into the recommendations, the committee received an unprecedented 598 pages of comments from reviewers, he said. The final recommendations were also derived from evidence- and clinically based data. Dr. Yager added, "The guidelines reflect the values of the Academy of Eating Disorders as much as those of the American Psychiatric Association."

Supplement Published in July

The Guideline includes three main parts, A, B, and C. Part A, "Treatment Recommendations," appears in the July 2006 issue of *The American Journal of Psychiatry*. This supplement contains general and specific treatment recommendations. Part B, "Background Information and Review of Available Evidence," and Part C, "Future Research Needs," will not appear in the Journal, but are available with Part A online (see box).

The practice guidelines are based on available evidence and clinical consensus. Each recommendation falls into one of three categories: I. Recommended with Substantial Clinical Confidence; II. Recommended with Moderate Clinical Confidence; and III.

May Be Recommended on the Basis of Individual Circumstances.

Underlying Assumptions and Values

The following assumptions and values are included:

- The evidence base (including data and clinical experience) for children and adolescents differs from that for adults.
- Well-conducted small-scale studies that demonstrate the feasibility or effectiveness of particular interventions cannot define community standards until clinicians trained in the application are generally available.
- Good clinical decisions about anorexia nervosa should not rely primarily on simplistic, artificial categories based on percentages of "healthy" body weights.
- Medical testing should be limited to what is required for clinical decision-making for the individual patient.

Changes from the 2000 Guideline

The 2006 APA Guideline contains new definitions of coordination of care, recommended settings for care, and choice of treatment site.

Coordination of care:

- It is not assumed that the psychiatrist is the leader of the treatment team, although the psychiatrist may be the team leader.
- The team approach is the recommended model of care for children and adolescents.
- A complete assessment usually requires at least several hours.
- A full physical examination is strongly recommended and should be performed by a physician familiar with common findings in patients with eating disorders.
- Family involvement and treatment are essential for children and adolescents with anorexia nervosa.

Settings of care criteria:

The committee received much feedback from clinicians expressing concern

that weight criteria included in the 2nd edition were too narrowly interpreted by insurance companies and, as a result, patients, families and clinicians were too much at risk or being boxed into low-weight requirements for residential or inpatient care. Thus, the new APA Guideline no longer includes a precise percentage of body weight as an indication for specified settings of care. This parallels the British (NICE), Australian, and New Zealand practice guidelines, according to Dr. Yager.

Choosing a treatment site:

- Adult patients who weigh less than 85% of individually estimated healthy weights have considerable difficulty gaining weight outside of a highly structured program. Such programs, including inpatient care, may be medically and psychiatrically necessary even for patients who weigh more than 85% of their individually estimated healthy weight.

Finally, the Treatment Plan includes fully revised and updated Tables, with self-help books and Internet resources, descriptions of physical complications of anorexia nervosa and bulimia nervosa, lab assessments for patients with eating disorders, and suggested levels of care for patients with eating disorders.

Online Sources

The complete APA Guideline is available in print format from American Psychiatric Publishing, Inc., at:

<http://www.appi.prg>.

The Guideline is also available online, in PDF format, through the American Psychiatric Association:

<http://www.psych.org>.

At the APA site, click on the left-hand panel, Psychiatric Practice, then Practice Guidelines, then Eating Disorders (May 2006) PDF "Practice Guideline for the Treatment of Patients with Eating Disorders" (128 pages). Or, select the Quick Reference Guide, "Treating Eating Disorders" (34 pages).

Treating Night Eating Syndrome with Sertraline

People with the night eating syndrome eat large amounts of food in the evening, awaken during the night to eat again, and have little or no appetite in the morning. Their mood is usually low and worsens as the day goes on. Night eating has many health implications because it is associated with psychological distress and obesity.

John P. O'Reardon, MD and colleagues at the University of Pennsylvania recently reported that sertraline, a selective serotonin uptake reuptake inhibitor (SSRI), was effective for treating night eating syndrome and was well tolerated in a small study. Thirty-four outpatients diagnosed with night eating syndrome were randomly assigned to receive either sertraline or placebo during an 8-week double-blind study with a flexible-dosage (50 to 200 mg/day) design (*Am J Psychiatry* 2006; 163:893). The study also measured changes in night eating symptoms, the number of nightly awakenings, and ingestions, total daily caloric intake after the evening meal, Clinical Global Impression (CGI) improvement ratings, quality of life, and weight.

Dramatic Results Appeared after 2 Weeks

On the CGI improvement rating scale, 12 of the 17 subjects who received sertraline responded; 7 of the 12 had remission or complete resolution of night eating symptoms. In the placebo group, only 3 responded, and only 1 of the 3 had remission of symptoms. The greatest reduction of symptoms occurred between baseline and week 2; according to the authors, overall, a subject receiving sertraline had a 30% chance of responding by week 2. Changes in night eating symptoms were also significantly greater among the sertraline group, and by week 8, the night eating symptom scores of the sertraline group had dropped by 18.1 points (57%) from baseline, compared with a reduction in symptoms of 5 points (16%) among those in the placebo group. There was also a significant reduction in the frequency of nocturnal eating episodes

The Prevention of Eating Problems and Eating Disorders: Theory, Research and Practice

(Michael P. Levine and Linda Smolak. Mahwah, NJ: Lawrence Erlbaum and Associates, 2006; 476 pp; \$135)

This is the best book on the prevention of eating problems and eating disorders I've seen in a long while. It's particularly notable because rather than offering up the usual compilation of edited chapters, this volume was completely written by two scholars who know the field cold. The authors are steeped in all aspects of the prevention story—values, controversies, successful and unsuccessful attempts, strengths, weaknesses, and opportunities. They discuss these issues clearly and objectively, with little redundancy, in a smoothly coherent writing style.

To start with Part I, after an excellent introduction and overview of the field of prevention, the authors turn to defining eating problems and disorders. In Part II, they review key concepts in developmental psychopathology, and then discuss what is known about risk factors for these disorders. I found their subsequent chapters, describing psychosocial influences in eating disorders from the perspectives of social cognitive approaches, nonspecific stressor-vulnerability models, and feminist empowerment, to be particularly interesting.

Part III centers around the prevention research literature. The key chapter here systematically lays out the evidence in text and tables, showing its insights and gaps. It covers studies conducted at the elementary, middle school and high school levels, and with older adolescents and young adults, including programs with healthy populations, as well as those targeted to populations already demonstrating subclinical levels of distress.

The authors address the relative merits and problems of prevention programs aimed at the "universal" population at large, where

among the sertraline group compared to the placebo group. The number of nocturnal ingestions in the sertraline group fell by 81%, versus a fall of 14% for the placebo group.

Caloric Intake, Weight Change, and Quality of Life.

Caloric intake after the evening meal

BOOK REVIEW

a few exposed individuals with disturbed body attitudes and eating may actually get worse. They then compare these programs with prevention programs specifically targeted to subpopulations that seem particularly at risk of eating disorders. They conclude that better programs addressing both populations are needed.

Lessons from the field are the focus of Part IV, starting with suggestions for curriculum and program development derived from substance abuse prevention work in early adolescents. Six excellent "lessons" are presented and discussed with respect to how they might apply to eating disorders. These school- and community-based programs offer specific ecologically sensitive suggestions aimed at several developmental levels from elementary school through college and young adulthood. These suggestions also apply to boys and racial and ethnic minority populations, and address the significant problems presented by obesity as well as conventional eating disorders.

Practical guidance follows on how to deliver and evaluate these programs, efforts on changing the ecology, and using media and media literacy instruction. The book concludes with chapters that can help local and grassroots preventionists decide exactly what audience they should target and how to go about their efforts. This section also lays out necessary future research directions.

As an added bonus, several excellent appendices offer sources for educators, clinicians, researchers and parents, and, unique to my knowledge, offer additional resources for those interested in advocacy and community activism. Accordingly, as expensive as it is, this book should appeal to a wide audience of those concerned with preventing disturbed eating and eating disorders at the school, community and political levels.

—J.Y.

fell by 68% in the sertraline group, from 47.3% of total daily calories at baseline to 14.8% at week 8. In the placebo group, in contrast, caloric intake after the evening meal fell by 29.3%, from 44.7% at baseline to 31.6% at week 8. Overweight subjects (14 in each group) in the sertraline group lost 2.9 kg versus

continued on page 8

QUESTIONS & ANSWERS

The Female Athlete Triad: Common or Not?

Q We hear a lot about the Female Athlete Triad, but exactly how common is it?
(D. T., Mobile, Alabama)

A Although precise data is hard to come by for the female athletic triad as a whole, some information is available about specific elements of the triad, particularly amenorrhea. Those who are at greatest risk of developing the triad are women who participate in so-called "aesthetic" sports such as cheerleading, diving and gymnastics, as well as "endurance" sports and "weight-class" sports such as rowing, judo, karate, boxing, body building, and long-distance running. Women who are at low weight to start with and who then do a lot of training are at greatest risk. Studies suggest that in contrast to the estimated rates of 1% for primary amenorrhea, where menarche hasn't yet occurred by the age of 15 in the general population, in one study 22% of female aesthetic sports athletes were more than 16 years old before they had their first menstrual period. And, whereas secondary amenorrhea with cessation of menses occurs in about 2% to 5% of the general population, on one track team 65% of the women were amenorrheic. In another study, 78% of

women athletes had anovulation and luteal phase deficiencies even while having a menstrual cycle at least once in three months. Women with disordered eating and menstrual disturbances also show low rates of bone formation (*The Lancet* 2005, 366 *Medicine and Sport*, s49-50). Careful screening and judicious management, as described elsewhere in this issue, are necessary to optimize the well-being of female athletes.

—J.Y.

NIGHT EATING continued from page 7

0.3 kg in the placebo group, a significant difference.

Effects

Sertraline was well tolerated, and no one withdrew from the study due to adverse effects. One person in each group dropped out because of lack of effect. Common side effects were mild and included dry mouth, fatigue, diminished libido and sweating.

The SSRI had an early and dramatic effect on the 14 night-eaters who received it. Even though the subjects had night eating symptoms for an average of 17.6 years before entering the study, 4 of the 5 fast responders achieved full remission after only 2 weeks of 50 mg of sertraline a day. The authors noted that in an earlier study a significant reduction in binge eating and vomiting was reported in a group of patients with bulimia nervosa after a single week of treatment with the SSRI fluoxetine (*Br J Psychiatry* 1995;166:660). They sug-

gested that the nocturnal eating, while not actually binge eating, share the psychological component of disinhibition with the eating binges of bulimia, and that serotonergic medications such as fluoxetine and sertraline have the potential to quickly ease the feeling of control present in both disorders.

Nibbles by Hunter

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"When they made Max, they should've used some intelligent design."

IN THE NEXT ISSUE

More from the AED meeting in Barcelona

Reports from Plenary Sessions II and III: An Alternative Perspective on Eating Disorders Diagnosis, and New Treatment Guidelines

PLUS

- **Sauna Treatment for Patients with Anorexia Nervosa**
- **Father-Daughter Relationships and Eating Disorders**
- **Text-messaging and Follow-up in Eating Disorders Treatment**
- **A book review of *Eating and Weight Disorders*, by Carlos M. Grilo**

and much more....

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**Continuing Education Quiz for
Eating Disorders Review**
July/August 2006 - Volume 17 - No. 4

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. Recent research has found that the rate of eating and the size of bulimic's binge are _____ to one another.
 - a. positively related
 - b. inversely related
 - c. unrelated

 2. According to Dr. Striegel-Moore, eating disorders are often under-diagnosed worldwide because most studies include
 - a. only college students and females
 - b. adults and European and U.S. groups
 - c. only anorexia and bulimia, and not binge-eating disorder, nighttime eating syndrome or eating disorders not otherwise specified
 - d. none of the above

 3. According to Dr. Striegel-Moore, the first Healthy People 2010 initiative did not include
 - a. obesity
 - b. body dysmorphic disorder
 - c. eating disorders
 - d. all of the above

 4. Data from the Minnesota Twin study shows that at age 11, genetic influences accounted for ____ percent of the eating disorders symptoms, where as at age 17, the accounted for up to _____ percent.
 - a. 0%; 60%
 - b. 10%; 75%
 - c. 22%; 45%
 - d. 61%; 30%

 5. Dr. Stein described an intervention technique in which videotaping feeding sessions helped to identify which of the following maternal feeding problems
 - a. the tendency to withdraw food too early, and thereby covertly reinforce the value of restricted eating
 - b. "instructional monologue" that encouraged the child to restrict feeding by saying things like, "that's enough", "don't overdo it," and "stop before you make yourself sick"
 - c. an inability to interpret the infant's feeding cues
 - d. all of the above

(continued on other side)

6. In a prospective study of Body Dysmorphic Disorder, researchers have found that ____ of their sample reported an optimally adequate experience with psychotropic medications.

- a. 16%
- b. 29%
- c. 43%
- d. 67%

7. The "Female Athlete Triad" consists of all of the following EXCEPT

- a. amenorrhea
- b. disordered eating
- c. osteoporosis
- d. anemia

8. The item on the Commitment to Exercise Scale that best predicted eating disorder psychopathology was

- a. "I feel guilty after missing an exercise session"
- b. "I would take time off work to exercise rather than the other way around"
- c. "Exercise and I are one"
- d. "No pain, no gain"

9. The American Psychiatric Association changes from the 2000 Guidelines for treating eating disorders include which of the following

- a. it is no longer assumed that the psychiatrist is the leader of the treatment team
- b. family involvement and treatment are essential for children and adolescents with anorexia
- c. there is no longer a precise percentage of body weight as an indication for specific settings of care
- d. all of the above

10. John O'Reardon and colleagues at the University of Pennsylvania recently reported that the use of a _____ was effective for treating night-eating syndrome.

- a. neuroleptic
- b. SSRI
- c. MAOI
- d. anxiolytic

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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