

EATING DISORDERS REVIEW

Current Clinical Information for the Professional Treating Eating Disorders



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UPDATE

Treating Young Anorectic Patients at Home

A pilot program in France offers a new approach to treatment of anorexia nervosa (AN) for younger patients—treatment at home. In 2003, staff members at Robert Debré Hospital, Paris, developed this special service as an alternative for patients 15 years of age or younger with moderate and severe AN. Home treatment is also offered to AN patients when they are discharged from the hospital, as a way to prevent relapse. The at-home treatment approach has been embraced by Debré Hospital staff. In 2004, 24 patients with AN (mean age: 13.8 years) were followed with inpatient treatment and 21 newly diagnosed patients (mean age: 11.4 years) were followed in outpatient treatment at home. Catherine Doyen, MD, a pediatric and adolescent psychiatrist who treated the children at home, presented a poster of the study at the recent International Conference on Eating Disorders in Barcelona. Dr. Doyen's treatment team also included pediatric nurses who monitored somatic signs, dietitians and a family therapist. Dr. Doyen reported that the results have been very positive, and most families endorsed the at-home system. Two families felt it was "intrusive," and one prepubertal patient developed tantrums and acted out against her nurses.

More from the 2006 AED Meeting in Barcelona

Meeting the Challenges of Diagnosing Eating Disorders

By Mary K. Stein
Managing Editor

At the International Conference on Eating Disorders in Barcelona, Spain, a special plenary session addressed a spectrum of current challenges to diagnosing eating disorders. Four eating disorders experts urged the audience to take a new look at old definitions and methods, to consider sociocultural and transcultural implications when making diagnoses, and to become better educated about diagnosing eating disorders in children. Diagnostic challenges that will be addressed in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* were also discussed.

A Challenge to Current Ways of Diagnosing Eating Disorders

Walter Vandereycken, MD, PhD, Professor of Psychiatry at Catholic University of Leuven and Clinical Director of the Eating Disorders Unit at Alexian Brothers Psychiatric Hospital, Tienen, Belgium, pointed out the very elusive and often contradictory nature of the diagnosis of eating disorders. In his presentation, "Eating Disorders

same time, the diagnosis should respect each individual patient.

Diagnosis—A Constructive or Constrictive Enterprise?" Dr. Vandereycken told the audience that the word "diagnosis" can be either the product of a process or the process itself. A good diagnosis, he said, should simplify complex phenomena, reveal what is not evident, create a bridge to treatment. At the same time, the diagnosis should respect each individual patient. Inconsistencies and conceptual weaknesses are inherent in the current diagnostic system because most eating disorder clinicians see larger numbers of atypical than typical patients, he said. In EDNOS (eating disorder not otherwise specified) patients, for example, the boundaries are weak because of the high incidence of comorbidity, and the fact that conditions change over time. "What is the value of the diagnosis if in six months it changes?" he asked. Because of this, should diagnosis move from the current state of defined categories to a spectrum, or transdiagnostic approach? he asked. "Diagnosis is not a value-free thing," Dr. Vandereycken said; adding, "Instead, we are dealing with human experience and most criteria are not factual but derived from evaluation. These are not facts; instead, we have to rely on what patients tell us," he added.

Legal and financial issues come into play as well, Dr. Vandereycken said. Health insurance companies rely on certain defined diagnoses for reimbursement. A DSM-based diagnosis is a must for reimbursement and coverage for patients. Also, he noted that for example, the high mortality rate cited for anorexia nervosa (AN) is misleading because it is based on clinical studies, not community-based samples. The DSM acts as a diagnostic credit card, he added, and for economic and profit reasons a treatment industry has sprung

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up based on would-be anorexics and would-be bulimics—what Hilde Bruch called the “me-too anorexics.”

Dr. Vandereycken also suggested that clinicians consider that AN and BN may be examples of modern hysterical promotion of prototypes in the professional world. Care with labeling a patient is also important, he added, asking, “Why does a patient label herself as a patient?” He noted that, “anorexics come in and say they don’t have anorexia but have read about a disease they claim they don’t have. We should ask ourselves whether we should ask the patient to look at other labels than eating disorders,” he said. A label could be avoidance of other problems, and clinicians must be very careful since a diagnosis with a medical implication can be a relief, but too often becomes a belief, he said.

Sociocultural Impact on Diagnosis

J. Armando Barriguete-Melendez, MD, PhD, FAED, a psychiatrist with Bio-Clinique Mexico, shared ideas and suggestions for working with indigenous people and improving the ability to make transcultural diagnoses of eating disorders. Dr. Barriguete-Melendez described his experience working with patients and families from indigenous cultures in Mexico, where there is a mixture of millions of people and more than 56 languages.

Dr. Barriguete-Melendez noted the importance of understanding the history and culture of a group, then including evaluation skills, including understanding the influence of race and gender, and the importance of the family. “Culture gives meaning to all facts,” he said, adding that culture is much like oxygen: you realize how important it is when you don’t have it. Before a diagnosis can be made, one must understand the culture and psychopathology, and how people handle stress and malaise, and how all of these affect the symptoms, he said.

He noted that the importance of culture upon disordered eating has largely been a footnote thus far in diagnostic guidelines for eating disorders. He also pointed out that the 1987 revision of

the *DSM III* was the first time culture was included, when the American Psychiatric Association established a task force to work on transcultural issues. In 1994, consideration of a person’s cultural background was included in the *DSM-IV*. In the *DSM-V*, Dr. Barriguete-Melendez would like to see a number of points covered, including the importance of cultural variables, and the social significance of human experience, culture, stress, and how malaise affects symptomatology. “We have to observe and describe the behaviors before we go on to make the diagnosis,” he said.

Eating and feeding behavior represent a social and cultural structure going back to our ancestors, he noted. For example, when Dr. Barriguete-Melendez and colleagues studied babies and mothers in an indigenous culture, they found eating and feeding was an early model to manage internal tension and a bridge for interpersonal relationships. Dr. Barriguete-Melendez and his group decided to investigate traditional practices—how a group ate, how they nourished themselves, and their attachment to cultural traditions. The researchers also sought to learn more about food and developmental stages, including rites of passage and initiation rites. Among one indigenous group, the researchers found the people had 17 different ways to describe “corn” and three different ways to talk about eating—eating just to satisfy hunger, eating a lot, like drunken animals, and eating when there was a relationship problem to share.

To better understand how eating disorders develop in immigrants, Dr. Barriguete-Melendez and co-workers evaluated how teens adjust when they move into a new culture. In some traditional groups, making an appointment for girls alone is unheard of, and they are terrified of going to a physician. Instead, the physician and group have to include the family. They also established a culture clinic, to include some traditional practices in their methods and to find out how patients think about their own origins. Translators were provided to help bridge the language gap.

When asked how culture might impact the expression of an eating disorder, Dr. Barriguete-Melendez

noted that in such groups, suffering is expressed differently from the way it is expressed in current American culture. In one native group, for example, the researchers found people suffer when they lose their social network or when they are separated from their families. Eating behavior is a part of a strong cultural network and when eating behavior stops being part of the social network, trouble begins. This cumulative effect of inclusion is particularly important with poor rural people, indigenous groups, and the disabled, he said.

On to DSM-V

Dr. B. Timothy Walsh, Professor of Psychiatry at Columbia University and Director of the Eating Disorders Research Unit at New York State Psychiatric Institute, outlined some of the challenges and questions that will be addressed in the *DSM-V*, due out in 2011. Dr. Walsh served on the committee for the *DSM-IV*, and has been appointed to the committee for the *DSM-V*.

“Why have a *DSM*?” he asked, noting that it is appealing to think that the material in the *DSM* could be easily divided along mental and behavioral dividing lines. However, he added, the purpose of the *DSM* is to provide clinical guidelines for people caring for patients in their practices.

He also noted that at the crudest level, the *DSM* is the standard insurance form that North Americans must fill out and a diagnosis must be inserted—without this there is no money, he said. This is not the real reason to have diagnostic guidelines, and if the guidelines are bad for the eating disorders field, they should be addressed and changed, he said.

Some issues that need to be addressed, according to Dr. Walsh are the weight guidelines for anorexic patients who are unable to maintain weight, the subtyping methods for AN, the issue of amenorrhea as a criterion for the diagnosis. Currently the *DSM-IV* suggests that 85% be used as a cutoff point. Although it was meant only as a suggestion, clinicians are taking it literally, as a rigid rule, Dr. Walsh said. “We can do better,” he said, suggesting that using the patient’s body mass index might be a better way of determining weight

gain. He also questioned whether the binge-purge subtypes are useful. The issue of amenorrhea as a criterion for the diagnosis has been challenged by many investigators, but the database against it isn’t yet overwhelming, according to Dr. Walsh.

There are similar concerns about bulimia, Dr. Walsh noted. For example, where does a normal large meal end and a binge begin? He pointed out that the *DSM-IV* requires at least two binges a week and compensatory behaviors at least twice a week in order to diagnose bulimia nervosa. A better guideline might be more helpful. Subtyping purging versus nonpurging individuals is also difficult, he said, and it is also hard to nail down fasting and excessive exercise.

“EDNOS is like the 400-lb gorilla in the room,” Dr. Walsh said. Probably the majority of people coming to eating disorder clinics have EDNOS. EDNOS is such a heterogeneous category that it is a problem, and the category needs to be narrowed down, he added. There also are relatively few evidence-based disorders beyond purging and night eating syndrome, he said.

Establishing more definite diagnostic boundaries might be a good idea, but where are they? he pondered. One suggestion has been to add a category of Purging Disorder, which shares a lot with bulimia nervosa; perhaps it could be a subtitle, he added. But, if this is done, then the category would include non-purgers with purgers, AN purging, BN nonpurging, and so forth. Or, the group could decide that these phenomena have more in common together than separately, and have no boundaries but describe them in another way.

Another area that needs improvement is defining eating disorders in younger children, and a goal of the *DSM-V* is to improve this portion, said Dr. Walsh. The new *DSM* will also coordinate better with the 11th edition of the *International Classification of Disease (ICD-11)*, using a generic code for both.

The *DSM-IV* is consciously conservative, he noted, because making changes can be very disruptive. However, he added, “Change comes with a price, and gains are worth the pain.” Past

editions have had a high threshold for change, he said; for example, binge eating disorder didn’t make it because not enough data showed that the diagnosis was useful or that it was a distinct category. He pointed out that the *DSM* process is open, and seeking comments from everyone. Because it is data-based; a change is made only when hard data show the need. “Eating Disorders are a small part of the *DSM*,” he added, noting that of the 350 diagnoses listed, three are eating disorders.

A careful timetable has been worked out, beginning with reviewing data from conferences during 2004-2007; appointment of *DSM-V* work groups in 2007; and publication of the final version in 2011, although that is a tentative date, he added.

Finally, Dr. Walsh noted that the *DSM* system should follow the field, not lead it, and what professionals in the field feel is the best way to categorize patients should be the rule. “We need your help,” he told the audience, and pointed out that the *DSM* committee welcomes data, clinical characteristics, and good clinical studies that collect data can help inform the process. Dr. Walsh told the audience that comments and progress on the *DSM-V* can be followed on the Internet at: www.dsmiv.org.

The Challenge of Diagnosing Eating Disorders in Children

Dasha Nicholls, MBBS, MRC Psych, lead clinician at the Feeding and Eating Disorders Service Department, Great Ormond Street Hospital, London, told the audience that a developmental perspective on disordered eating includes the range of feeding and eating problems seen across the spectrum of childhood into adolescence.

Dr. Nicholls described the still-slow development of diagnostic criteria for eating disorders in children. In the *ICD 9*, for example, for those with AN, there was a tendency to give children an emotional or behavioral diagnosis, which came from a belief that if you gave an adult diagnosis, it would be set in stone. Adult criteria for eating disorders often miss the mark for children, she noted; for example, it is difficult to pinpoint psychopathology in children because

abstract reasoning is not fully developed; it is also hard to define “loss of control.” Although Hilde Bruch wrote about the infant’s struggle for control in infant-mother relationships, no such link between this and the development of an eating disorder has been shown, she said.

Data on feeding disorders are also nearly nonexistent, she said. Some patterns have been noted. For example, in one study, 442 patients were divided into two clusters. In the first group, children were poor eaters and had little interest in food, and had difficulties with texture. Overall they had poor weight gain, and ingested insufficient calories for growth. The second group had an emotional reaction to food, including fears and panic about food.

Developmental tasks involved in feeding children include: selection of appropriate foods, physically handling food, sensory integration, taste, and smell, food hygiene and safety, sharing, table manners, developing regular eating, recognition of hunger, communication—understanding what the child means, and finally helping the child move from dependence to independence.

As for early markers of eating disorders in children, there is little evidence that feeding disorders in children go on to develop into eating disorders, she said. And, the state of the science is such that it doesn’t allow clinicians to specify the risk of developing an eating disorder.

Dr. Nicholls said that despite the lack of data, it is possible to reliably diagnose eating disorders in children, and that they can be differentiated from adult eating disorders. She reiterated that there is very little relationship between feeding and eating disorders, and that diagnosing eating disorders in children provides very little information about prognosis.

Text Messaging Promotes Healthy Eating and Activity

Although family-based behavioral interventions are effective, they can be limited by cost, commitment, and commute. In a pilot study, University of North Carolina researchers put modern technology to work with a cell phone text-messaging program designed to improve healthy eating and activity among children 5 to 13 years of age. Fifty-nine families were randomized and 32 participated in the study.

At the beginning of the study, all families completed a packet of self-report measures, had their height and weight measured, and were then randomized to one of three conditions for monitoring their progress. One group used a paper and pen system, the second used text messaging, and the third used no monitoring system. All families then participated in a weekly three-session intervention aimed at helping their children increase physical activity and decrease consumption of sugar-sweetened beverages and TV time.

Families assigned to the monitoring conditions (pen and paper or text messaging) continued to monitor the three targeted behaviors for 8 weeks. Families in the pen and paper monitoring group mailed in their monitoring report forms weekly, while those in the automated cell phone group submitted daily inputs about the three targeted behaviors and received automatic feedback messages on their cell phones.

Cell phones worked best

Preliminary results show that the cell phone system was the most effective for following up and enhancing healthy choices among the children. Nearly twice as many families dropped out in the non-monitoring group than in the text messaging system. The dropout rates were 28%, 42%, and 50% for the text-messaging, pen and paper, and no monitoring groups, respectively. This suggested that the cell phone system is a feasible approach to self-monitoring. Jennifer Shapiro, PhD and her colleagues presented the results of their study at the Academy for Eating Disorders meeting in Barcelona, Spain,

in June. According to the authors, this pilot study shows that this innovative technological upgrade of a current family-based weight loss intervention may be a useful and cost-effective tool to consider in current treatment programs.

Fathers and Daughters with Eating Disorders

The father-daughter relationship and its impact upon eating disorders is still largely unexplored territory in eating disorders research. At the recent International Conference on Eating Disorders in Barcelona, Dr. Maya Wolff and co-workers at Bar Ilan University and Shalvata Medical Health Center, Israel, added details of their recent study of fathers and women with eating disorders.

The authors assessed the father-daughter relationships of 136 women, specifically looking at attachment, parental bonding, and internal father representation. Three groups were studied: subjects with DSM-IV criteria for eating disorders, and two control groups, one with depression and anxiety (comorbid for eating disorders, PC) and a normal control group (NC).

A complex relationship

Overall, fathers of daughters with eating disorders emerged as a complex mixture of frequently distant, sometimes punitive, but also overprotective parents. All three groups of women differed in their abilities to have emotional investment and in moral standards.

Women with eating disorders had more difficulty bonding and attaching with their fathers, compared with women in both control groups. Women in the eating disorders group and PC group perceived their fathers as more distant and less caring than did women in the NC group.

Fathers of women with eating disorders and those in the PC group were also reported to be less benevolent and more punitive than were fathers

Order AED Meeting CDs

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of women in the NC group. Fathers of women with eating disorders and those in the PC group were also viewed as less affectionate than fathers of women in the NC group. At the same time, fathers of women with eating disorders were rated as the most overprotective of all three groups.

The researchers report that they are currently studying the effects of the father-daughter relationship on eating disorder prognosis.

Dads & Daughters

Resources for daughters with eating disorders and their fathers are available on the Internet, including books, websites, and links to workshops. One website, www.dadsanddaughters.org, is specifically designed for fathers and daughters. This site has links to information such as "What Fathers with Daughters Should Know About Eating Disorders."

Prior Life Events and Disordered Eating in BED

Binge eating disorder (BED) was first officially recognized in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* in 1994. Although factors such as adverse childhood experiences and disturbed family function can increase the risk, until recently it wasn't known why a particular individual develops BED at a certain point in time.

Dr. Kathleen Pike and a team of researchers recently traced the effects of life events during the 12 months before the onset of symptoms of BED in two groups. The first group included 162 matched pairs of black and white women with BED and women with no psychiatric disorders (NC group). The second group included 107 matched pairs of women with BED and a control group with a current psychiatric disorder (PC group) (*Psychiatry Research* 2006; 142:19).

The researchers explored two main questions. First, do individuals with BED have a significantly greater number of stressful life events during the year immediately before their disordered eating develops than do matched sub-

jects with either other current general psychiatric disorders (PC group) or with no current psychiatric disorders (NC) at the same stage of their lives? Second, are particular types of antecedent life events especially likely to precede the onset of BED?

The study included women recruited from the community for the New England Women's Health Project who participated in 15-minute screening interviews. Women over 40 years of age, or with physical conditions known to influence their eating habits or weight were excluded, as were those who were pregnant, or who had a psychotic disorder.

Current and lifetime psychiatric disorders were assessed with the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-IV). An abbreviated diagnostic version of the Eating Disorder Examination was also used; and prior life events were assessed with the Oxford Risk Factor Interview (RFI). The RFI, which includes 17 items with behavioral definitions of key concepts, is designed to minimize the biases of memory or reconstruction of events that often occur in retrospective reporting.

Results

BED group vs. NC group. The BED group reported a significantly greater number of adverse life events than did the NC group during the year before the onset of BED symptoms. A higher percentage of the BED women than the NC women reported three or more life events stressors during the previous 12 months. Exposure to a greater number of life events (3 or more) was associated with a sixfold higher risk of BED. Specifically, the BED group reported a significantly greater number of major changes in their lives and relationships, including a major house move, death of a close relative, friend, or partner, change in family structure, and the end of a relationship with a boyfriend or partner.

Critical comments about shape and weight also took a toll. According to Dr. Pike and her colleagues, women with BED were seven times more likely to report being criticized for their weight and shape, and six times more likely

to report physical abuse than were NC control subjects.

BED group vs. PC group. As in the first group, women with BED reported a greater number of stressful life events than did women in the PC group; exposure to a greater number of life events was associated with a relatively higher risk of developing BED.

Compared with the PC group, the BED group reported significantly more frequent exposure to several life events during the preceding year. The BED group reported more frequent changes in family structure and more critical comments about shape and weight. Also, compared with the PC group, the BED group showed a trend for more frequent ending of relationships with boyfriends/partners and increased concerns about safety or feeling unsafe in a variety of settings.

In both BED and control groups, previous life stressors were varied and idiosyncratic, and nearly one-third of the women with BED reported an event not otherwise assessed by the interview. For example, stressors mentioned included getting married, having a sister with an eating disorder who had to be hospitalized, starting to use drugs, and graduating from college. While these events are not all considered "adverse," they did make the individual feel overwhelmed, stressed, and with a diminished capacity to cope.

There was no race-specific exposure to previous life events; among both groups, there was only one race-specific stressor—black women reported a significantly higher risk of becoming pregnant during the year before the onset of eating disorder symptoms than did white women.

The authors concluded that for most women who developed BED, it was not a matter of a single potent stressor, but the accumulation of a series of stressful events that finally triggered the eating disorder.

In addition to experiencing more adverse events, it's also possible that women who develop BED may be more prone than others to experience and report that ordinary events of life, such as getting married or graduating from college, are more distressing for them than for others.

ADHD: An Associate of Bulimia Nervosa?

Attention-deficit/hyperactivity disorder (ADHD) is estimated to affect 5% to 10% of children and 4% of adults. Impulsivity is one of the key features of ADHD and also is an indicator of poor prognosis for persons with bulimia nervosa (BN). Could there be an association between ADHD and BN?

To answer this question, Craig B. H. Surman, MD and two colleagues at Massachusetts General Hospital, Boston, systematically identified rates of BN in individuals with and without ADHD among four groups, two large groups of children (522) and two large groups of adults (742) (*J Clin Psychiatry* 2006; 67:351).

An association is found

Among the two large pediatric groups, 1% of girls with ADHD and none without ADHD met diagnostic criteria for a history of BN. The ages at onset of BN for the two girls with ADHD and BN were 12 years and 14 years, respectively. No boys with or without ADHD had a diagnosis of BN.

Among the adult groups, a significantly higher proportion of women with ADHD met diagnostic criteria for a history of BN than did gender-matched control subjects (12% vs. 3% in one group, and 11% vs. 1% in the second group). The rates of BN were negligible among men with or without ADHD.

What does this mean?

The authors note that this is the first evaluation of the comorbidity between ADHD and BN. Their results show that BN was selectively overrepresented in women with ADHD but not in girls with this disorder. According to the authors, this suggests that symptoms of BN emerge in adulthood in women with ADHD. However, they also note that since BN commonly appears in late adolescence, the ability to fully assess BN was limited because only 20% of the girls with ADHD and 26% of the control girls in the study were 15 years of age or older.

Although the reasons for the overrepresentation of BN in women with ADHD remain unclear, there are several

possible explanations, according to the authors. A factor common to both ADHD and BN may have mediated the apparent association between the two conditions in the authors' clinical samples of adult women.

Also, common predisposing environmental or familial factors could have contributed to the manifestation of both conditions in persons with ADHD. For example, high rates of major depression and substance abuse have been described in studies of persons with BN (*Clin Psychol Rev* 2003; 23:57) and in subjects with ADHD.

Treatment with psychostimulants

In a small study of six patients with comorbid ADHD and BN, all patients reported complete abstinence from binge eating and purging after treatment with psychostimulants. All remained within a healthy weight range (*J Women's Health* 2005; 14:345).

Excess Androgen in Obese Adolescent Girls

The four- to fivefold upswing in overweight among children and adolescents in recent years has been accompanied by a marked increase in the prevalence of both type II diabetes and the metabolic syndrome (MBS) in these age groups. The subsequent increase in androgen levels and increased risk of cardiovascular disease have become topics of concern.

Recently, Dr. A. D. Coviello and colleagues at Northwestern University Feinberg School of Medicine, Chicago, reported that of a group of adolescent girls with polycystic ovary syndrome (PCOS), as many as 63% of girls who were obese also had MBS. In comparison, in the NHANES-III study, 32% of obese girls had MBS (*J Clin Endocrinol Metab* 2006; 91:393).

After adjusting for body mass index, girls with PCOS were four times as likely to show features of MBS. The odds of MBS characteristics being present were four times higher for each quartile increase in plasma unbound testosterone. Thus, there was strong evidence that teens with PCOS have a higher prevalence of MBS and that above-normal androgen levels increase

the risk for MBS, independent of obesity and insulin resistance.

Disordered Eating Takes a Toll Among Some Dancers

Like other athletes, ballet dancers are at higher-than-normal risk for injuries such as fractures and tendonitis. However, many ballet dancers do not exhibit or report injuries, suggesting that certain subgroups of dancers may be at greater risk than others.

Since previous studies have shown that individuals with eating disorders are at high risk of fractures because of decreased bone mineral density, and ballet dancers are at increased risk for eating disorders, researchers evaluated the association between eating disorder behaviors and injuries among a large group of adolescent ballet dancers.

A group of 239 female ballet students from five U.S. ballet schools filled out a survey containing items on lifetime eating disorder behaviors and injuries. Jennifer Thomas and her colleagues reported the results at the recent International Conference on Eating Disorders in Barcelona, Spain.

Almost two-thirds had been injured

Nearly two-thirds of the dancers (148) reported a history of injuries such as stress fractures, broken bones, and/or tendonitis. Using logistical regression, the researchers found that a lifetime history of vomiting and/or fasting was associated with taking a greater number of days off from ballet practice or performances to recuperate. The researchers also reported that dancers who endorsed vomiting missed approximately twice the number of days of dancing after an injury than dancers who didn't endorse vomiting. The results indicated that a lifetime history of fasting and/or vomiting is associated with lifetime injury as well as a longer recuperation period. A history of fasting and purging, along with other physical risks (the ironic flexibility of joints due to lax collagen in the joints, for example), places dancers at higher-than-normal risk of injuries.

An Overview of Pro-Ana Websites

The Internet is like a river of information flowing in two directions. It is an invaluable source of health information for adolescents, but it can also provide dangerous medical misinformation. A good example of this is the case of pro-anorexia, or “pro-ana,” websites. These sites promote anorexia nervosa through misinformation, use of religious and inspirational themes, stories of individuals, poetry, and seemingly supportive suggestions.

A team of eating disorders experts recently tracked down and analyzed the 20 most popular pro-ana websites (*Int J Eat Disord* 2006;39:443). Mark L. Norris, MD and colleagues used interviews and focus groups to determine how best to review Internet websites. They then used three search engines, Google, Yahoo, and MSN, to visit and evaluate 60 pro-ana websites, and selected the final 20 because of multiple listings and links. Half of the websites reviewed were hosted by one of two free home page providers.

What was on the websites

Disclaimers and warning. Warnings and/or disclaimers before entry into the web pages were posted on 58% of the websites. These disclaimers including messages asking non-eating-disordered persons to leave the website, making clear that the website supported the pro-ana movement, and stating that persons under 18 years of age could not enter the website without prior parental consent. Although information on purging was supposedly not allowed by any web hosts, two-thirds of the sites offered information on laxatives and other ways of purging.

Lifestyle choice versus medical disease. Only one of the websites stated that it viewed anorexia nervosa as a lifestyle choice. Almost half of the website creators noted that their websites were a means of supporting individuals with eating disorders. About two-thirds of the webmaster/creators were listed, and all of these were female; 4 were younger than 18. Two gave histories of self-harm and/or suicidal attempts.

Information on the website. More than 90% of the websites had “thin-spirational” content, or visual images

and motivational quotes promoting thinness (for example, “nothing tastes as good as thin feels..”) They also featured photographs of extremely thin celebrities, and a few offered sexually explicit photos and cartoons.

Two-thirds of the websites offered “tips and tricks” for losing weight. These ranged from using laxatives and diet pills to use of cleansing enemas. Some included slight warnings about excess weight loss but others provided potentially hazardous information about starvation, fasting, and alternative medicine. Other tricks included methods of hiding weight loss and creative ways to “avoid calories.”

More than half of the websites included calculations of body mass index, basal metabolic rate, and the number of calories burned per activity. It was also common to see stories and poems sent by viewers; the themes usually were weight, self-image, and emotions. Many sites offered “ana” accessories, including a red “ana bracelet.”

Religious metaphors were common

More than two-thirds of the sites included religious metaphors, most commonly the Ana Psalm and Creed. In a few cases, according to the authors, viewers were encouraged to make a pact with Ana and to sign it in blood. “A Letter from ANA” could also be found on most personal websites. The content in this letter included phrases such as “I expect a lot from you. You are not allowed to eat much. I will expect you to drop your caloric intake and increase your exercise....I will push you to the limit. You must take it because you cannot defy me. Pretty soon, I am with you always....”

The “tips and tricks” sections contained the most serious and risky suggestions, especially though promotion of fasts, laxatives, and alternative medical procedures for weight loss. The tricks and tips often were framed in a way to promote the “safe management” of extremely dangerous behaviors.

Awareness can help counteract these sites

The authors stressed the importance of clinicians being aware of and know-

BOOK REVIEW

Eating and Weight Disorders

(Carlos M. Grilo. Published in the series “Clinical Psychology: A Modular Course.” New York: Psychology Press/Taylor and Francis, 2006; 246 pp, \$40)

Designed as an introductory text for survey courses intended for college and professional students in psychology, medicine, social work and nursing, Carlos Grilo’s *Eating and Weight Disorders*, published as one of the “modular courses” in a series of parallel clinical psychology books, fulfills its mission nicely. This concise, clearly written, well-illustrated book presents an excellent distillation of the major issues of the field. It is amply illustrated with tables, figures, and text boxes that break up the written text to focus on a range of issues, from clinical case examples through theoretical models. Each topic is well researched, and the most important current references are cited.

The early chapters discuss the epidemiology of eating and weight disorders, including issues of normative eating, dieting and body image concerns, and development. The next series of chapters cover understanding, assessing, and treating anorexia nervosa, bulimia nervosa, atypical eating disorders and binge eating disorder, and obesity. Interested students are pointed toward other helpful resources for more information.

While many topics are inevitably given short shrift in such an abbreviated text, and from my perspective biological aspects of the origins and pathophysiology of the disorders receive scant attention, this highly readable book offers educators in search of a short college-level or early-graduate-level text an excellent option.

—J.Y.

ing the content of these websites so they, parents, and caregivers can help counteract the information. They also noted that web providers hosted half of the websites at no cost, and each of the free websites disregarded the provider’s outlined terms of use, raising the question of how well such websites are being monitored—if the guidelines were enforced, half of the websites selected for study would have been taken off the Internet, according to the authors.

QUESTIONS & ANSWERS

Translating the 'Transdiagnostic Approach'

QI've heard about research in eating disorders that deals with a "transdiagnostic approach." Can you explain what this is? (B.C., Chicago)

AMany concerns exist about the current system of *DSM-IV* diagnoses for the eating disorders, and these concerns are likely to heat up in the discussions leading to the development of *DSM-V*. Basically the present system is primarily "categorical," with distinct diagnostic criteria and cutoff points established for the various criteria used to diagnose anorexia nervosa (both the restricter and binge eating/purging types) and bulimia nervosa, so that you either "have it or you don't."

The large wastebasket of "Eating Disorders Not Otherwise Specified," or EDNOS, comprises probably the largest group of patients with food and weight issues seen in clinical practice. The transdiagnostic approach recognizes that many overlapping dimensions exist in the eating disorders, and suggests that thinking about eating disorders as a whole from a behavioral dimension and/or psychological dimension perspective may yield important insights into these disorders.

Some recent behavioral-genetics studies have adopted this strategy. Re-

search studies using these approaches have looked at "lifetime eating disorder behaviors" such as objective binge eating, self-induced vomiting, laxative misuse, fasting and self-reported low body weight. Psychological dimensions, including depressed mood, poor self-esteem, impulsivity, perfectionism, body dissatisfaction, weight and shape concerns, neuroticism, dependency, and harm avoidance, also have been examined (*J Nerv Mental Diseases* 2006; 194:510).

We are all eager to see what specific advantages and advances for eating disorders assessment and treatment might emerge from research based on these approaches.

-J.Y.

Predicting Dropout and Remission in Family Therapy for AN

A team of clinicians at Stanford University has identified three main factors that may help predict dropout and remission among adolescents with anorexia nervosa (AN) who are being treated with family therapy (*Int J Eat Disord* 2006; e-publication).

Dr. James Lock and colleagues at Stanford University School of Medicine, Palo Alto, CA, found that comorbid psychiatric disorder and being randomized to longer treatment predicted greater dropout. The researchers used data from a randomized clinical trial comparing short-term and long-term family therapy for adolescents. In addition, the presence of comorbid psychiatric disorder, being older and problematic family behaviors led to lower rates of remission.

Reducing child behavioral symptoms, lessening problematic family behaviors and early weight gain were all treatment changes that increased the chance of remission from AN.

Nibbles by Hunter



IN THE NEXT ISSUE

Denial of Illness in Anorexia Nervosa

By Walter Vandereycken, MD, PhD
Denial of illness and noncompliance with treatment are major challenges for detecting and further clinical assessment of persons with anorexia nervosa. It is also easy to underestimate the impact of denial upon treatment.

PLUS

- **More on the Link Between Bulimia and Serotonin**
- **Highlights from the National Eating Disorders Meeting**
- **Is it Bad for Overweight Girls to Like Their Bodies?**
- **Preventing Body Dissatisfaction for Women Seeking Medical Treatment**

and much more....

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