

EATING DISORDERS REVIEW

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UPDATE

Is It Bad for Overweight Girls to Like Their Bodies?

Based on anecdotal research, some investigators have suggested that some degree of body dissatisfaction might motivate overweight individuals to change unhealthy eating behaviors. That is, being unhappy about their shape or weight might lead to healthier eating behaviors. Patricia van den Berg, PhD, of the University of Minnesota, reported a very different result in her study of 187 overweight girls followed over 5 years. The girls were enrolled in Project EAT, a population-based study of eating and physical activity among a large, ethnically diverse group of teens. The primary outcome measure in this study was body mass index (BMI) at follow-up 5 years later. Dr. van den Berg reported that when the investigators re-interviewed the 187 girls 5 years later, body dissatisfaction was a significant positive predictor of the girls' current BMI. Dr. van den Berg urged clinicians working with teens to avoid any techniques that stress body dissatisfaction as a means of increasing healthy eating and activity. Dr. van den Berg presented her findings at the recent International Conference on Eating Disorders in Barcelona, Spain.

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Dealing with Denial in Anorexia Nervosa

By Walter Vandereycken, MD, PhD
Catholic University of Leuven • Leuven, Belgium

In his classic 1873 description of a patient with anorexia nervosa (AN), Charles Lasègue was struck by how readily the patient accepted the symptoms. He noticed that, in contrast to other patients with extreme weight loss and lack of appetite, "hysterical anorexics have an inexhaustible optimism, against which supplications and menaces alike are of no avail. 'I do not suffer and must then be well,' is the monotonous formula," he wrote.¹

This is still true today for many AN patients. We simply call it denial, but this term is far from simple. Clearly, the concept of denial of illness has been interpreted by clinicians and operationalized by research in so many diverse ways that it not only lost its original psychodynamic meaning as a defense mechanism but also became a heterogeneous and confusing notion. Also, research on denial has been hampered by a lack of agreement as to whether it

is unconscious or conscious, a trait versus a state, an indication of psychological disturbance, or a functional coping mechanism.

Pryor, Johnson, Wiederman, and Boswell have defined denial in these patients as (a) meeting the DSM-IV criteria for AN and simultaneously (b) scoring within the normal range of the Eat-

ing Disorders Inventory (EDI) symptom scales.² On instruments assessing personality features, deniers scored higher

"Deniers" often maintain a sense of arrogance and superiority about their anorexic symptoms.

on scales indicating sociability (histrionic) and confidence (narcissistic) and lower on scales referring to social disinterest (schizoid) and discomfort (avoidant) as well as pessimism (passive-aggressive). In these authors' experience, "deniers" often maintain a sense of arrogance and superiority about their anorexic symptoms. They seem to view themselves as superior to other people who are "weak" and "give in" to bodily needs and desires.² Indirectly, research on locus of control also points in the same direction. Adolescent AN patients with more internal locus of control scores showed more rapid weight gain during treatment, whereas those scoring in a more external direction showed greater denial of illness, fear of weight change, rigidity of self-imposed controls, and body image distortion.³

Differential Diagnosis

The "inexhaustible optimism" Lasègue noted in his anorexic patients became a basic differential diagnostic criterion for AN. Even physicians who were not too familiar with AN could recognize the patient's peculiar attitude as a pathognomonic sign—denial of thinness, denial of hunger, and denial of fatigue became a classic diagnostic triad.

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Denial of illness—scored as “persistent claims to well-being and health”—also was one of four variables, along with amenorrhea, pulse rate and lanugo, which were significant for differentiating those with AN.⁴

The patient's attitude toward her own condition became a central topic in the work of Hilde Bruch.⁵ In her view, the primary or “true” anorexic could be differentiated from secondary forms of the illness on the basis of the central features of the former group: the patient actively pursues thinness and denies being too thin. In contrast, patients who lose weight due to organic conditions or psychiatric disorders will complain about the weight loss or are indifferent to it, but they do not take pride in it. In the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), denial of the seriousness of the current low body weight is one of the three symptoms lumped together in the diagnostic criterion C of AN.⁶

Neither the measurement of insights in psychosis nor the assessment of denial of serious physical distress has added helpful information to the research in AN. Since denial among these patients is often considered “typical” if not pathognomonic of the illness, judgment about it is usually based on impressions gathered by a healthcare professional dealing with the patients concerned. Some clinicians, for example, have rated patients on “pressure of suffering” (e.g., does the patient accept help because he or she is aware of suffering?) and the understanding and feeling of being ill.

But, as Hilde Bruch said: “It is exceedingly difficult to get objective statements about how anorexics feel.”⁷ This factor will undermine the reliability of any self-report study and is a serious but often overlooked trap in research. For example, many studies document the use of the Eating Attitudes Test (EAT) to screen eating disturbances in the first part of a two-part diagnostic screening in a variety of cultures. The results of this self-report instrument may be seriously affected by denial and social desirability. In one study, for example, upon admission to a specialized inpatient unit, 13 of 40 anorexia nervosa

patients scored below the cutoff score on the EAT. These patients (deniers) significantly differed from those scoring within the pathological range of the EAT (admitters) on the Amsterdam's Biographic Questionnaire and on the Minnesota Multiphasic Inventory (MMPI).⁸

Gauging the Patient's Motivation

One way of assessing denial is to use the concept of precontemplation within the stages of change model. The Stages of Change Algorithm provides a way to determine the stage the individual is in. One version adapted for eating disorders was used with 51 AN patients attending a clinic (mean age: 27 years); 23.5% were found to be in the precontemplation stage.⁹ Some useful instruments related to gauging motivation have been adapted to assessing patients with eating disorders:

The Readiness and Motivation Interview. This semistructured interview is designed to rate the person's attitude in four domains: restriction, cognitive, binge eating, and compensatory strategies. The individual is in the precontemplative stage when she “either does not see the symptom as a problem or does not wish to change.” In one study of eating-disordered women, higher precontemplation scores correlated with less likelihood of accepting the offered residential treatment and with greater chances of dropping out during further treatment.¹⁰

The Anorexia Nervosa Stages of Change Questionnaire. This self-report instrument rates 20 items (weight, shape, eating behavior, for example) with scores ranging from 1 (precontemplation) to 5 (maintenance). Some of the questions relating to precontemplation include: “As far as I am concerned, I do not need to gain weight” and “My fear of becoming fat is not excessive.” Among 44 inpatients with AN, 9.1% were classified in the precontemplation stage.¹¹

The Motivational Stage of Change for Adolescents Recovering from an Eating Disorder. This brief, simple scale is rated by the individual or a parent or clinician.¹² One item is used to define precontemplation: “Other people think I have an eating disorder, but I don't.”

When tested among 34 girls with an eating disorder (15 AN outpatients with a mean age of 16 years), 29.4% were found to be in the precontemplation stage, which also correlated with body image distortion.

Another instrument, the *Goldberg Anorectic Attitudes Scale*, contains a factor “denial of illness,” which includes four items (for example, “Yes, I did lose some weight but not enough for everybody to

get as worried as they did”).

In a follow-up study of 105

AN patients, less denial correlated significantly with weight gain.¹³

Reluctance to Accept Treatment

All too often the idea of denial of illness is automatically linked with refusal to be treated or reluctance to change. It is estimated that only about a third of all AN patients seek treatment. Why do so many patients avoid seeking help or avoid it entirely? The severity of illness seems to be one answer. The results of a study of a semi-structured telephone interview with 78 consecutive patients referred to an eating disorders clinic showed that patients with more severe eating problems tended to avoid treatment.¹⁴ When less apparent and less severe symptoms are present, and with the patient’s ability to deny or conceal the illness, the likelihood of detection and referral is low.

In the difficult-to-treat AN patient, one finds a passionate refusal to change, in conjunction with a profound sense of illness. Thus, the link between denial of illness and resistance to treatment seems logical. The patient may say, “I’m not sick; I don’t need help.” In Ryan and Deci’s theory of self-determination, the concept of amotivation is introduced to convey the idea that some clients feel discouraged and helpless about their efforts to change.¹⁵ Amotivation, which involves the lack of clear intentions for action, arises in people when they feel incompetent to achieve an outcome, or experience a lack of a connection between their behavior and the outcome, or do not value the behavior or outcome. Denial and amotivation are two very different notions and the

refusal or postponement of seeking help may be attributed to lack of recognition of problems.

Among the barriers between patients and seeking treatment are the patient’s fear of disclosure to others and fear of being labeled as having a disorder. The fact that an individual recognizes a problem does not automatically imply the need or willingness to change nor does this lead to seeking help. Denial does not

automatically mean lack of compliance; which is a person’s informed decision not to adhere to a therapeutic recommendation.

Another factor to consider is that some healthcare professionals, as well as the general public, may themselves fail to recognize the seriousness of the eating disorder or believe that these patients are willful and not really ill. This myth is reinforced by the denial that comes from the fact that the socioeconomic group at greatest risk for eating disorders parallels that from which the care providers are drawn. Also, our current cultural bias toward thinness is so strong that it adds to the denial that is characteristic of this illness.

Seeking and/or accepting treatment depends on the person’s expectation of gains and losses involved. When asked to describe their anorexia nervosa as either a “friend” or an “enemy,” patients have to reveal the cost-benefit ratio of their eating disorder. Commonly expressed benefits of the illness include feeling looked after or protected, gaining a sense of control, being attractive, avoiding uncomfortable emotions, and feeling special. Perceived costs include constant thoughts about food, feeling taken over, and negative impacts on personal relationships.

AN is highly valued by the sufferer and internal reinforcers appear to play a more powerful role than social reinforcers (such as attention and praise due to weight loss) in the maintenance of the disorder.¹⁶

As Eckert and Labeck have said, “Denial may serve a purpose: it may be the glue that holds a shattered self-esteem system together. Hence, high levels of support must be available if the patient

is to begin to acknowledge his or her illness.”¹⁷ But communicating with someone who has an eating disorder but denies it is not easy. Family and friends surrounding the patient can help by showing support and concern (otherwise they will seem uncaring), expressing empathy and understanding (if not the usual response will be: “You don’t understand”), and finally telling the truth (otherwise the denial will persist). This confrontation within a context of support and understanding may be crucial in the process of recognizing the problem. While very ill people with AN may refuse the truth or rage and bluster, you have said your truth in the most acceptable way. The positive effect may come later.¹⁸

With regard to other means for overcoming or bypassing denial in patients with AN, we refer readers to the very useful contributions by Vitousek and colleagues.^{19,20} In my view, the bottom line of the lesson for the clinicians involved can be summarized as follows: It is first and foremost a matter of positive attitude.

References

- This contribution has been based upon: Vandereycken W. Denial of illness in anorexia nervosa. *Eur Eat Disord Rev* 2006; 14:341.
1. Lasègue EC. On hysterical anorexia. *Medical Times and Gazette* 1873; 2: 265.
 2. Pryor TL, Johnson T, Wiederman MW, et al. The clinical significance of symptom denial among women with anorexia nervosa: Another disposable myth? *Eating Disorders: The Journal of Treatment and Prevention* 1995; 3:293.
 3. Strober M. Locus of control, psychopathology, and weight gain in juvenile anorexia nervosa. *J Abnorm Child Psychology* 1982; 10:97.
 4. Wright, WS, Manwell MK, Merrett JD. Anorexia nervosa: A discriminant function analysis. *Brit J Psychiatry* 1969; 115: 827.
 5. Bruch H. *Eating disorders: Obesity, anorexia nervosa, and the person within*. New York: Basic Books, 1973.
 6. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders* (4th ed.) (DSM-IV). Washington, D.C.: APA, 1994.
 7. Bruch H. *The golden cage. The enigma of anorexia nervosa*. Cambridge (MA): Harvard University Press, 1978.

8. Vandereycken W, Vanderlinden J. Denial of illness and the use of self-reporting measures in anorexia nervosa patients. *Int J Eat Disord* 1983; 2:101.

9. Blake W, Turnbull S, Treasure J. Stages and processes of change in eating disorders: Implications for therapy. *Clin Psychol & Psychother* 1997; 4:186.

10. Geller J, Drab-Hudson DL, Whisenhunt BL, et al. Readiness to change dietary restriction predicts outcomes in the eating disorders. *Eating Disorders: The Journal of Treatment and Prevention* 2004; 12:209.

11. Rieger E, Touyz SW, Beumont, PJ. The anorexia nervosa stages of change questionnaire (ANSOCQ): Information regarding its psychometric properties. *Int J Eat Disord* 2002; 32:24.

12. Gusella J, Butler G, Nichols L, et al. A brief questionnaire to assess readiness to change in adolescents with eating disorders: Its applications to group therapy. *Eur Eat Disord Rev* 2003; 11:58.

13. Steinhausen HC. Attitudinal dimensions in adolescent anorexic patients: An analysis of the Goldberg Anorectic Attitudes Scale. *J Psychiat Res* 1986; 20:83.

14. Burket RC, Hodgins JD. Factors predicting reluctance to seek treatment in patients with eating disorders. *Southern Med J* 1993; 86:529.

15. Vansteenkiste M, Soenens B, Vandereycken W. Motivation to change in eating disorder patients: A conceptual clarification on the basis of self-determination theory. *Int J Eat Disord* 2005; 37:207.

16. Serpell L, Treasure J, Teasdale J, et al. Anorexia nervosa: Friend or foe? A qualitative analysis of the themes expressed in letters written by anorexia nervosa patients. *Int J Eat Disord* 1999; 25:177.

17. Eckert E, Labeck L. Integrated treatment program for anorexia nervosa. In J E Mitchell (ed), *Anorexia nervosa & bulimia: Diagnosis and treatment*. Minneapolis (MN): University of Minnesota Press, 1985.

18. Bock LP. Secrets and denial: The costs of not getting help. In R Lemberg (ed), *Controlling eating disorders with facts, advice, and resources*. Phoenix (AZ): Oryx Press, 1992.

19. Vitousek K, Daly J, Heiser C. Reconstructing the internal world of the eating disordered individual: Overcoming denial and distortion in self-report. *Int J Eat Disord* 1991; 10:647.

20. Vitousek K, Watson S, Wilson GT. Enhancing motivation for change in treatment-resistant eating disorders. *Clin Psychol Rev* 1998; 18:391.

Profiling Midlife Eating Disorders

Patients who present with eating disorders in midlife are often overlooked but do have some distinguishing characteristics, according to two clinicians from the Eating Disorders Center of Denver.

As Tamara Pryor, PhD and Kenneth L. Weiner, MD, reported at the recent National Eating Disorders Association Meeting in Baltimore, women who develop anorexia nervosa or bulimia nervosa in midlife may have experienced long-term struggles with body image, may have had an eating disorder earlier in life and have left treatment, and may have endured years of serious but not incapacitating symptoms. As some women age, they may feel challenged by loss of status in our youth-orientated culture, which may then lead them to develop an eating disorder.

'The desperate housewife syndrome'

Dr. Pryor described receiving a phone call asking if anyone could speak to the phenomenon of the "desperate housewife syndrome." She had never heard of this but when she searched on the Internet, she got more than 3,000 hits. Was this accurate or a media-driven phenomenon? She wondered.

As Dr. Pryor's research continued, she learned that many women with an eating disorder first detected in midlife actually had a chronic course in which they had an eating disorder earlier in life, then a relapse. In other cases, a few middle-aged women developed an eating disorder after a critical illness, such as cancer or a brain tumor.

One significant difference between women who developed eating disorders early in adulthood and those who did so in midlife was that those with early-adult-onset eating disorders had higher novelty-seeking scores than did older adults. Both early-adult onset and midlife-onset eating disorder patients had higher-than-normal scores on harm avoidance measures. Persistence was slightly higher in young adults.

A classic case

Dr. Kenneth Weiner, Director of the Eating Disorder Treatment Center of Denver, described a classic case of an eating disorder uncovered in midlife. Dr. Weiner used a videotaped interview

with a patient, a successful, well-educated middle-aged woman who nearly died of her eating disorder.

When he first encountered the patient, she was 52 years old, and in a coma in an intensive care unit. A diagnosis of end-stage anorexia nervosa had been made. Dr. Phil Mehler, of the Denver Treatment Center, questioned the diagnosis and asked the staff physician to look for an underlying infection. This turned out to be the case. The woman improved and began therapy for a long-term eating disorder.

Dr. Weiner told the audience that the woman actually had a chronic eating disorder that began 20 years before, when she went through a difficult divorce from a man who was 22 years older. During the marriage, she was always concerned about her appearance, and became even more threatened and competitive with younger women after her divorce. She began restricting her eating, but no one recognized the pattern until she was 38 years old and had lost a dramatic amount of weight.

When her family finally confronted her, she agreed to meet with an eating disorders therapist and seemingly went along with treatment. However, she related that although she lied during treatment and resisted treatment, no one confronted her because she was happily remarried, and ran a well-known and successful interior design business, and just seemed "slim."

The woman later told Dr. Weiner that being a mature adult helped her deflect any comments about her disordered eating. On the surface it appeared that her life was completely in control; she even told people that she was naturally slim and that her father had been thin. The 5' 5" woman's weight ranged between 80 and 90 lb, and she told Dr. Weiner that she spent time thinking about how she was going to be able to purge all through her life to stay thin.

Her physical state worsens

As a result of her eating disorder, she lost all her teeth at age 43, had multiple broken bones (no one questioned her low weight or bone status), underwent many severe illnesses, had a miscar-

riage and gradually went downhill physically.

Suggestions from the patient for family and physicians

What could have been done to intercept and successfully treat the eating disorder earlier? The patient related that because things seemed good on the surface, no one confronted her—"as an adult you could fend them off," she said. In the videotaped interview with Dr. Weiner, the patient urged family and friends to persist, mustering all the effort possible to help, and to remember that "Your loved one is suffering a life of hell, secrecy, and self-loathing." Don't let it go, she urged, and instead suggested a serious search for professional help.

She also noted that if therapists had been more confrontational with her and had involved her second husband in therapy (he was never involved in her treatment), the outcome might have been better.

Overlooking the superficial

Dr. Weiner added that the patient was such a functional anorexic that no one persisted in her treatment—superficially all seemed well. Instead, he advised therapists to carefully look at the data, to take a very detailed, long history to see what previous interventions were made, and to talk with other providers because it is not unusual for people to end up in multiple treatment centers. It's important to look at what has happened, what broke down in recovery, what were the precipitating events, and what were the physical ailments, he said.

Dr. Weiner also stressed the importance of working with the patient's family to get a clear picture. The history you get is often state-related rather than trait-related, he said. "Patients will often give you a state-related history—do not accept this at face value," Dr. Weiner said. He added, "We aren't used to seeing a middle-aged woman or man, particularly an accomplished adult, develop an eating disorder in midlife."

He urged the audience to remember that eating disorders don't just affect the young: "If it looks like an eating disorder, it may well be one," Dr. Weiner said.

Never Too Old for an Eating Disorder?

Although eating disorders and body dissatisfaction are most often described among women from 18-25 years of age, there is evidence that both also occur at midlife and later.

Barbara Mangweth-Matzek, PhD and colleagues at Innsbruck Medical University, Innsbruck, Austria, evaluated a random sample of 1,000 women 60-70 years old from the general population of Innsbruck (*Int J Eat Disord* 2006; 39:583). This age range was selected because this is the first decade of retirement in Austria. The women were asked to fill out a self-report questionnaire, and 475 responded.

The group profile included some eating disorders

Most of the respondents were married and had at least two children; only 38% had graduated from college. Most described a healthy eating pattern and more than two-thirds said they regularly ate at least three meals a day. More than half said they restricted their eating to prevent weight gain, and 88% evaluated their eating behavior as normal and healthy.

On further evaluation, the authors found that 18 women met the criteria for an eating disorder: 1 had anorexia nervosa (AN), 2 had bulimia nervosa, and 15 had eating disorders not otherwise specified (5 had binge eating disorder). The woman with AN first developed symptoms of the illness in her late 50s. The two bulimic women reported vomiting and use of laxatives.

The majority of the women reported being dissatisfied with their weight and shape, no matter what their body mass index was. The authors note that this finding goes along with other studies that describe a pattern of body dissatisfaction across the life span, regardless of actual weight. It also correlated with the higher percentage of women who were trying to control their weight (86%).

Thus, even though most women in the sample had healthy eating behaviors and normal body weights, most also were dissatisfied with their shape

and weight. Although eating disorders are reported much more commonly among young women, the authors suggest that eating disorders

be included in the differential diagnosis of elderly women who present with weight loss, weight phobia, and/or vomiting.

New York State Passes Insurance Parity Law

New York State recently joined 34 other states in passing a mental health insurance parity law. The New York law requires insurance companies to provide 30 inpatient days of treatment and 20 outpatient days of treatment for all mental illnesses, including obsessive-compulsive disorder, bulimia nervosa, anorexia nervosa, and binge eating disorder.

The New York law, or "Timothy's Law," was named after Timothy O'Clair, a 12-year-old boy diagnosed with depression, attention deficit hyperactivity disorder and other illnesses who took his life in 2001. His parents believe that if their health insurance policy provided more adequate coverage for treatment relating to mental illnesses, their son would have obtained the help he needed and might still be alive today.

To address cost concerns raised by small businesses, Timothy's Law directs the New York State Superintendent of Insurance to develop a method to hold businesses with 50 or fewer employees harmless from any increase in premiums from incorporating this measure. The State Insurance Department and the New York State Office of Mental Health are also required to conduct a two-year study to determine the effectiveness and impact of mental health parity legislation in New York and other states. The bill will take effect January 1, 2007, and will expire on December 31, 2009, in order to amend the law based on findings and recommendations of the two-year study.

National Eating Disorders Association Meeting Declares ‘It Takes a Team’ to Combat Eating Disorders

Following the theme, “It Takes a Team,” the National Eating Disorders Association (NEDA) meeting in Bethesda, MD, September 14-15, set attendance records and provided two days of seminars on topics ranging from eating disorders among athletes to self-injury and eating disorders and eating disorder in midlife.

Dr. Ovidio Bermudez, Chairman of the Board of Directors of NEDA, told the audience that not even the brightest minds in eating disorders research can help families and patients if they work alone. Representatives of the five major eating disorders organizations then described individual goals and activities of their organizations. Dr. Bermudez urged all the groups to come together to work “to make eating disorders a thing of the past.”

NEDA: Promoting Advocacy and Research

Dr. Bermudez said that NEDA’s mission is to improve the public’s understanding of eating disorders, to promote access to treatment, and to promote advocacy and research in the field. He added that the organization is especially concerned about those affected by eating disorders and those who are trying to care for them. One of the organization’s primary efforts has been working to promote education and awareness through media and public relations efforts, and radio public service announcements campaigns, such as that with Clear Channel Broadcasting.

He also noted that another nationwide NEDA program, National Eating Disorders Awareness Week, scheduled for February 25-March 3, 2007, will have the theme, “Be comfortable in your genes. Wear jeans that fit the REAL you.” The campaign will stress that body size and shape are strongly influenced by biological factors, including genetics, and will highlight the role of genetics in the development of eating disorders. The organization’s Information and Referral Hotline (800-931-2237) receives more than 1,500 calls per month, he said.

Academy for Eating Disorders: Promoting Excellence in Treatment and Research

Dr. Kelly Klump, associate professor of psychology at Michigan State University and president-elect of the Academy for Eating Disorders (AED), said the AED is a professional organization with more than 1,400 members worldwide. It is also a transdisciplinary organization, she said, and includes all disciplines who are working to treat, prevent, and research eating disorders.

“Our mission is to promote excellence in treatment, prevention and research of eating disorders,” she said, and told the audience that such efforts are needed more than ever due to decreased federal funding for research and prevention of eating disorders. Dr. Klump noted that collaboration with other organizations has been essential to the organization’s success, and pointed to AED’s annual conference and training day, which provides state-of-the-art information on research and treatment, and collaboration with other organizations such as NEDA.

International Association of Eating Disorders Professionals: An Educational Focus

Rick Bishop, MD, CEO, president of IADEP, noted that just as Julius Caesar wrote that Rome had defeated Gaul by dividing and conquering, “We have been divided and conquered in the eating disorders field. Coming together is necessary for us to have an impact,” he said. Dr. Bishop lamented that research funding for eating disorders has been disproportionately lower than for other fields, such as schizophrenia and Alzheimer’s disease. The IADEP mission, he said, has been primarily to educate mental health professionals and dietitians about eating disorders; in addition, he said, for many years the organization has been involved in the certification of professionals who treat patients with eating disorders. “Too many people still undertake treatment of eating disorders without having enough expertise in the area,” Dr. Bishop said. “People may

not realize that lots of dedicated people are treating eating disorders—some are master’s level therapists who are not making much money but are dedicated to treating eating disorders, he said.

Eating Disorders Coalition: Making Washington More Aware of Eating Disorders

Samuel Menaged, JD, President of the Eating Disorders Coalition for Research, Policy & Action and founder and President of Renfrew Center and Renfrew Foundation, said he sees the Eating Disorders Coalition, the newest of the eating disorders organizations, as a natural outgrowth of the other four organizations. The mission of the Eating Disorders Coalition is to make policymakers in Washington more aware of the epidemic proportions of eating disorders, their life-threatening nature, and the lack of education in public and private schools and the need for research in the eating disorders, he said.

Genetics Research Consortium

Dr. Walter Kaye, professor of psychiatry at Western Psychiatric Institute, and Director of the Eating Disorders Clinic at the University of Pittsburg, told the audience that genes actually make a major contribution to eating disorders, but researchers don’t yet understand the vulnerability to eating disorders. There has been a rich collaboration of many people in the eating disorders field, collecting samples and studies that began more than 10 years ago, he added.

Dr. Kaye noted that genotyping is getting less expensive and new results on genotypes will be available over the next few months. The studies are very complicated and millions of dollars are needed to continue the collaborative studies. He added that the group is finishing a study for the National Institutes of Mental Health, which involves collecting data from 400 families with two or more family members with anorexia nervosa. The group still needs about 50 families for the study. (For more information, see www.pitt.edu).

BOOK REVIEW

Spiritual Approaches in the Treatment of Women with Eating Disorders

(By P. Scott Richards, Randy K. Hardman, and Michael E. Berrett. Washington, DC: American Psychological Association, 2007; 304 pp, \$59.95)

This book is one of the first I've seen that systematically, comprehensively and thoughtfully addresses the many connections between eating disorders and spiritual issues in treatment. The authors, including a professor of counseling psychology at Brigham Young University, are all associated with the Center for Change in Orem, UT. The Center for Change is an eating disorders center that uses a multimodal and multidisciplinary approach in the treatment of patients with severe eating disorders. This center and organization and several other well-known treatment centers across the country incorporate spiritual assessments and treatment methods alongside traditional "evidence-based" practices.

This book addresses the rationale for such practices within the medical-scientific paradigm, and examines how many patients with eating disorders experience their eating disorders from a spiritual and religious perspective. It outlines how the authors have integrated their spiritual interventions into patients' treatment programs. The authors' rationale is based on the fact that many patients strongly adhere to spiritual and religious beliefs, and a substantial literature exists that suggests that patients who are believers who receive treatment that addresses and incorporates these beliefs and traditions do better than others. Of note and importance, the authors clearly state that ethical guidelines of their profession preclude prosthetizing patients during treatment and that each patient's beliefs, including those beliefs of those who are agnostics or atheists, should be respected.

In the spirit of full disclosure, I'm an agnostic-deist-secular humanist—depending on my ego state—who fell away from an Orthodox Jewish tradition early in life. I fully understand and accept that faith and spirituality are important and helpful for many—but not all—of my patients, and very often in ways that are very, very different from how I see things.

The authors identify themselves as "The-

ists," i.e., believers in God, without necessarily specifying exactly what that entails, and as ecumenical with regard to accepting others' views. They present a substantial Theistic theoretical perspective on how religion and spiritual matters may contribute to eating disorders pathogenesis and treatment. These formulations, based on hearing patients' religious and spiritual formulations and struggles, available literature, and consistent with the authors' own world-views, are carefully laid side by side with conventional biological, psychological, interpersonal, and sociocultural perspectives.

The interventions they describe have evolved over the years, and in structure resemble many other cognitive, imaginal, journaling and other humanistic individual and group psychotherapy techniques, complete with workbooks. In addition, in accord with patient's individual religious and spiritual beliefs, preferences and explicit permissions, the authors employ techniques involving connection with higher spiritual beliefs, including 12-Step practices and sometimes prayer on the part of patient and therapists as well that are clearly not part of conventional psychotherapies. They also present preliminary data from a modest study showing that patients in their program who participated in spiritually oriented groups had some general outcomes that were slightly better than patients in a control group that received nonspiritual emotional support.

What's especially valuable here is the authors' attempt to explain the bases for their activities within the scientific-clinical tradition to an audience they know will include many skeptics and nonbelievers. With respect to eating disorders, these issues have, for the large part, been talked about in the Academies of Medicine and Psychology only in hushed voices and quiet corners, or derisively, and with far more heat and smoke than careful reflection.

Since the ranks of patients and practitioners include many people of faith as well as many who see themselves as atheist or agnostic secular humanists or spiritual but nonreligious deists, to start, it's important that we flush out inevitable issues of *values* and *underlying assumptive world-views* in psychiatric diagnosis, ideas about pathogenesis, and treatments. What's clear is that no system of psychiatric practice is values-free. The virulent atheism of some early (and current) psychoanalysts, psychiatrists, psychologists

and other mental health professionals may seem to rest not only on their fears that an "unscientific" world view will hamper medical truth and progress, but also on their need to build protective walls around their own belief systems.

Of importance, the authors' own beliefs in God and prayer undoubtedly add to the enthusiastic beliefs they bring to their practices and convey to their patients. In line with Jerome and Julia Frank's salient observations in their book, *Persuasion and Healing: A Comparative Study of Psychotherapy* (Johns Hopkins Press, 1991, when practitioners and their patients strongly share the same beliefs and attitudes about causation and treatment, treatment adherence and results are likely to be much better than when these things are discrepant. When clinicians *really* believe in what they're doing and patients share their beliefs, outcomes benefit. That's not bad, regardless of the belief system.

But, what gives me pause is that the primary beliefs of the Theistic worldview (to which I might subscribe as a private individual) inevitably fall outside of the scientific one, in that Theism's fundamental assumptions cannot be tested. However, many of its practical clinical sequelae may be, and, in that spirit the authors offer a substantial set of researchable questions concerning beliefs, treatment and outcomes.

I recognize that some atheist-skeptical readers will immediately, out of hand, want to reject what these authors are talking about and trying to do, and that others, out of emotional allegiance, might uncritically cheerlead their efforts. My sense is that neither position would be correct. Rather, from the perspective of my scientific-humanist agnostic-deist world view, I think this book is worth a very serious reading.

In passing, a major research article by Zhong and Liljenquist in the September 8, 2006 issue of *Science* presents the results of laboratory experiments showing unexpected parallels between feelings of moral purity and physical cleanliness that the authors claim may help explain the ubiquity of religious cleansing rituals. I'm struck by the fact that these experiments may, with some extension, be pertinent to understanding aspects of eating disorders, too, in a direction compatible with spiritual as well as psychological formulations. What's next?

— J.Y.

QUESTIONS & ANSWERS

Bariatric Surgery and Psychiatric Problems?

Q An increasing number of patients are seeking bariatric surgery these days. Is information available on how many of these patients have psychiatric problems in general and eating disorders in particular? (D.E., Philadelphia)

A The most recent large-scale study suggests that psychiatric disorders and eating disorders per se are not uncommon among patients seeking bariatric surgery. In a study by Rosenberger and colleagues of 174 patients who were consecutively evaluated at Yale by means of the SCID (Structured Clinical Interview for DSM-IV), 24% had a current psychiatric disorder and 10.3% had a current eating disorder (the ratio was roughly 2:1 eating disorders not otherwise specified, or EDNOS, over binge eating disorder, or BED). Lifetime rates of psychiatric comorbidity were even higher: 36.8% and 13.8%, respectively. Of those who had eating disorders, 66.7% had some sort of psychiatric comorbidities, most often anxiety disorders (J Clin Psychiatry 2006; 67:1080). The take-home lesson for clinicians working with patients seeking bariatric surgery is that a good assessment for psychiatric disorders is indicated, and that monitoring these patients for psychiatric and eating disorder symptoms following surgery may improve long-term recovery.

—J.Y.

Nibbles by Hunter



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"It's my new 'beehive' hairdo - If you measure my height from the top, my BMI gets really low."

In Recent Poll, Nearly 20% of Students Admit to Disordered Eating

A recent poll measuring awareness and prevalence of eating disorders on college campuses across the nation produced a startling statistic: Nearly 20% of students who responded believe that at some point in their lives they had had an eating disorder. (Available research has set lifetime prevalence rates of eating disorders between .05% to 4%.) And, 75% of those who said they had or still have an eating disorder never received any treatment.

The poll was conducted by Global Market Insite for the National Eating Disorders Association (NEDA). Using online data collection, NEDA polled 1,002 students on private and public campuses, asking about their general knowledge about eating disorders, how many of their peers they know are dealing with eating disorders, the causes, and actions that they may have taken to help those suffering with eating disorders.

More than half of those polled (55%) knew at least one person who struggled with an eating disorder and 57% said they took steps to speak with them about the problem. Eighty percent reported dieting and 75% have dieted and avoided or skipped meals. Forty-four percent of the students knew someone who compulsively exercises more than two hours at a time more days of the week than not, or who purge by vomiting (38.5%) or use laxatives to lose weight (26%).

When asked what they believed caused eating disorders, 57.3% said cultural pressure to be thin was the main cause. Other factors cited were: stress from their family and from life in general (40.3% and 40.2%, respectively), and personal choice (39%). More than 35% believed the disorders were due to mental illness; 17.9% thought trauma was the cause, and 17.6% felt genetics played a developmental role.

IN THE NEXT ISSUE

The Effectiveness of Internet-Based Programs for Preventing Eating Disorders

By Mandi Newton, RN, PhD

The Internet offers an enticing approach to helping clinicians treat eating disorders, but how well have existing programs worked so far? Dr. Newton examines the results of studies to date.

PLUS

- More Highlights from the National Eating Disorders Association Meeting
- Eating Patterns Among Obese Patients with Binge Eating Disorder
- Suicidality in Eating Disorders
- Eating Disorders and Media Exposure
- Smaller Plates, Smaller Meals?
- Body Checking and Weight Loss Programs
- Review: *Drawing from Within*

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