

EATING DISORDERS REVIEW

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UPDATE

Does Perfectionism Change After Recovery?

Perfectionism is one of the most common personality traits associated with eating disorders. Some have suggested that this trait plays a crucial role both in the development of and maintenance of eating disorders. But, what happens to perfectionism after the patient recovers from an eating disorder? Dr. Ceri Jones and colleagues at the University of Birmingham and Queen Elizabeth Psychiatric Hospitals, Birmingham, United Kingdom, studied perfectionism among 66 women with a current eating disorder, 29 women who reported they had recovered from an eating disorder, and 50 female undergraduate students (controls). All three groups completed the Eating Disorders Inventory. A combination of a relatively high perfectionism scores and relative low scores on ineffectiveness, interpersonal distrust, and interoceptive awareness differentiated recovered women from women who currently had eating disorders and the control group. The group's findings indicate that perfectionism is a persistent trait present in persons with eating disorders, regardless of remission of symptoms. According to the authors, their study results also underscore the relative importance of perfectionism compared to other ego dysfunction characteristics in women who have recovered from an eating disorder.

The Transition Phase of Treatment: A New Model – Part 1. Beginning at the Beginning

By Mary K. Stein
Managing Editor

Transition: A passage or movement from one form, state, or condition, to another—*Webster's New World Dictionary*.

Traditionally the transition phase of treatment begins when inpatient treatment is nearly complete and the patient is preparing to go back home. At the Eating Disorder Center of Denver (EDC-D), however, transition begins when the patient first walks in the door, according to Center Director Kenneth Weiner, MD, and Clinical Director Tamara Pryor, PhD.

The EDC-D treatment program has a unique design using partial hospitalization, which differs from typical inpatient programs. Like other inpatient programs, the Denver Center offers an 11-hour treatment day 7 days a week. The program includes group and individual therapy, psychiatric and medical monitoring and three meals and two snacks facilitated by a dietitian and a master's level clinician.

This is where the similarities end: at the end of the treatment day, EDC-D patients return home or to an apartment at the Center or to local hotels. They can then apply what they have

the transition phase of treatment actually begins when a patient enters the program. Work on transition begins with a phone call within the first 48 hours to the referring therapist and to the referring psychiatrist. This contact continues once a week throughout the course of treatment. The Denver program also offers contact with the outpatient therapist on a weekly basis throughout the course of treatment. Patients also are involved with their care from the beginning and help define their own treatment goals.

Dr. Weiner says, "Any good intensive treatment has a beginning, middle, and end, but if you start thinking about transition at the end, that's too late and you are not going to be able to effectively accomplish your goals. The idea and goal of working to return to their lives is incorporated all through their treatment."

When a patient is involved in the program and their therapist is in the area, the therapist is invited to participate in the patient's staffing every week. Most therapists seem to like the idea of staying involved with their patients while the patient is in the partial program, says Dr. Weiner.

Inpatient vs. Outpatient Care: A Surprising Finding

Before joining the staff at EDC-D two years ago, Dr. Pryor ran an eating dis-

learned that day and practice healthy ways of coping in real life. EDC-D is one of only a few programs in the country that offers partial hospitalization for eating disorders patients.

Transition Begins at the Beginning

According to Dr. Weiner,

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order program in Wichita, KN. A study by her group gave her a new perspective on inpatient care. She says, "We realized we were operating with the assumption that more is better and therefore inpatient care was a more effective form of treatment. We decided to do a study to find out if inpatients did better than outpatients. We were very surprised to find that outpatients did better than outpatients at 6 months and again at a 2-year follow-up."

The outpatients reported better outcomes because they had a greater sense of ownership of their recovery. She added that many of the patients who were inpatients felt that although they were able to interrupt their hurtful behaviors and did well in the hospital, but when they left the hospital they claimed, 'it was like falling off a cliff.' They did not have the life skills to incorporate the changes into their lives once they left the program. Dr. Pryor also noted that compared to inpatients, outpatients had a better sense of self and more confidence to continue in their recovery. Joining the Denver program provided evidence of how an empowerment model that emphasizes increasing self-directedness through transition work can truly effect change.

Patients in the partial hospitalization program work all day in treatment programs, then go home to their apartments or homes in the evening and continue to practice their skills in the outside world. And, Dr. Pryor noted, if they have a problem or challenge with behaviors, they can come back the next day to discuss it, and to see what they might have done differently. She added, "We are working on transition every day they are here." This is also a population

that has a great difficulty with change, she noted, adding that the treatment team coaxes them along with that outcome in mind, and are constantly working on helping patients take responsibility for their recovery, using lots of education and an expectation of success. Dr. Weiner adds, "Whether we are

talking about inpatient, residential, or partial hospitalization, all these issues pertain to transition."

Patients must be 16 years of age or older and younger patients are seen at the nearby Children's Hospital of Denver. Most patients are admitted within one to three days after assessment,

and the length of treatment is determined individually with each patient according to their diagnosis and needs. For patients with AN, the weight restoration goal is at least 90% of their ideal body weight. The length of stay in the partial hospitalization program ranges from four to eight weeks, and is individualized.

Does the Program Work for Everyone?

Dr. Weiner notes that during the five and one-half years the partial hospitalization program has been in place, only about 5 of 500 patients have needed referral to a higher level of care. "We try not to treat patients where there isn't a good fit, he added, and noted that people often underestimate the severity of the illness that can be treated with the partial hospitalization model of care.

He also added that part of what the treatment team attempts to do is to provide lots of education about the expectations of the program before a patient is admitted to the program. Nutrition is admittedly one of the largest hurdles. In the very beginning days of the partial hospitalization program,

A Different Structure for Coverage

Unlike many eating disorders treatment programs that have a minimum length of stay or require a large upfront payment, EDC-D does not require a minimum stay, nor does it require a large prepayment. Another difference is that most inpatient programs divide care into 25% to 30% of 3rd party pay, and 70% to 75% of self-pay. At the EDC-D, most of treatment is covered by insurance. Typically insurance covers a fixed number of inpatient days—generally 30 to 45 days. According to Dr. Weiner, partial hospitalization offers a two-for-one proration, doubling the covered treatment time. Another key to their success, according to Dr. Weiner, is full-time medical support from two clinicians, with support from an internist three days a week.

there was some difficulty feeding anorexics, partly because they would resist refeeding. Now, at the end of the first 48 hours of partial hospitalization, patients have to prepare their own food plan, or they must go on an alternate food plan. Educating the patients before they enter the program has made the difference. Usually it takes a few days for the patient to settle in to the routine of the program. Then being there becomes the leverage to do what they set out to do in the first place—getting well.

Patients like to be in the program, in a nurturing environment. He adds, “Our message is that you can’t be here and do what you have always done, because then you will get what you have always gotten—if you do what you have always done, you’re not going to get well.” Patients are told that the staff would not be ethical if they allowed the patient to stay yet also to continue to engage in harmful behaviors. He has been amazed at how few people leave treatment once they have entered the program. By the time patients have gone through the education program, an orientation to the treatment model, and finally being admitted to the partial hospitalization program, once they get through the anxiety of the first few days, they don’t leave treatment, he says.

Preparing to Leave the Program

Even with all the preplanning and structure, it is never easy for a patient to move from treatment to home, said Dr. Weiner. This is true even though patients go home each night, and even though they are continually working on transitioning back to their lives from the moment they enter the program. It is more difficult for patients from out of the greater Denver area, who cannot stay connected to the program via the Center’s outpatient program. The EDC-D outpatient program allows a full continuum of care as long as needed. To help patients from outside the Denver area with transition, the staff is in touch with their referring clinician, and parents are encouraged to visit the program and to participate in person.

(In Part 2, in the next issue, the phases of transition and the role of the transition therapist).

Caring for Caregivers: A Study of Persons Caring for Those with Bulimia

Two previous studies have reported that a family’s burden of caring for a family member with anorexia nervosa (AN) was comparable to caring for someone with psychosis, and AN caregivers also reported high levels of unmet needs (*Eat Weight Disord* 1997;1:44; *Eur Eat Disord Rev* 2003;11:125). Is the same true for caregivers of persons with bulimia nervosa (BN)?

Several features of BN make it hard to take care of someone with the disorder. For example, parents may be faced with the expense of repeatedly replacing large quantities of food that disappear from the pantry or dealing with toilets that are often dirty or even blocked from the patient’s frequent purging. Caregivers may also have to deal with comorbid symptoms such as depression and anxiety or impassive behaviors such as substances abuse or self-harm.

An exploratory study

Suzanne Winn, Dr. Ulrike Schmidt and others devised an exploratory study of the mental health and experience of people who care for teens with BN. One-hundred and twelve persons caring for patients with BN (from 1 to 4 persons per patient) and 68 adolescents with BN or an eating disorder not otherwise specified (EDNOS) completed self-report questionnaires, including the General Health Questionnaire, the Experience of Caregiving Inventory, the Level of Expressed Emotion, the Self-Report Family Inventory, and the Inventory of Interpersonal Problems (*Int J Eat Disord* 2007; 40:171). Caregivers included mothers, fathers, sisters, brothers, partners, friends, or step-parents. Most caregivers (62.5%) were female, and 37.5% were male. Most (87%) of caregivers were currently living with the person who was receiving care.

Results: Two factors that might be changed

More than half of caregivers reported some mental health problems, and a few were in considerable distress. A negative caregiving experience predicted the mental health status of the

caregiver. Two relationship-related factors predicted a negative experience, namely expressed emotion (as reported by the patient) and weekly contact hours. Interestingly, there was a clearer relationship between the patients’ as opposed to caregivers’ ratings of a negative experience of caregiving. The authors reported that more information on patient-caregiver contact time will be required to better understand why this factor predicts a more negative experience for the caregiver.

In the current study, levels of difficulties were not lower than in previous studies of caregivers of patients with chronic AN or psychoses. The authors were surprised by this finding, given the fact that the patients were relatively homogenous in terms of having a short duration of symptoms. In addition, the BN patients in this study were local referrals from primary care physicians, and much less highly selected than those in previous studies of caregiving for AN patients (*Soc Psychiatry Psychiatr Epidemiol* 2001; 36:343).

Selected characteristics did not predict negative experiences

There was no evidence that selected patient and caregiver characteristics predicted negative caregiving experiences. This contrasts with reported evidence that disturbed behavior predicts caregiver distress in those who care for individuals with traumatic brain injury, HIV/AIDS, and cognitively impaired elderly persons. However, individuals with BN often feel ashamed of their binge eating and vomiting and keep these behaviors a secret. Thus, the authors think it’s possible that some caregivers were not aware of the severity of these bulimic behaviors

Though there were certain limitations to the study, such as small size, the authors reported that two steps might help reduce the stress upon the person caring for a patient with BN. The first would be to limit the amount of expressed emotion allowed, and the second would be to shorten the contact hours between patient and caregiver.

Anorexia Nervosa: When Should Patients Be Coerced to Have Treatment?

Involuntary admission for treatment of severe anorexia nervosa (AN) poses tremendous challenges for patients, parents and significant others, and clinicians alike. For clinicians, the risk of what may be a life-threatening illness balanced against the need to maintain a therapeutic relationship is often a clinical medicolegal tightrope where guidelines may be hazy. In addition, in some jurisdictions, such as Israel and until recently New South Wales in Australia, AN does not qualify as a mental illness warranting involuntary mental health admission and treatment. A team of researchers in Australia recently identified several criteria that might serve as guidelines for coerced admission for treatment of seriously ill AN patients (*Isr J Psychiatry Relat Sci* 2006; 43:159)

A 5-year review of admissions

Terry Carney, PhD, LLB, and colleagues in Sydney and Canberra, Australia recently reviewed all 177 admissions for treatment of AN to a specialist Australian AN program over nearly 5 years. The researchers divided the admissions into two groups, patients who agreed to hospitalization (informal admissions) and those who had been coerced into treatment.

Seventy-five patients accounted for 96 admissions, including some multiple admissions (up to 5 admissions to the unit) over the 5 years. Twenty-seven admissions resulted from mental health committals or adult guardianship orders. In 7 cases, admissions considered for coercion resulted in patients agreeing to informal admission, following a strategic confrontation and abandonment of resorting to the law. Slightly more than a third (36%) of admissions involved patients younger than 20, one-third were sole events within the sample periods, and three-fourths of those admitted were diagnosed with comorbid conditions. Approximately 40% of admissions were for less than 3 weeks, and the mean stay in the hospital was 49 days.

Four telling patient characteristics emerged

As the researchers continued their

evaluation, certain characteristics emerged among those who had to be legally admitted for treatment of AN. These were: (1) young age at admission, (2) critically low body mass indexes (BMIs, or mg/kg²), (3) multiple prior admissions for treatment, and (4) comorbid mental health conditions.

• Mental health comorbidity

The group that had to be coerced into treatment differed not only in the proportion of those who had comorbidity (85% vs. 75% among those who agreed to treatment) but in the number of comorbid conditions. The coerced patients tended to have a much greater number of comorbid psychiatric diagnoses than did the informal treatment group.

• Low presenting BMI

A critically low BMI was significantly associated with the likelihood of coerced admission ($P = 0.05$). Among the coerced patients, in 29% of admissions the patient had a BMI less than 12 at the time of admission. Nearly two-thirds (61.5%) had a BMI less than 14. In comparison, 8.6% of those who were voluntarily admitted had a BMI less than 12. Although both groups had low BMIs, the composition of BMIs within the two groups was very distinctive: coerced patients had a lower BMI (10-12, in the very severely emaciated category) than did the informal patients.

• Multiple admissions

Dr. Carney and colleagues also found that coerced patients were more likely than informal patients to have been admitted for treatment of AN or related conditions (80% vs. 57%, respectively). More than 1 in 3 of the coerced patients had been admitted 6 or more times previously, compared to only 1 in 10 of the informal patients.

• Very young age at admission

Youth by itself did not prove to be statistically significant. However, 30.8% (8 patients) in the coerced admissions group were younger than 18 years of age, compared to 10% (7 patients) informally admitted to the unit. In addition there was a more marked trend for

coercion to be used among for younger patients (under 18 years of age) with higher numbers of prior admissions to the unit. These patients tended to be better known to staff members in the unit and to have medically compromised weight (life-threatening BMIs of 10-12 kg/m²) and most developed the refeeding syndrome.

When first admissions were evaluated, the researchers found that patients who were coerced were statistically less likely to each as high a BMI on discharge as did the informal admissions group.

Wider implications of studies on coercion

In this study, the policy of the specialist treatment unit evolved to concentrating on preserving the physical integrity and safety of patients rather than on achieving acceptable BMIs or other goals. These cases also presented major dilemmas once features such as refeeding syndrome emerged. With neither family nor third parties (such as an appointed guardian) able to provide alternative community-based management or to bring informal persuasion/support to bear to encourage compliance with treatment, clinicians have few remaining options other than coercing treatment. Persuading patients of the severity of their illness is often a forlorn prospect, according to Dr. Carney. While they certainly do not wish to die, many patients lack the "insight" to understand how seriously ill they are.

Deciding when coercion should be used

Who should be coerced for treatment and how is this best achieved? According to the authors, the answer is never easy. By the very nature of severe AN, most patients will react badly to any attempts at refeeding. Since their reasoning is often impaired by the overlay of comorbid conditions and the possibility of brain atrophy, their capacity of reasoned judgment may be further hindered. Finding a way to balance the urgency to intervene and the therapeutic relationship is a true challenge, and while adult guardianship might cause less anger and resentment, it is often ineffective for these patients.

Major Depressive Disorder and Eating Disorders: Watch for a Comorbid Connection

Eating disorders and affective disorders are no strangers—major depressive disorder (MDD) and dysthymia are among the most commonly reported comorbid Axis I disorders in individuals with bulimia nervosa (BN) and anorexia nervosa (AN). However, despite many studies, the relationship and mechanisms between MDD and eating disorders is still only partially understood.

A large collaborative study has shown that eating disorders and MDD first occur relatively closely together, within

a 3-year window. Dr. Fernando Fernandez-Aranda and colleagues found that 43.6% of onsets of MDD and an eating disorder occurred within 1 year of each other and 67% within 3 years (*Austral N Zealand J Psychiatry* 2007; 41:24). The lifetime prevalence of MDD by eating disorder subtype is shown in the table.

The study

Lifetime MDD and depressive symptoms were evaluated in 1371 women with a history of eating disorders (AN, restricting and purging subtypes, BN, purging and nonpurging subtypes, and eating disorders not otherwise specified, or EDNOS). The researchers first explored the prevalence of MDD across eating disorder subtypes and ages of onset of MDD and the eating disorders were compared.

Symptoms of depression were examined in women who developed MDD before and after the onset of the eating disorder. The researchers were particularly interested in whether the nature of the MDD differed in those individuals who developed depression prior to an eating disorder.

Results

Dr. Fernandez-Aranda and his colleagues found that patients who developed MDD before an eating disorder had a longer duration of symptoms of MDD, more frequent psychomotor agitation, and greater thoughts of their own death than did those who developed an eating disorder first.

However, the authors did not find a greater degree of suicidality among those individuals who developed eating disorders after MDD.

The authors also reported that several factors might

explain the proximity of the two types of disorders.

First, stressful triggering events, such as puberty, trauma, or transitional times in life, may activate processes that lead to the expression of both MDD and eating disorders in individuals who are genetically vulnerable to both disorders.

Second, in instances where MDD emerges first, factors associated with MDD, including loss of appetite or low self-esteem, may themselves activate underlying genetically mediated vulnerability to eating disorders.

Finally, among those who develop an eating disorder, the first, aspects of the disorder, such as starvation, may serve as triggers for an underlying latent vulnerability to MDD.

Dr. Fernandez-Aranda and colleagues noted that the clinical implications of their study are clear. The period of time bracketing the onset of an eating or affective disorder is a high-risk time for developing additional psychopathology in at-risk individuals.

Increased vigilance urged

The researchers note that clinicians treating individuals with new-onset

eating disorders or MDD should remain vigilant for the emergence of additional psychopathology, especially during the first 3 years after the onset of the first disorder. This is particularly true for individuals who have a family history of eating disorders or major depression.

A False Report of Bulimia Nervosa

Sometimes what first appears to be an eating disorder turns out to be something else. For example, the signs and symptoms of eating disorders and certain gastrointestinal disorders can be similar, leading to a false diagnosis of an eating disorder. This was underscored by a recent case reported by Marie L. Borum, MD, MPH and Eashen Liu, MD, of George Washington University, Washington, DC (*Prim Care Companion J Clin Psychiatry* 2006;8:5).

A 25-year-old woman with a history of bulimia nervosa (BN) was referred for a second opinion after a preliminary consultation with her primary care physician. The woman had episodes of vomiting that resulted in an unintentional weight loss of about 25 lb. Initial tests showed no unusual findings and her primary care physician and gastroenterologist suspected her eating disorder had recurred.

When she was reexamined, the patient complained of nausea, vomiting and early satiety. She denied having depression, a distorted body image or sleep disturbances. She also had no abdominal pain or diarrhea. The patient was 5'6" tall and weighed 100 lb. Colonoscopy was normal and all symptoms seemed to point to a recurrence of BN.

The true diagnosis—Crohn's disease—was only made after an upper endoscopy revealed pyloric stricture and biopsy samples showed noncaseating granulomas. The authors note that recurrent vomiting and unhealthy weight loss are symptoms that could describe either an eating disorder or duodenal Crohn's disease. When evaluating a young person for an eating disorder, they suggest adding the possibility of Crohn's disease or another gastrointestinal disease to the differential diagnosis.

Subtype	% with MDD (n)	% without MDD (n)
AN, restricting subtype	65.6 (246)	34.4 (129)
AN, purging subtype	81.0 (166)	19.0 (39)
AN, bingeing subtype	69.0 (89)	31.0 (40)
BN, purging subtype	72.1 (173)	27.9 (67)
BN, nonpurging subtype	84.2 (16)	15.8 (3)
BN, history of AN	80.7 (276)	19.3 (66)
EDNOS	54.1 (33)	45.9 (28)

A Pilot Test for Detecting BED Among Children

Binge eating disorder, or BED, can manifest differently in children than in adults. For example, the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* criteria for defining “loss of control of eating” is very hard to define among children. Some children may report losing control of eating after consuming a small amount of food (even a single cookie), while others may feel a loss of control after eating a much larger amount of food, such as a full box of cereal.

Children may also find it hard to recall binge-eating episodes; for example, if symptoms have lasted longer than 3 months, the month of onset is usually inaccurately reported. When symptoms have

lasted a year, a child often can't name the year that symptoms began. Although many studies have shown that BED starts in late adolescence, some individuals have reported that they began binge eating earlier, for example, between 11 and 13 years of age.

A briefer, structured test just for children

Dr. Jennifer R. Shapiro and colleagues at the University of North Carolina, Chapel Hill, recently tested a brief, structured interview-based scale specifically designed to detect BED among children (*Int J Eat Disord* 2007; 40:82). The Children's Binge Eating Disorder Scale (C-BEDS) is a simple, relatively short, and easy-to-understand interview for assessing binge eating in children. Seven questions were developed, based on the seven critical behaviors proposed by Marcus and Kalarchian (*Int J Eat Disord* 2003; 34 (suppl) S47-S57 (see table)).

Study design

Fifty-five children participated as part of a larger intervention aimed at promoting healthy eating and activity. After parents underwent a brief telephone screening interview, parents and child were screened with a 30-minute interview, during which they completed a series of questionnaires. Eligible children then met individually with the interviewer for a structured diagnostic interview, which included the BED section of the *Structured Clinical Interview for the DSM (SCID)* and the C-BEDS questionnaire.

The average age of the children participating in the study was 8.7 years (range: 5-13 years). Sixty-percent were female, and 58% were white. The boys had a mean height of 54.7 in. and a mean weight of 118.3 lb, with a mean body mass index (BMI, or g/kg²) of 26.6 and were in the 94.8 BMI percentile, which is in the overweight range. The girls had a mean height of 55 in. and their mean BMI was 26.6 kg/m². Most of the parents were women, and these mothers had a mean BMI of 32.1 kg/m²; the 5 fathers who participated had a mean BMI of 34.3 kg/m².

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C-BEDS and SCID: Comparing the results

Five (9%) of the children met full SCID diagnostic criteria for BED. In comparison, with the amended provisional criteria of the C-BEDS, 16, or 29%, of the children met the diagnostic criteria for BED.

The authors note that the very subjective nature of a binge-eating episode makes BED difficult to diagnose among adults, and particularly challenging among children. With the exception

of the Children's Eating Disorders Examination (ChEDE), which is comprehensive but lengthy and requires special training to administer, there are no other readily available interview tools for children that can measure BED. In addition, according to the authors, the nature of BED among children is still largely unexplored territory, and the measures used in adults may not be appropriate for children.

Almost half reported eating when not hungry

Using the C-BED, the authors found that about half of the children reported that they sometimes eat when not hungry; once they start eating they cannot stop; and they want food as a reward for doing something well (see table). Sixty-three percent reported eating because of negative emotions. There were some limitations: all the participants were children who were interested in increasing their healthy eating and activity, and although the study was open to all children, those who participated were in the overweight range and their parents were in the obese range. No differences were noted by gender.

The authors stress that the C-BEDS is a preliminary tool that will be refined with further study. Some of the questions, such as using food as a reward, might apply to normal behavior and might be too sensitive to be an indication of binge eating.

Testing Dietary Restraint

Many studies have questioned the validity of the dietary restraint hypothesis. One reason is concern over the legitimacy of different methods used to measure dietary restraint. Researchers at the Pennington Biomedical Research Institute recently tested four popular measures of dietary restraint in 48 subjects randomly assigned to 4 treatment arms in a 6-month study. The subjects were evaluated with the Dutch Eating Behavior Questionnaire, the Eating Inventory (EI), Revised Restraint Scale (RS), and the Current Dieting Questionnaire. The RS was the most valid measure of the intent to diet and actual caloric restriction (*Appetite* 2007;48:183).

Children's Binge Eating Disorder Scale

(Percentage Who Said Yes)

1. Do you ever want to eat when you are not even hungry? (44%)
2. Do you ever feel that when you start eating you just cannot stop? (52%)
3. Do you ever eat because you feel bad, sad, bored, or any other mood? (63%)
4. Do you ever want food as a reward for doing something? (48%)
5. Do you ever sneak or hide food? (28%)
6. How long have you been doing this? (transformed to weeks) (120 weeks)
7. Do you ever do anything to get rid of the food you ate? (0%)

Self-Injury and Eating Disorders: Some Common Threads

Self-injurious behaviors (SIBs) are loosely defined as behaviors involving the deliberate infliction of physical harm on one's own body without any intent to die as a consequence of that behavior. According to a team of researchers at the University of Padua, Padua, Italy, eating disorders are frequently found among young women who compulsively or impulsively attempt to harm themselves physically (*J Clin Psychiatry* 2007; 68:122).

Compulsive vs. impulsive SIBs

Compulsive SIBs, such as hair-pulling and severe nail-biting, are usually habitual, repetitive, and "automatic." They are not associated with conscious intent or with an affective experience and are typical of compulsions. That is, there is a sense of mounting tension when the person tries to resist the behavior and relief of anxiety after the behavior. Impulsive SIBs, such as skin-cutting or head-banging, are usually episodic, involve little resistance, and provide some form of gratification beyond relief of tension or anxiety. Patients who admit to these behaviors say that the behavior helps them control negative emotions, such as depression or loneliness, and also satisfies other needs, such as the need for self-punishment and manipulation of others.

A community study

Angela Favaro, MD, PhD, Silvia Ferrara, PhD, and Paolo Santonastaso, MD studied a community sample of women 18-25 years of age living in the city of Padua. After interviewing 934 of the 1198 women from the large sample, the authors discovered that one-fourth of the women in the smaller group reported SIBs. Nail-biting and skin-picking were reported by 278 women, or 30%, and in 185 (20%) of the 934 women, respectively.

Interestingly, a lifetime history of eating disorders was found in a number of the women. Among 143 women who manifested compulsive SIBs, 3 reported a lifetime history of anorexia nervosa

Treating Bulimia in Adolescents: A Family-Based Approach

(Daniel le Grange, PhD and James Lock, MD, PhD; New York: Guilford 2007; 260 pages, \$35)

Based on the well-regarded Family-Based Treatment (FBT) model first used in the appropriately well-respected studies of individual and family psychotherapy for eating disorders that have emerged from the Maudsley Hospital in London since the 1980s, this volume serves as a companion for the highly popular and useful *Treatment Manual for Anorexia Nervosa: A Family-Based Approach* (Guilford Press, 2001) by these authors and their Stanford and London-based collaborators. Their thrust has been to develop evidence-based treatments that work, and the treatment manual contained in this book puts their family-focused protocols into the hands of clinicians sensible enough to use them.

The book begins with the required introductions to bulimia nervosa and to the background and rationale of the family-based treatment approach for this disorder. As a premise, families are expected to assume responsibility for seeing that their adolescents adhere to the program and for helping manage the recovery. By chapter three, you're immersed in the clinical work, with detailed instructions for conducting the initial evaluation, the first face-to-face meetings with the family, conducting a family meal, and "action plans." The work is divided into three phases, conducted in approximately 20 sessions.

(AN) and 6 reported a lifetime history of bulimia nervosa (BN), while 15 women reported a lifetime history of any type of eating disorder. In the impulsive SIB group, 9 women had a lifetime history of AN, 11 had a lifetime history of BN and 31 reported a lifetime history of any type of eating disorder.

Suicide attempts

Among the entire sample of women, 20 reported suicide attempts; among this group, the frequency of AN was 5%, of BN, 30%, and of any eating disorder, 40%. The authors note that although many studies have reported a high frequency of SIBs among patients with eating disorders, this is the first study to show a specific, significant association between impulsive SIBs and eating dis-

BOOK REVIEW

Each phase includes a clear description of the goals, strategies, and tactics to be used and accomplished, and then transcript-segments illustrating details of what it's actually like to put these tasks into action. The descriptive chapters are organized in many helpful paragraphs headed "How" and "Why," and contain numbers of "frequently asked questions" that clinicians are likely to be asking as they proceed through this work.

A recent study conducted at the University of London provided evidence for the effectiveness of a modified form of this treatment in their 18-year-old patients, comparable in efficacy to therapist-guided cognitive behavioral therapy (Schmidt U et al, *Am J Psychiatry*, April 2007; 164:591). It also showed that many adolescents were not keen to be in family therapy, so that this approach may not work for all teenagers and their families. However, as a clinician I can't imagine *not* including families in significant ways in my work with adolescent patients with eating disorders. Since the treatment model described and spelled out in this book has been used in several research studies, and provides a state-of-the-art approach, clinicians treating these adolescents will definitely want to purchase, study and use many of the ideas contained in this book for many of their patients.

— J.Y.

orders in a community sample.

The self-damaging behaviors typically found in eating disorders, including fasting, self-induced vomiting, abuse of laxatives and/or diuretics, showed a dimensional link with SIBs. This finding led the authors to hypothesize that in eating disorders compensatory behaviors and SIBs could share some characteristics and psychological functions. For example, both SIBs and eating disorders could reveal a need to control the body after the uncontrollable changes due to puberty, and they could both be associated with body dissatisfaction, ineffectiveness, and asceticism.

Finally, the authors stress the importance of keeping eating disorders in mind when assessing young women who attempt suicide.

QUESTIONS & ANSWERS

Patients Regain Healthy Weight But Amenorrhea Persists

QI have a number of patients with anorexia nervosa (AN) who regained a healthy weight more than a year ago but who still haven't resumed their menses. What do we know about the relationship of weight gain to return of menses in AN? Are there any predictors of how long this will take? (E.D., Portland, OR)

A Although there's no precise relationship between regaining weight and the return of menses, it's clear that it is necessary for patients with AN to gain back to a healthy weight (i.e., to just about 100% of what was previously healthy when the person was menstruating) before menses will resume. One recent study examined 61 patients with AN over a year of treatment, and found that during that time 69% of these women experienced weight recovery, defined as a weight of at least a body mass index (BMI, or kg/m²) of roughly 19. But, in that time only 39% of those who had weight-recovered resumed menses. Several factors correlated with return of menses. Those regaining menses tended to be a little older (19.8 years of age, compared to 16.9 years of age, on average), and to have had higher initial levels of follicle-stimulating hormone, or FSH—on aver-

age 3.8 IU/L in those regaining menses vs. 2.0 IU/L in those not regaining menses. They also had initially higher levels of two other endocrine measures, inhibin B and anti-Müllerian hormone (AMH). Thus, patients whose ovarian function is suppressed less profoundly at the start of treatment are more likely to have earlier menstrual cycle recovery when they regain weight. A multivariate prediction combining all of the endocrine factors demonstrated that although each marker was weak by itself, by combining all three investigators could derive a reasonably sensitive way of predicting who would recover menstrual function within the year (*Fertil & Steril* 2007; 87; 902).

An Outcome Study of Anorexia Nervosa in Singapore

Anorexia nervosa (AN) is a growing problem among young women in Singapore. A team of dietitians led by Lin Su Lin, chief dietitian at National University Hospital in Singapore, conducted a retrospective review of 94 patients seen at the hospital from 1992 to 2004 (*Singapore Med J* 2007; 48:222). Nutritional intervention included individualized counseling for weight gain, personalized diet plans, and individualized counseling about dietary intake and healthy eating.

The median body mass index (BMI, kg/m²) was 14.7, and 76% of the AN patients were between 13 and 20 years old.

Ninety-six percent were female, and 86.2% were Chinese. The majority of patients improved with follow-up care; 68% had had an average weight gain of about 12 lb after treatment. Those who improved had more outpatient follow-up sessions with dietitians (4.2 consultations vs. 1.2 consultations, respectively). Those who did poorly had AN longer than 2 years, and in general had delayed seeking help for AN.

Nibbles by Hunter



IN THE NEXT ISSUE

The Transition Phase of Treatment: A New Model, Part 2 Working with the Transition Team

In the partial hospitalization program at the Eating Disorders Center of Denver, the transition phase of treatment begins when the patient first comes to the center. Part 2 examines the stages of transition and the role of the transition therapist.

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