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Three Experts Outline Strategies to Counteract Insurance Denials

Highlights From the National Eating Disorders Association Meeting

For most clinicians, eating disorders patients, and families, insurance is a confusing game for which few have any training, according to members of a panel discussion at the NEDA meeting in Los Angeles in October. The panelists included attorney Lisa S. Kantor, Esq., of Kantor & Kantor LLP, Northridge, CA; Stacey Brown, Director of Nursing and Utilization Review and Dr. David Christian, Clinical Psychologist and Consultant, Avalon Hills Eating Disorders Treatment program, Logan, UT. Lisa Kantor litigates insurance coverage issues for eating disorders across the country. At Avalon Hills, Stacey Brown oversees all cases of insurance pre-certification, appeals and reviews, and David Christian trains therapists to document patient care in ways that maximize insurance authorizations.

Panel members told the audience, "How you play the game can help or hurt you and the outcome, and the more clinicians know about the insurance game, the more effectively they can play it." In fully funded plans, the insurer has complete governing power until a claim goes to an external review. A state-funded plan is often governed by different state laws, and fighting a rejected claim often requires litigation, said panel members. Self-funded plans, which operate under ERISA (the Employee Retirement Income Security Act) often do not have an external appeal option. ERISA also imposes higher-than-marketplace standards on insurers. For example, it sets forth a special standard of care upon a plan administrator, namely that the administrator "discharge" his or her duties in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of the plan. This factor underscores the importance of accurate claims processing, and demands that administrators "provide a full and fair review" of claim denials."

Common Reasons Claims Are Denied

The panel outlined out three common reasons insurance claims are denied. The first reason involves the question of medical necessity. Parity laws require that mental health coverage be provided commensurate with medical health coverage. Second, medical stability will occur long

before psychological stability. State definitions trump an insurer's definition of medical necessity. Finally, clinicians should look for loopholes.

A second reason is exhaustion of benefits. To counteract this, clinicians, family, and patient should be very familiar with the individual policy because the company may deny benefits that are clearly included. It is also helpful to know the state's degree of involvement with mental health parity laws, because the state may or may not participate in parity. A third reason for denial is rigidity about what the insurer thinks treatment be; for example, telephonic family treatment or partial treatment with boarding (one can legally bill for a lower level of care than what is being delivered). And, some companies attempt to selectively exclude eating disorder patients.

Seven Deadly Fallacies

The panel described what they termed "The seven deadly fallacies" of health insurance, which include conflict of interest, the rubber ruler, a straw man argument, false authority, red herring, non sequitur, and post hoc fallacy. Conflict of interest is like a two-headed snake, said panel members. That is, the company sets up the insurance policy so it can play both prosecution and judge. A good example is when the company writes and interprets the policy, or allows an external appeal that is not truly independent. To respond to this, it is important to confront capricious interpretations of the policy and make sure external appeals truly are independent, said the panel members. The next fallacy is "The Rubber Ruler," or "bad standard," which involves using poor measures of recovery, or measures that are not American Psychiatric Association (APA) standards. For example, the company may state, "Your patient does not meet our standards for residential care, so we are denying it." A good counterattack is to point out where their standards are not consistent with best practice, for example, APA standards.

The "Straw Man Argument" involves emphasizing an irrelevant issue and ignoring more pertinent issues. An example might be stating that a patient is now in her ideal weight range so she is ready for partial hospitalization. A counterattack would be pointing out that the company is ignoring the larger psychological, social, and environmental factors in the case. "False Authority" occurs when the company appeals to a false authority, such as Dr. Jones, the company's clinical director. A counterattack is to check his credentials, to determine if Dr. Jones is a true authority in eating disorders through training and experience. Is he biased because of previous decisions in this case? If so, the clinician can request review by another professional who has the proper credentials.

Another tactic the trio pointed to was what they call "The Red Herring," or "distraction trick." In such a case, an irrelevant issue is raised to divert the clinician and family. For example, the insurance company may complain about something that is clinically insignificant, such as authorization not being obtained in a timely fashion, to distract attention from their ethical and clinical obligations. To counter this, clinicians should bring the attention back to the ethical and clinical issues most pertinent to the patient's care. The "Non-Sequitur," or "circular reasoning," occurs when the company's conclusions don't follow the premises for care. For example, the insurer may state that the patient is not improving very much and therefore she needs to be stepped-down to intensive outpatient treatment. A good counter procedure is to try a reversal—that is, to assert that the patient who is not improving needs more intensive residential treatment or possibly hospitalization.

"Hypocrisy," or "the double standard," is defined when the company applies one standard to a patient and another to themselves. For example, one insurance company's medical director denied residential treatment because it involved telephonic family therapy. He said phone therapy cannot

be as good as live therapy” however, the denial was based completely on data that the insurance company itself obtained by telephone. The panel urged pointing out the inconsistency of the company’s logic.

The final fallacy, “Post Hoc Fallacy,” or “After it, therefore because of it,” is defined as setting up a denial explanation based on the false premise that A is the cause of B because B follows A. An example would be claiming that because relapse followed treatment, treatment was inadequate or was the cause of relapse. An effective response to this is to point out that correlation does not mean causation” instead, it is often effective to point out the other plausible causes of the event.

Panel members also urged clinicians to use APA-consistent documentation, which includes such elements as motivation to recover, co-occurring disorders, and ability of control compulsive exercising.

When Should a Denial be Challenged?

According to the panel, claim denials should be challenged when: (1) the denial is clinically inappropriate (by APA guidelines); (2) there are inherent conflicts with the insurer; (3) the insurer has logical fallacies in its reasoning; (4) the company violates the policy or plan terms; and (5) the company violates the law. The panel of experts then discussed the obligation to communicate, noting that under federal law and ERISA guidelines, the insurance company must provide to every claimant who is denied a claim written notice setting forth their reasons and the insured party’s rights and options. This must be provided in a way that is understandable to the claimant. Thus, the insurance company must give the specific reason or reasons for the denial, specific reference to pertinent plan provisions on which the denial is based, a description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary. In addition, the company must provide appropriate information about the steps needed to be taken if the claim is to be submitted for review. And, if benefits are denied in whole or in part, the reason for the denial must be given in reasonably clear language, with specific references to the plan provisions that form the basis for the denial. If the plan administrators believe more information is required, they must ask for it.

Two critical things to know about ERISA appeals are that the insured is entitled to a copy of the claim file *before* the appeal is decided and the insurer or plan may be entitled to discretion in deciding the appeal. (The claim file, also termed the administrative record, is any document, record, or other information that was relied upon in making the decision about the benefit, or is a statement of policy or guidance with respect to the plan concerning the denied treatment.) The insured is entitled, upon request, and without charge, to a copy of the claim file. In some cases, many plans or policies provide that the entity deciding whether to pay a claim has the “discretionary authority” to interpret the insurance plan and determine eligibility of benefits. Thus, a court will defer to the decision of the plan or insurer, and the decision does not have to be right, only reasonable. However, if the same entity is deciding whether to pay claims and is paying approved claims, the Supreme Court has ruled that there is an “inherent” or “structural” conflict. Conflict of interest may be shown when the reasons for the denial are inconsistent or insufficient, determining a material fact without supporting evidence, failing to follow plan procedures, failing to provide a full and fair review of the denial, and acting as an adversary bent on denying the claim.

The experts then gave an example of the contents of an appeal letter. Important elements of the letter included a summary of all prior letters and documents, demonstrating inconsistencies and

irregularities, and omissions. They urged clinicians to enclose any new documents, such as treatment records, letters of support, journals, videos, and results of independent medical examinations. The letter should conclude with specific requests. It is also important to include all denial letters, to give the most accurate information for appeal.

The panel also urged the audience members to become familiar with their insurance policies, to be assertive, and not to give up when a claim is denied. If litigation is chosen, the panel advised audience members to seek out attorneys who specialize in insurance litigation. Finally, in line with viewing insurance denials as a game, the trio advised audience members to think of appealing a denied insurance claim as a marathon, rather than a sprint.

UPDATE: Girls Happy with Their Body Image Don't Binge-Eat

At the Obesity Society meeting in Orlando, FL, in early October, Dr. Kendrin Sonneville of Children's Hospital, Boston, described the results of her 11-year follow-up study of overweight adolescent girls. Girls who said they were fairly satisfied or totally satisfied with their bodies had 61% lower odds of meeting criteria for an eating disorder compared with girls who were only slightly dissatisfied or completely dissatisfied with their body image.

The girls satisfied with their body image also gained significantly less body mass per year than other girls. Sonneville and her colleagues examined the relationship between body satisfaction and binge eating disorder (BED) by examining data from the Growing up Today Study (GUTS), an ongoing study of the offspring of women in the well-known Nurses Health Study II. All girls were from 9 to 15 years of age when the study began in 1996.

During the 11-year follow-up, the mean body mass index (BMI) change was 5.1 kg/m². About 1 in 10 girls (9.5%) met criteria for a diagnosis of BED at least once during the follow-up period. After adjustment for age, BMI, time viewing TV, and maternal overweight or obesity, girls who were satisfied with their bodies gained less weight and were less likely to develop BED during follow-up compared with their less-satisfied peers. The level of satisfaction seemed to matter, as the attenuation of the BMI increase and the reduction in the odds of developing BED increased as satisfaction increased. For example, girls who were very or totally satisfied with their bodies gained 0.13 fewer BMI units than did those who were not at all satisfied, and were 85% less likely to develop a pattern of binge eating.

Estrogen Replacement and Bone Density in Teens with AN

Patients may need to reach BMD levels above those of their healthy peers.

Unfortunately, the onset of anorexia nervosa (AN) often occurs when normal bone accrual is underway. This normal accrual of bone during adolescence is essential to optimize peak bone mass, which affects the risk of fractures later in life. Could estrogen replacement in physiologic doses that mimic puberty preserve bone mineral density (BMD) in teens with AN?

Yes, say a team of researchers from Massachusetts General Hospital and Harvard Medical School. As recently reported by Madhusmita Misra, MD, MPH, her group showed for the first time that controlled physiologic estradiol replacement increased spine and hip BMD in a group of girls with AN (*J Bone and Mineral Res* 2011; 26:2430).

Dr. Misra and colleagues enrolled 110 girls with AN and 40 normal-weight controls 12 to 18 years of age and of similar maturity in an 18-month trial. Mature girls with a bone age of at least 15 years (n=96) were randomized to receive 100 mcg of 17-beta estradiol with cyclic progesterone in transdermal patches applied twice weekly or placebo for 18 months. Immature girls with a bone age less than 15 years (n=14) were randomized to incremental low-dose oral ethinyl estradiol (3.75 mcg daily for from 0 to 6 months, then 7.5 mcg from 6 to 12 months, then 11.25 mcg from 12 to 18 months, to mimic pubertal estrogen increase), or to placebo for 18 months. At 18 months, all the girls underwent dual-energy x-ray absorptiometry (DXA) to measure BMD.

Girls with AN who received estrogen had greater increases in BMD-Z scores at the spine and hip than did girls with AN who received the placebo. BMD changes were predicted inversely by baseline age and positively by weight changes. In addition, BMD changes were predicted inversely by height and years since menarche. After controlling for baseline height, age, years since menarche, duration of amenorrhea, and weight changes, differences between the two groups became even greater. Adverse effects did not differ significantly between the treatment and control group.

The authors noted that oral estrogen has been used effectively as replacement therapy in normal-weight hypogonadal teens, such as girls with Turner syndrome. However, many studies have shown that oral estrogen given as an oral contraceptive does not increase BMD in girls with AN. The reason for this lack of efficacy with oral contraceptives is still speculative but may be due to nonphysiologic dosing and/or suppression of systemic insulin-like growth factor-1 (IGF-1) by oral estrogen, as occurs in postmenopausal women. Transdermal estrogen, which does not suppress IGF-1, should thus be a more effective approach to increasing BMD. IGF-1 levels did not differ in the two study groups, which was consistent with the authors' hypothesis that physiologic estrogen replacement wouldn't suppress IGF-1 levels. Levels of carboxy-terminal collagen crosslinks (CTX), a serum marker of bone resorption, decreased in girls with AN randomized to receive estrogen, but the change was not significant—perhaps because levels of bone turnover makers were already very suppressed.

One area that still needs to be addressed, according to the authors, is that in order to normalize and "catch up" BMD over time, girls with AN may not only need to gain bone mass at a rate comparable to that of control girls (as in this study) but may need to surpass that of healthy girls. To do so, other hormonal alterations in AN may need to be addressed; examples would be raising IGF-1 through weight recovery or administration of recombinant human IGF-1. Another strategy might be to use bisphosphonates; however, the authors caution that these products have a long half-life and are associated with marked reductions in bone turnover, which is already reduced in teenagers with AN.

Inpatient Refeeding: Adding Science to Art

Methods and goals usually vary from center to center.

There is as yet no single optimal approach to refeeding underweight eating disorder patients, and refeeding such patients can be described as more art than science. Refeeding methods and goals differ between treatment centers and countries and, according to a group of Australian clinicians, there is little if any scientific evidence to use as an overall guideline. For example, although the American Psychiatric Association recommends a weight gain of 0.1 to 1.4 kg per week for underweight eating disorders patients, there have been few actual descriptions of weight gain during inpatient treatment.

With all this in mind, Dr. Susan Hart and her colleagues at the University of Sydney and the University of Queensland, Australia, examined weight records of female patients admitted to a specialty eating disorders clinic for treatment between January 2000 and December 2006. Patients were categorized as severely underweight (body mass index, or BMI, $<14.0 \text{ kg/m}^2$); moderately underweight (BMI $14.01\text{-}17.49 \text{ kg/m}^2$); and slightly underweight (BMI $17.5 \text{ to } 18.99 \text{ kg/m}^2$). Those in the moderately underweight category had diagnoses of restricting or purging anorexia nervosa, and those in the slightly underweight category included patients with bulimia nervosa and eating disorder not otherwise specified (EDNOS). The patients included in the analysis were all females because there were too few male patients available to participate (*Eur Eat Disorders Rev* 2011; 19:390).

Methods

All women were placed on the refeeding program of the unit with weight gain goal of 1.0 kg per week to a minimum BMI of 19.0. All were medically stable prior to admission to the study. Their refeeding program consisted of 3 meals and 3 snacks with no nasogastric or parenteral nutrition. The refeeding program was designed to be an age-appropriate "normal" diet similar to what the patients' peers might eat, as determined by the dietitian and team. Oral liquid supplements were sometimes included for underweight patients, to meet their energy requirements if they had trouble achieving their weight gain target or could not tolerate the volume of food needed for weight gain. The refeeding regimen for those eating food only was a mean intake of 1980 kilocalories, with 20.5% from protein, 47% from carbohydrate, and 32.5% from fat. For 96 patients, from 1 to 4 liquid meals were added to their meal plans (liquid meals contained 19% of nutrition from protein, 46.5% from carbohydrate, and 34.5% from fat). Each patient had an individual meal plan that was reviewed weekly by an experienced dietitian, and registered nurses supervised all meals (one nurse for 6 to 8 patients). Once progress was seen, the women were given ever-greater autonomy until they were eating without supervision, eating outside of the hospital, and eating at home with their families by the time of discharge.

Results

The final study group included 247 female patients out of 414 admissions admitted for refeeding. For a majority of patients (73%), this was their first admission for inpatient treatment for an eating disorder. The severely underweight group gained significantly more weight between the first admission and discharge from their last admission and significantly more weight; however, it took longer for them to gain their weight. Nearly a third of patients with BMIs less than 17.49 voluntarily included the liquid supplements to help meet weight gain targets, compared with only a single patient in the slightly underweight group.

The authors also reported that there were 4 deaths among patients who had six or more admissions or occasions of care. The patients were not receiving any eating disorder treatment when they died—3 died from complications of malnutrition, and a fourth who was in the normal weight range when she was discharged from the clinic. The fourth patient died from unknown

causes.

Based on the results of their study, the authors suggest there is a need for more research on identifying patients who best respond to inpatient weight restoration programs. As the authors reported, some patients lose weight or only gain a small amount while hospitalized, as was the case with 88 women in their series. The authors would like to see much more research on identifying the differences between patients who do well in terms of nutritional rehabilitation and weight change and those who do poorly.

A Case for Early Intervention in Anorexia Nervosa

Recovery prospects fade when family therapy is delayed.

Drs. Janet Treasure and Gerald Russell recently revisited the original "Maudsley Model" of family therapy versus individual therapy for anorexia nervosa (AN). They note that family therapy was more effective in teens who had been ill for a short time. According to the authors, however, this was only part of the story (*Br J Psychiatry* 2011; 199:5).

The authors note that the outcome of AN is predicted by body mass index, physical risk, age and duration of illness, and that recovery from the disease becomes much less likely the longer the illness has persisted. Treatment is more likely to succeed if the illness is recognized early, before weight loss becomes more protracted and severe.

Noting that the National Institute for Health and Clinical Excellence has only partly endorsed the evidence for effectiveness of family therapy for AN, randomized controlled trials since 2004 have added new information. When Drs. Treasure and Russell did an analysis of earlier studies, they found some evidence that family therapy may be more effective than individual supportive therapy in patients with a shorter duration of illness, suggesting that unless effective treatment is given within the first 3 years of the onset of the illness, the outcome is poor.

What causes inadequately treated AN to persist? According to the authors, starvation and stress are key factors that promote persistence of the illness.

Caring for the Caregivers

A program designed to help caregivers combat stress.

Caring for a patient with an eating disorder can produce high levels of distress. In one study, 40 caregivers of eating disorder patients had a poorer quality of life than did a normal reference group. Mental health, vitality, and emotional functioning were most impaired, and the eating disorder appeared to affect families' lives substantially. Caregivers reported feeling anxious, powerless, sad, or desperate. The relationship of the caregiver with the eating disorder patient had also changed. Caregivers were more worried, lost their trust, and reported more conflicts. Seventy-five percent welcomed professional support (*Eat Disord* 2005; 13:345).

To help caregivers combat such stress, a team of British researchers have proposed a cognitive interpersonal maintenance model of eating disorders. The program is Expert Carers Helping Others (ECHO). This cognitive interpersonal maintenance model provides a theoretical basis for intervention, according to Dr. Elizabeth Goddard and colleagues at Kings College, London (*Br J Psychiatry* 2011; 199:225). The British researchers recently tested the model in a community sample of caregivers recruited from the United Kingdom between Septembers 2006 and February 2009. The participants were partners, siblings, other relatives, and friends who provide unpaid help and support for patients with eating disorders.

All caregivers were first assessed once consent was obtained; they then waited for 6 weeks and were reassessed before the actual 6-week intervention was initiated. This waiting period allowed the researchers to examine the stability of the care-giving experience over a period equivalent to the intervention period. After a second assessment, 119 caregivers were randomized to receive self-help only (ECHO) or guided self-help (ECHO). All participants were given a book and five DVDs after the second assessment. These self-help materials included information on behavior and health, identifying barriers to change, general encouragement, behavioral goals and contracts, modeling, promotes and graded tasks, self-talk, and stress-management skills. Those in the guided self-help group also received 3 additional telephone coaching sessions (approximately 40 minutes in length), plus an introductory telephone call lasting 15 to 20 minutes. Most of these sessions were delivered by two coaches, one of whom had been a caregiver herself and another who was a senior clinical nurse specializing in eating disorders.

A number of measures were used to assess caregiver distress, including the General Health Questionnaire and the Hospital Anxiety and Depression Scale. The caregivers were asked to mark which characteristics and behaviors they could identify in their loved one at that time, including severe underweight, food restriction, and excessive exercising. They were also asked to rate on a visual analog scale the proportion of DVs they watched (0= none; 10= all).

How effective was the intervention?

The aims of the exploratory study were to test the interpersonal maintenance model and to test whether telephone guidance improved the effectiveness of a self-help intervention. Caregiver distress and almost all secondary outcomes derived from the model improved after the intervention. The caregivers also reported improvements in the loved one's level of functioning and eating disorders symptoms. However, the researchers were surprised to learn that adding telephone coaching did not add additional benefits to the self-help-only intervention.

The impact of the ECHO program was greatest for caregivers with the highest levels of expressed emotion, accommodation and enabling behaviors and the lowest self-efficacy. Watching more DVDs also produced a greater reduction in expressed emotion and accommodating and enabling behaviors.

The authors note that the cognitive interpersonal model was supported by the results of this study. The skills training involved is low in cost and can be easily disseminated. Dr. Goddard and colleagues also feel that acceptability of the ECHO program could have been improved by making the training materials more attractive and salient. They note that a Phase III trial with direct measurement of eating disorder psychopathology, and using a treatment control group would be an excellent addition for the future.

Improving Patient Weigh-ins

Patients preferred accuracy to modesty in a small study.

All roads in anorexia nervosa seem to lead back to weight, and weigh-ins are an integral part of the treatment process. Yet, as Dr. Tony Jaffa and co-workers at the Cambridgeshire and Peterborough National Health Services Foundation Trust in the UK report, how patients are weighed and what they wear during weigh-ins vary greatly (*Eur Eating Disord Rev* 2011; 19:368). So, Dr. Jaffa and other researchers designed two anonymous website-based surveys to ask ex-patients and eating disorders professionals what they preferred.

Twenty ex-patients and 98 professionals responded. Both groups were more concerned with accuracy than with privacy. Patients preferred being weighed in underwear as opposed to street clothing. When the professionals explained their policy for what patients wore when being weighed, most were primarily concerned with obtaining an accurate weight and only 9% thought that accuracy was less important. A fourth of professionals sought privacy, dignity, and the patient's comfort over accuracy.

More than half of the former patients who were weighed in underwear reported feeling comfortable with the way they were weighed versus 26% of those who preferred being weighed in normal clothing. Ninety percent of patients were concerned with accuracy or preventing falsification of weight, while 70% were concerned with privacy and dignity. Of those who voted for weighing in underwear, about a fourth felt that a light garment such as a t-shirt or hospital gown could be worn over the top if more comfortable. No patients recommended weighing in normal clothing. Interestingly, as outpatients, about half were weighed in their underwear.

Between 30% and 57% of patients reported falsifying their weight during treatment. The lowest rate was 30% on the authors' inpatient unit, 47 % in general practices, 50% on medical pediatric wards, and 57% in outpatient settings.

Brief Motivational Intervention for People with Eating Disorders

Can education and counseling increase readiness for change?

Patients with eating disorders are often ambivalent about recovery, and readiness for change is not always present. In fact, refusing treatment, dropping out of therapy, and relapse are all too common among patients with eating disorders.

Josie Geller, PhD, and colleagues in Vancouver and Honolulu tested a brief motivational program to see if education and counseling could increase readiness for change. The program, termed Readiness and Motivation Therapy (RMT) is a five-session individual preparatory intervention (*Int J Eat Disord* 2011; 44:49).

Motivational Interviewing was originally developed for use in patients with alcohol and substance

abuse and is designed to increase clients' willingness to engage in future treatment, which may be extensive. The approach has been adapted for many other populations, including individuals with obsessive-compulsive disorder, suicidality, and for pathological gamblers.

The Readiness and Motivation Interview is a semi-structured interview that assesses an individual's degree of pre-contemplation (not wanting to change), contemplation (thinking about change), or action/maintenance (actively working to reduce or maintain change to eating disorders behaviors).

Subjects in the study were recruited from a tertiary care Canadian eating disorder treatment program when they were first referred to the treatment center. After the initial assessment, 181 individuals who met the study criteria were randomly assigned to a treatment group (5 sessions of RMT; n=57) or to a wait-listed control group (n=56). If at any time a patient became psychiatrically or medically unstable, she (or he) was withdrawn from the study.

RMT Therapy

Participants first completed the Readiness and Motivation Interview and measures of eating disorder symptoms, self-esteem and psychiatric symptoms at intake. RMT treatment involved study therapists who were clinical psychologists, counseling psychologists, and nurse clinicians. These therapists were trained by two of the authors of the study, and read the study manual and listened to tapes of pilot sessions. The therapists were then supervised while conducting five sessions of RMT with pilot participants. The sessions were then tape-recorded and reviewed to make certain that the therapists were adhering to the study protocol.

Patients in the treatment group were provided with five 1-hour sessions given once a week. The first session was designed to increase the participants' understanding of the eating disorder and to help them decide what, if anything, they wished to change. In the second session, participants were provided with detailed feedback from their research assessment about their eating disorder and psychiatric symptoms, quality of life, biological complications, self-esteem, and readiness for change. The third session focused on increasing the patient's awareness and understanding of the purposes that the eating disorder served in their lives. Personal strengths were highlighted in this session. At the fourth session, participants were invited to identify their personal values and encouraged to explore what, if any, changes would be needed for them to live according to these values. At the fifth and final session, participants were encouraged to reflect on their experience of the previous sessions. Possible next steps, which might or might not include further treatment, were discussed.

During the 5-month study, the authors also tracked patients' treatment decisions. The authors found that 63% of patients received some form of individual therapy. In addition, 54% of patients saw a psychiatrist, 84% saw their family doctor, 66% visited a dietician, 84% saw a physician who specialized in treating eating disorders, 20% attended community support groups, 21% attended family therapy, and 56% took part in psychoeducational groups.

Some unexpected results

At baseline, there were no demographic variables between the two groups. The groups also did not vary in baseline readiness for change, eating disorder and psychiatric symptoms, or self-esteem. Over time, there was a significant reduction in patients' contemplation of restricting eating and an increase in restriction over time in both the RMT and control groups. Both groups had been studied with the Eating Disorder Inventory, and there was a significant reduction in EDI

composite scores (sum of drive for thinness, bulimia, and body dissatisfaction in both groups).

Improvements in readiness for change as well as in depression, drive for thinness and bulimic symptoms occurred at 6-week and 3-month follow-up in both groups, with no group differences.

The authors had not anticipated that the control group would improve. Was it the clinical setting, where most participants received some form of treatment during the study period? Or could exposure to other health care professionals have led to improvement in readiness to change? Despite the limitations of the study, the authors noted at both time points that persons who participated in RMT were significantly less likely to be highly ambivalent about treatment than those in the control condition, which suggested that RMT was especially useful in this group.

Dr. Geller and colleagues concluded that RMT may be beneficial to highly reluctant, clinically challenging patients', and may help them make better use of future, action-oriented, treatment.

Gender Differences in Eating Disorders Patients?

A study in Spain uncovers a few.

The results of two studies have provided a little more information on differences and similarities between male and female eating disorders patients.

Most studies have shown that men have clinical symptoms similar to those of women patients with eating disorders. Noting that an increasing number of males with eating disorders are being reported in Spain, Araceli Nunez-Navarro and colleagues designed a case-control study of 60 males and 60 females with eating disorders and 120 healthy controls (60 males and 60 females). Among the male patients, 10 had anorexia nervosa (AN), 25 had bulimia nervosa (BN), and 25 had eating disorders not otherwise specified (EDNOS). All had consecutively attended the outpatient department of the University Hospital of Bellvitge-IDIBELL, in Barcelona (*Eur Eat Disorders Rev* 2011; published online; DOI: 10.1002/erv.1146).

This is the first study using a large sample of male eating disorder patients compared with female eating disorder patients and a large healthy control group. This study also is assessed gender differences in diverse eating disorder subgroups. All patients were diagnosed according to the DSM-IV. The patients were also assessed with the Eating Disorder Inventory-2 "Symptom Checklist-Revised and Temperament and Character Inventory-revised, as well as other clinical and psychopathological indices. The mean age of the total sample was 24 years.

Many similarities, but a few differences

Overall, the authors found many similarities between the male and female eating disorder patients; however, there were some differences by gender. Male eating disorder patients reported a higher mean number of weekly vomiting episodes than did the women (16.4 vs. 2.9 episodes, respectively) and a lower mean frequency of laxative use than females (mean weekly frequency was 1.0 vs. 5.5, respectively). Male patients with EDNOS had had significantly fewer previous treatment sessions than did females and a higher age at onset of their symptoms than did women (20.0 years versus 17.2 years, respectively).

Decision-making by male AN patients

In a second study, Dr. Kate Tchanturia and colleagues at King's College, London, investigated

decision-making among 48 individuals with AN (19 males and 29 female patients) and 61 healthy controls (20 males and 41 females). The researchers used the Iowa Gambling Task (IGT). The IGT, originally developed to help detect decision-making impairment in patients with prefrontal cortex injuries, is a computerized assessment that is carried out in real-time and is designed to resemble real-life situations. The task involves selecting cards from four decks displayed on the computer screen. Examinees are instructed that the selection of each card will result in winning money but that, every so often, a card selection also will result in losing money. Examinees are told to attempt to accumulate as much money as possible.

Both male and female AN patients performed significantly worse than did healthy controls on the gambling task. No gender differences in IGT performance were found across groups. Overall, male patients had higher impulsivity scores than did women, but impulsivity did not predict poor decision-making performance (*Eur Eat Disorders Rev* 2011; published online; DOI:10.1002/erv.1154).

The authors concluded that both males and females with AN have impaired decision-making capabilities. Their data suggest that male patients with AN are very similar to female patients in decision-making and as a result treatment approaches to improving decision-making should be similar for both genders.

Unusual Sunburn in Two Patients

A necklace-like pattern pointed to malnutrition and anorexia nervosa.

After only about 10 minutes of exposure to the sun, a 38-year-old woman noticed erythema with a burning sensation on her hands and calves. An 18-year-old woman was alarmed at erythema on her face and neck after only a few hours of exposure to the sun. In both cases, the women were found to have anorexia nervosa (AN) (*J Dermatol* 2011; 38:1037).

According to her husband, the 38-year-old woman had been rigidly dieting and using laxatives. When she was seen for the sunburn, she had a body mass index (BMI) of only 10.8 kg/m². Acute liver damage was suspected. She refused hospitalization and psychiatric consultation. She died shortly afterward and an autopsy pointed to malnutrition. The 18-year-old was also severely malnourished, and had lost 12 kg of weight over the previous month. She was treated with a topical steroid, and returned the next summer with the same pattern of sunburn. When she was seen again, her BMI was 14.2 kg/m². At follow-up, she was being treated and was struggling to regain weight.

In both women, the unusual skin eruptions were related to malnutrition-related pellagra, which is characterized by sunburn-like erythema with blistering, hyperpigmentation, and peeling in exposed areas. The clinical presentation in such cases will show a variety of abnormalities, including a classic "necklace-like" pattern of sunburn. In these two cases, erythema followed the clavicles and resembled a necklace-different from the usual pattern of sunburn that covers the entire chest. Pellagra-related skin changes or "sunburn" of this nature is considered to be due to phototoxicity. Although the mechanism is not fully understood, according to the authors, it may result from a deficiency of urocanic acid, which absorbs ultraviolet light.

Dr. Mami Sato and colleagues note that sunburn-like skin changes such as these may compel malnourished patients who do not know they have AN to seek treatment. For general physicians, pellagra-like dermatitis in a very thin patient may be a serious sign, and psychiatric consultation is warranted.

BOOK REVIEWS: *Eating Disorders and the Brain*

(Bryan Lask and Ian Frampton, Wiley, Hoboken NJ, 2011, 254 pages, 2011, \$92.95. ISBN: 978-0-470-67003-3.)

Bryan Lask, an eminent British professor of child and adolescent psychiatry, and his colleague Ian Frampton, a distinguished neuropsychologist, are to be commended for pulling together this timely, erudite, and occasionally provocative volume. The international contributors they've engaged in this effort elegantly summarize what we currently know about structural and functional aspects of the brain and related genetic, neurochemical, and neuropsychological processes associated with eating disorders. Then, they offer tantalizing glimpses of how everything ties together.

For decades, perhaps more commonly in recent years, eating disorders experts have pondered whether eating disorders are "brain diseases"; the extent to which eating disorders reflect choices based on 'free will'; the extent to which eating disorder symptoms may be epiphenomenal to underlying brain processes; the extent which abnormal brain processes in eating disorders stem from genetic and early developmental processes and/or result from the more acute stressors imposed upon them by patients' acute nutritional and behavioral abnormalities; how all the bio-psycho-social-developmental systems levels presumed to contribute to the etiology and pathogenesis of eating disorders inter-relate; implications of these understandings for treatment; and related concerns.

While these thoughtful authors can't definitively answer all of these questions, they grapple earnestly with the issues. Well written and well edited, nicely balanced between academic reviews and integrative theoretical syntheses, the readable chapters will inform readers who lack deep knowledge about biological aspects of eating disorders as well as those who are better informed. Chapters are scholarly without being stuffy, and contributors summarize pertinent studies in structural and functional neuroimaging, neuropsychology, and the neuroscience of body image.

Two chapters that I found particularly stimulating bear mention. The first is a broad-ranging, sometimes speculative, inquiry and discussion of "Why clinicians should love neuroscience: the clinical relevance of contemporary knowledge." Here David Wood contemplates far-ranging issues, starting with mind-body dualism, free will and determinism; and vertical etiological dimensions from genes and neurotransmitters through trauma and attachment, including implications of neuroscience for psychoanalytic observations, and implications of psychoanalytic observations for neuroscience research. He also addresses spatial "horizontal" etiologic systems dimensions encompassing neuroscience and individual psychology through families, social systems, and cultural concerns.

The second, perhaps lynchpin, chapter of the book, by Kenneth Nunn, Bryan Lask, and Ian Frampton, considers, contrasts, and compares recent conceptual models bridging neuroscience and clinical eating disorders research. Included are a neurodevelopmental model for anorexia

nervosa proposed by Connan et al.; a model translating experimental neuroscience into clinical practice proposed by Southgate et al; a habit-learning, cognitive neuroscience hypothesis for anorexia nervosa proposed by Steinglass and Walsh; a neuroscience model focusing on the role of the insula by Nunn et al; models involving functional disturbances in frontostriatal circuits proposed by Marsh et al; insights into symptoms and neurocircuits for anorexia nervosa proposed by Kaye et al; and a multifaceted integrative neuroscience model for anorexia nervosa proposed by Hatch et al. The models are then compared along frameworks for investigation corresponding to the recently promulgated NIMH Research Domain Criteria.

A novel chapter discusses implications for patients and families of understanding neurobiological models (more accurate attributions resulting in less stigma, shame and blame, for example), including changes in the patient's self-representations. Beyond these are questions concerning the commercialization of biomarkers (beware the scams) and issues concerning participation in genetic and neuroscience research. Treatment implications include educating patients and their families about brain biology and eating disorders, and an excellent review and update on cognitive remediation therapy. Frampton and Lask cap the book with an uplifting and visionary summary and push toward the aforementioned NIMH Research Domain Criteria. We're looking forward to "connectomics."

Anything here that's new to you? I certainly found lots new to me. For serious eating disorders clinicians as well as academicians, there's much in this book to study and ponder.

— JY

Q & A: A Patient Disgusted by the Sight of Food

Q. One of my patients with anorexia nervosa describes to me not only that she doesn't want to eat because she's fearful of gaining weight, but that the sight of food positively disgusts her. Is this a characteristic feature of anorexia nervosa? Does this have any clinical implications? (P.R. Des Moines, IA)

A. Although not ubiquitous among patients with anorexia nervosa (AN), the feeling of disgust toward food is certainly a common-enough finding (*Eur Eat Disord Rev*; 2011 Jul 25. doi: 10.1002/erv.1124). Studies of disgust sensitivity in patients generally, but not always, find that patients with AN show greater disgust sensitivity than do controls, especially in the domain of food (*Int J Eat Disord* 2000; 27: 446). Of note, disgust sensitivity has been associated with obsessive-compulsive disorder, particularly among patients whose major symptoms concern contamination fears.

Neuroimaging correlations involving the insula, an area of the brain implicated in processing the emotions of disgust, have been associated with these findings, suggesting a specific neurophysiological basis for this phenomenon (*Metab Brain Dis* 2006; 21:267). Conceivably, AN patients with comorbid obsessive-compulsive disorder (a sizable minority of patients) are more prone to feelings of disgust than are others. Patients with such aversions may also develop conditioned disgust, for example when specific foods have been associated with serious illness and vomiting. One of us (W.V.) has seen such a case, when specific foods were associated with forced oral sex. You might want to assess your patient for the presence of co-morbid obsessive-compulsive disorder and for a history of events that might possibly relate to disgust-associated

conditioned responses.

— JY, WV

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