I am excited to announce that we are near our final recruitment goals for the “Eat Study!” As I write this article, we are working to recruit our final ten participants into the study, to reach our final goal of 250 participants. I cannot thank our participants enough for their amazing commitment to contributing to scientific knowledge of disordered eating behaviors. As you will see from the rest of this newsletter, contributions from our participants have enabled our center to conduct cutting-edge research that will likely lead to improvements in how disordered eating is diagnosed. I also want to take this opportunity to thank our dedicated group of research assistants and clinical interviewers. Managing a study of this size and scope has been a big undertaking, and they have shown a strong commitment to making the study as pleasant as possible for our participants. Thank you one and all for helping us get close to our important recruitment milestone!

—Kelsie Forbush, Ph.D.

We will be contacting some persons who participated in the “Eat Study” for a new study that is designed to identify the biological mechanisms that contribute to eating disorder symptoms. Specifically, our new study will test brain circuits that are associated with reward, sadness, and anxiety. We will test how these brain circuits interact with a stress hormone called ‘cortisol.’ This study will be conducted at the Hoglund Brain Imaging Center in Kansas City, Kansas. We plan to start recruiting participants in late May or early June. Participants will receive $100 for their time (and reimbursement for mileage), and also get a picture of their brain!
A New Approach to Diagnosing Eating Disorder Behaviors

One of the main reasons that we started the “Eat Study” was due to problems with how eating-disorder behaviors are currently diagnosed. We had an ambitious goal to see if we could come up with a new diagnostic system that would be more compatible with how people experience eating disorders in the “real world,” by using cutting-edge statistical methods to reinvent the way eating disorders are diagnosed.

How are Eating Disorders Currently Diagnosed?

The diagnostic criteria for eating disorders (like most other mental illnesses) are decided by a group of experts who form Work Groups that debate important issues and come to a consensus about how to diagnose each eating disorder. For example, the *DSM-5* Work Group met for several years and debated issues such as: 1) how many times per week does a person need to engage in a disordered eating behavior to warrant a diagnosis; 2) how many symptoms does a person need to meet diagnostic criteria for each eating disorder; and 3) should binge-eating disorder be included as an official eating disorder category. The *DSM-5* Work Group for eating disorders did a great job in many ways. On the other hand, there are still a lot of problems with how eating disorders are diagnosed. These include: 1) high diagnostic migration among different types of eating disorders (i.e., people “bounce” over time among eating disorder diagnoses without recovering); 2) high rates of “other” specified eating disorders; 3) limited scientific basis for determining the number of symptoms a person needs in order to meet criteria for a diagnosable eating disorder; and 4) exclusion of mood and anxiety issues that we know contribute to the development and maintenance of eating disorders.

How is the “Eat Study” Changing the Way Eating Disorders are Diagnosed?

We used a statistical method that grouped symptoms together to form dimensions of eating, mood, and anxiety concerns. A key way that our model is different from the traditional diagnostic system is that our model is dimensional, so people can range from low to high and anywhere in between for each dimension. This is different from the traditional categorical model (either you have a disorder or you do not). Instead of anorexia nervosa, bulimia nervosa, binge eating disorder, and “other specified” eating disorder, we found two broad eating-disorder dimensions characterized by binge-eating problems and weight “phobia” problems. One thing that was really important is that we found that the binge-eating dimension was closely linked to problems with body dissatisfaction, self-consciousness, social anxiety, and insomnia. Weight phobia was closely tied to restricting, purging, excessive exercise, trauma history, obsessive-compulsive disorder, claustrophobia, and panic. We tested our model compared to the traditional system to see which method better predicted impairment related to an eating disorder. We found that our new approach predicted 38.2% of impairment related to an eating disorder, whereas the traditional approach predicted just over 10%. This was a statistically significant result and we are very excited about this!

What is Next for the “Eat Study?”

We are still testing participants so that we have enough people in the study to look at our model and predictors of impairment over time. This will help us determine whether our new approach is more stable than the current system and whether we do a better job than the traditional diagnostic system of predicting whether people recover or stay ill. Stay tuned for more updates as we continue the follow-up portions of the study!
To accurately assess eating disorder behaviors and track symptom changes over time, it is important to use tools that are stable. Unstable measures make understanding patterns of symptom change difficult. We completed a study that tested the six-month stability of the Eating Pathology Symptoms Inventory (EPSI). The EPSI is a measure Dr. Forbush and her team created that is now being used across the United States to measure disorder eating!

All seven subscales of the EPSI were significantly correlated at baseline and six-month follow-up. This suggests that changes in EPSI scores likely reflect true eating disorder symptom change.

Danielle Chapa is working on a research project that she will present at the upcoming International Conference on Eating Disorders. Danielle was interested in understanding dietary restricting (i.e., limiting the types or amounts of foods being consumed to lose weight, maintain low weight, or compensate for binge-eating episodes). Dietary restricting is a prevalent eating disorder symptom (approximately 29% of first year “Eat Study” participants reported restricting their intake), so it is important that we understand the effects that it might have on an individual’s well-being and behaviors. The purpose of this study was to test which definition of dietary restricting was most highly associated with clinical impairment and binge eating in a sample of 204 adults from the “Eat Study.” Results indicated that participants who engaged in dietary restricting behaviors for 24 hours were significantly more clinically impaired compared to those who restricted for eight hours or less. Length of dietary restricting was also significantly associated with number of binge-eating episodes (i.e., going for longer periods of time without eating or eating very little was associated with more frequent binge-eating episodes). Our findings suggest that reducing dietary restricting may help improve well being and lead to fewer over-eating episodes. In other words, people should focus on eating healthy foods throughout the day and avoid long periods of not eating.

Less than half of individuals with eating disorders never receive treatment for their eating-related problems. We completed a study that asked the question, “What promotes treatment seeking in people with eating disorders?” We used data from a large, nationally representative sample of approximately 600 people with eating disorders. We found that family/friend support was positively associated with treatment seeking (i.e., good family/friend support made it more likely that a person with an eating disorder would seek treatment). We also found that having a recent diagnosis of bulimia nervosa was associated with a higher likelihood of seeking treatment among Hispanic persons. To our knowledge, this is the largest study to examine factors related to treatment seeking in people with eating disorders. Our results suggested that emphasizing the family unit in the treatment of eating disorders might be beneficial for promoting recovery, and that improved eating disorder education and outreach to healthcare professionals about eating disorders in Hispanic persons is needed.

What Leads People to Seek Treatment for an Eating Disorder?

How Should We Define Dietary Restricting?
Other Brain Research

Dr. Forbush is collaborating with Dr. Laura Martin at the Hoglund Brain Imaging Center on some additional research projects. These projects will test: 1) brain regions and neurochemicals that we hypothesize lead people to develop chronic forms of anorexia nervosa and 2) how the medication Vyvanse works in the brain to reduce binge eating. These projects are currently being reviewed by grant-funding agencies. Keep your fingers crossed that we will receive funds to carry out these studies so that we can continue our work to better understand what leads people to stay “stuck” or recover from an eating-disorder problem.

Contributing to the Center for the Advancement of Research on Eating Behaviors (CARE)

Our center depends on the contributions of donors and funding agencies to conduct our cutting-edge research on eating and weight disorders. If you are interested in making a charitable donation or monetary gift to CARE, please contact Elizabeth Buckland at the University of Kansas Endowment and mention CARE in your email or phone message. Ms. Buckland can be reached at 785.832.7477 or bbucklin@kuendowment.org.