# For Some Bulimia Patients, Try E-Mail Therapy

BY KATE JOHNSON
*Montreal Bureau*

MONTREAL — Psychotherapy for eating disorders can be delivered effectively by e-mail and can reach a segment of the population that might otherwise decline treatment, Paul Robinson, M.D., said at an international conference sponsored by the Academy for Eating Disorders.

He recruited 97 participants with eating disorders from a university e-mail list for his study. The diagnoses of bulimia nervosa, binge-eating disorder, and eating disorders not otherwise specified (EDNOS) all fulfilled DSM-IV criteria and were made using online questionnaires and assessments.

Roughly 80% of the cohort had received no previous treatment for their eating disorder, said Dr. Robinson, a psychiatrist with the eating disorders service of Royal Free Hospital, London.

"They were a population of people who don't approach mental health care or any sort of health care, and they said they wouldn't have done so if it hadn't been for this program," Dr. Robinson said in an interview.

Study participants were randomized to e-mail bulimia therapy (EBT), to self-directed writing (SDW), or to a treatment waiting list, which was the control, he said.

The EBT group (36) received 12 weeks of e-mail therapy from professionals who were experienced in the outpatient management of eating disorders. Participants were asked to write twice weekly in a food, behavior, and emotions diary, to which the therapists responded.

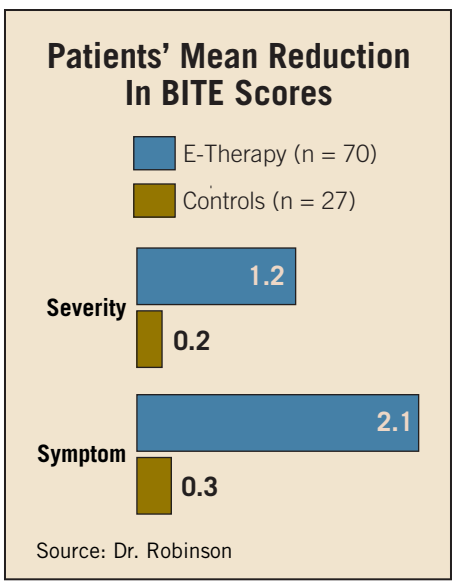
"We looked at the diary and annotated it with our own comments," said Dr. Robinson. "For example, if a patient wrote that she had eaten nothing for breakfast or lunch and then binged in the evening, we might have responded by saying that eating nothing all day might be triggering the binge at night," he said.

Participants in the SDW group (34) were asked to write about their eating disorder and e-mail their comments to Dr. Robinson twice a week, although he acknowledged the e-mails he sent did not offer specific counseling to this group.

"They knew I was reading [their comments], and they knew that if I thought they were in danger I would act, and I think that was important to them," he said.

Participants in the control group (27) waited 12 weeks and were then randomized to either EBT or SDW.

At the 12-week assessment, the e-mail therapy and SDW groups were combined into one "E-Therapy" group and compared with the control group.




The results showed that, while none of the control participants lost their eating disorder diagnosis, 18.6% of the E-Therapy group did.

Assessments using the Bulimic Investigatory Test, Edinburgh (BITE), severity and symptom scores showed a mean reduction in BITE severity score of 1.2 in the E-Therapy group, compared with a reduction of 0.2 in the control group. Similarly, the mean reduction in the BITE symptom score was significantly greater in the E-Therapy group (2.1 versus 0.3).

When asked about their desired body mass index (BMI), participants who had completed the e-mail therapy indicated that they were more willing to accept the idea of a higher BMI than were those participants in the control group.

There was a significant correlation between the number of words a participant wrote and the degree of symptom improvements in the e-mail bulimia therapy group only, Dr. Robinson said.

"It is hard to explain the response in the self-directed writing group, although there is quite a lot in the literature about the therapeutic efficacy of writing, and how it can lower depression scores," he noted.

Although the study found no difference in outcome between EBT and SDW, there was a trend in favor of EBT. "In a bigger study, I would expect and hope that therapy patients would do better," he said.

E-mail therapy was well accepted by the participants, with 84% saying that they would be willing to engage in further therapy either online or face to face. There also was a feeling among therapists that this form of therapy took about half the time of traditional therapy, although it was not measured, Dr. Robinson said. ■

# Vicious Circle of Comorbidity Links Medical, Mental Illness

BY CARL SHERMAN
*Contributing Writer*

NEW YORK — Schizophrenia and bipolar disorder pose a triple health threat: The conditions themselves are associated with a higher prevalence of serious medical illness, some drugs used to treat them increase disease risk, and affected individuals are likely to have inadequate medical care, Ilise D. Lombardo, M.D., said at a conference on schizophrenia sponsored by Columbia University.

The unhealthful influence is bidirectional: The psychiatric course tends to be worse in individuals with chronic medical conditions or medical risk factors like obesity. (For example, a survey of 1,379 bipolar patients found that 44% had comorbid medical conditions and linked the presence and severity of medical problems to the severity of the psychiatric disorder.)

"Psychiatrists should monitor risk factors, coordinate care with internists, and involve families in medical issues," said Dr. Lombardo of the university.

Serious mental illness is life-threatening: The rate of mortality from natural causes among patients with bipolar disorder and schizophrenia is double that of the population as a whole; for unipolar depression, the mortality rate is 1.5 times that of the general population. Cardiovascular disease and, to a lesser extent, endocrine disorders are mainly responsible for the higher rates.

**'If a patient with schizophrenia is hospitalized with chest pain, he is less likely to have aggressive cardiac care and more likely to die of a myocardial infarction.'**

This increased mortality is not surprising in light of the high prevalence of cardiovascular risk factors in the psychiatric population, Dr. Lombardo said.

Among patients with schizophrenia, 18% have elevated total cholesterol levels, 20% have hypertension, 75% smoke cigarettes, about 50% are overweight or obese, and 72% are sedentary.

An estimated 30%-60% of schizophrenia patients have metabolic syndrome—a constellation of abdominal obesity, lipid abnormalities, and abnormal glucose metabolism that triples the risk of dying of a myocardial infarction, Dr. Lombardo said at the meeting, which was cosponsored by the New York State Psychiatric Institute.

But although the medical needs of people with severe and persistent mental illness would appear to be greater, they "have less access and less quality medical care," said Dr. Lombardo, who is also medical director for Pfizer Inc.

A review of 175,653 patients in Veterans Affairs medical centers in Southern California and Nevada found a highly significant association between a diagnosis of schizophrenia and fewer physician visits. Two-thirds of schizophrenia patients did not have such prevalent conditions as diabetes, hypertension, or chronic obstructive pulmonary disease listed among their medical diagnoses.

"If a patient with schizophrenia is hospitalized with chest pain, he is less likely to have aggressive cardiac care and more likely to die of a myocardial infarction," Dr. Lombardo said.

Obesity, a risk factor for both diabetes and cardiovascular disease, is highly prevalent among patients with both schizophrenia and diabetes. In one study of 114 new-onset patients with schizophrenia, the mean body mass index at the time of diagnosis was 24.5 kg/m$^2$—the upper limit of normal. After 1 year, mean body mass index in these patients had climbed to 27.5, within the obesity range. "Most weight gain occurred in the first 6 months," she said.

"Is it due to the illness itself, lifestyle changes related to the psychological burden of the illness, or treatment? There is good evidence that all three are involved," Dr. Lombardo said.

The problem is at least as pronounced in bipolar disorder: A study of 644 patients found that 60% were overweight, 20% were obese, and 5% were "extremely obese."

Not only is being overweight associated with an increased risk of hypertension, arthritis, and diabetes, it apparently has negative psychiatric consequences as well. In one group of bipolar patients, time to relapse was significantly shorter among the 46 who were obese than among the 79 who were not. In 20 weeks, 30% of the obese patients had relapsed, compared with a negligible number of the nonobese.

In a study of individuals with schizophrenia, 26% of normal-weight patients were noncompliant with treatment, compared with 39% of overweight and 47% of obese patients, Dr. Lombardo said. ■