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Personality and eating disorders

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Abstract

Objectives of review. The objective of this chapter is to examine the current state of research on personality traits, personality disorders, and personality subtypes in eating disorders (EDs).

Summary of recent findings. Personality pathology, whether relatively mild or severe, is notably ubiquitous in ED patients. Patients with EDs tend to have problems with negative affect, whether linked with perfectionism, acute obsessivity, and overcontrol of impulses and emotions (often seen in restricting anorexia); or with emotional dysregulation, rejection sensitivity, and uncontrolled outbursts and emotions (often seen in patients with bulimia symptoms with or without anorectic features). Data using several methods have converged on three personality subtypes that appear to cut across different ED diagnoses, but have implications for understanding and treating patients with EDs.

Future directions. Although data are converging on several key constructs in the study of personality in EDs, different measures may be tapping different constructs or subconstructs, suggesting the need for research employing a range of measures of similar constructs in the same sample. Given the ubiquity of personality pathology in EDs and data suggesting that personality may moderate treatment response, it would seem prudent for all treatment research on EDs to assess personality carefully and to consider personality variables when constructing treatments for EDs.
Introduction
The earliest systematic clinical accounts of eating disorders (EDs) in the 1970s suggested a link between personality and EDs. Empirical developments in the study of EDs and of psychopathology more broadly (Krueger 2002; Kendler et al. 2003; Westen, Gabriëls and Biebiov in press) have recently borne out the importance of studying psychopathology in the context of personality. However, characterizing the precise nature of the link between personality and EDs poses a number of challenges.

Causal arrows linking eating and personality can run in multiple directions (see Bloks et al. 2004; Lilienfeld et al. in press; Sjöce et al. in press). Personality could predispose individuals to EDs; EDs could affect personality (e.g., patients with anorexia nervosa (AN) could become more obsessional while starving); or personality and eating pathology could mutually influence each other. Although the evidence is not definitive, and the causal arrows are surely multidirectional, personality variables do appear to represent diatheses for EDs. Recent prospective studies implicate neuroticism and its close cousins, negative emotionality (Ghaderi and Scott 2000; Sjöce 2002; Cervera et al. 2003), obsessive-compulsive personality features (Lilenfeld et al. in press); impulsivity (Wonderlich et al. 2004), perfectionism (Bloks et al. 2003; Sherry et al. 2004), and poor interoceptive awareness (Lilienfeld et al. in press) as risk factors for EDs. Further research is necessary, however, to establish both the temporal relations and precise processes through which personality processes contribute to disordered eating (see Wonderlich et al. 2006a,b).

In this chapter we review three primary ways in which researchers have conceptualized and studied personality in EDs. We then discuss the clinical implications of recent research. We conclude by discussing future directions.

Literature review
Personality refers to enduring patterns of cognition, emotion, motivation, and behavior that are activated over time or circumstance. These patterns may express themselves in many situations (e.g., a tendency to feel inadequate) or may repeatedly express themselves only under certain very specific conditions (e.g., a tendency to choose troubled or inappropriate romantic partners). Researchers have conceptualized and studied personality in EDs in three ways, focusing on personality traits, disorders, and subtypes. We examine each in turn.

Personality traits
Traits are emotional, cognitive, and behavioral tendencies on which individuals vary (e.g., the tendency to experience negative emotions). Researchers studying personality traits in EDs tend either to focus on traits first observed clinically in ED patients or to compare different kinds of ED patients using trait dimensions assessed in omnibus personality inventories.

Three clinically observed personality traits – perfectionism, impulsivity, and anxiety – have been associated with disordered eating (Steiger et al. 2002). When compulsive patients, impulsivity may overlap with AN patients (e.g., Vail 2004). A widely studied subtype, bulimia nervosa, is a cultural syndrome that varies across cultural contexts. Empirically, multi-dimensional personality disorder (Nixon 2002). The culturally modular nature of personality disorder means that it can be more impulsive, and it is associated with lower levels of empathy and poorer self-regulation. Studies using a non-clinical sample of Japanese show that AN also had a greater impulsivity and lower empathy than healthy controls. Emerging research focuses on the role of personality in AN patients and in compulsive eating.

Emerging research questions about the role of personality in AN patients and in compulsive eating.

Personality disorder
A second way in which personality disorders are studied is by assessing personality disorders and personality traits.
Benjamin et al. (1969) in their study of eating disorders (EDs) in the 1970s described developments in the 1980s: Kendler et al. (1997) went on to identify the role of personality. However, personality and EDs are complex and multiple directions exist. Personality could be considered as a level indicator of EDs. Recent prospective studies have found significant associations between perfectionism and EDs. For example, studies have reported a strong correlation between perfectionism and the development of EDs (Anderluh et al. 2003). Although the data are not yet conclusive, it is suggested that a causal relationship between perfectionism and EDs exists. This relationship is significant for the understanding of EDs, as it may provide insight into the etiology and prevention of EDs.

Three clinically observed traits have received substantial empirical attention. Two - perfectionism and obsessiveness - were first identified in AN patients, and one - impulsivity - in bulimia nervosa (BN) patients. Studies have consistently reported a significant contribution of EDs and obsessive-compulsive disorder (OCD). Obsessional-compulsive personality traits in childhood are highly predictive of subsequent ED development (Anderluh et al. 2003). Although the data are not yet conclusive, it is suggested that a causal relationship exists between perfectionism and EDs, as a number of studies suggest that the perfectionism trait predicts and increases the risk of ED development (Anderluh et al. 2003). Compulsive and inhibited traits in ED patients also appear to be associated with distinct biological correlates, particularly in serotonergic functioning (Steiger et al. 2003; Bruce et al. 2004).

Whereas compulsiveness has been most frequently identified in anorexia patients, impulsivity is more common in bulimia patients than in patients with other restricting EDs (e.g., Vervaet et al. 2004). Obsessive-compulsive traits in bulimia have been linked to binge eating, whereas impulsive patients only binge and purge. Externally, patients with anorexia nervosa and obsessive-compulsive disorder (OCD) may display several forms of impulse control behaviors (e.g., stealing, substance abuse) in addition to binge eating. This raises questions about whether impulsive patients only binge and purge.

Exams and intelligence quotient (IQ) are important factors in the development of EDs. For example, patients with AN have higher IQs than healthy controls. In addition, patients with AN have lower scores on subscales of intelligence, which suggests that anorexic patients may have lower intelligence. However, this relationship is not consistent across studies.

Research on which individuals are at risk for EDs is important in identifying potential EDs. Research has shown that there is a strong correlation between perfectionism and EDs, particularly in AN patients. These results have been replicated in other studies, indicating that perfectionism is a significant risk factor for the development of EDs. However, the relationship between perfectionism and EDs is complex, and further research is needed to fully understand the role of perfectionism in the development of EDs.
Statistical Manual of Mental Disorders, 4th edition (DSM-IV), Whereas Cluster A (odd- eccentric) diagnoses are frequent in ED samples, Cluster C (anxious- fearful) disorders are frequently observed in AN patients, and Cluster B (dramatic- erratic) in BN patients. Research suggests that Cluster C PDs are the most common among patients with all ED diagnoses, while Cluster B disorders are only present in those with bulimic symptomatology (Ilkjaer et al. 2014).

Borderline personality disorder is particularly common among binge-purging AN and BN patients (Skodol et al. 1993; Braun et al. 1994; Vitousek and Marke 1994). Conversely, EDs are very common in BPD samples. A recent prospective follow-up study of 290 BPD patients (Zanarini et al. 2004) found that, within six years of initial BPD diagnosis, 34% had met the criteria for a specific eating disorder and an additional 28% for eating disorder not otherwise specified (EDNOS). Among those whose BPD had remitted at six-year follow-up, rates of eating pathology declined from 55% to 26%. For nonremitting BPD patients, EDs were relatively stable (approximately 50%).

Personality subtypes

Research on axis II comorbidity in EDs tends to echo both the consistencies and inconsistencies in the literature using other personality constructs, such as traits (see Milos et al. 2003, 2004). Patients with AN, particularly restricting AN, tend to be avoidant (i.e. higher in negative affectivity and harm avoidance, and lower in extraversion) and obsessive (higher on rigidity, constraint, and compulsivity). Patients with BN are more likely to have borderline features (including negative affectivity, impulsivity, and introversion), although in some samples they are distinguished from other ED patients by their relative freedom from personality pathology. Complicating matters, binge-purging AN patients sometimes resemble AN patients and sometimes resemble BN patients, and most ED patients (cross over) from AN to BN or vice versa at some point in their lives (Eddy et al. 2002), raising questions about how the two classes of ED could have differing personality profiles.

The combination of consistency and inconsistency in the literature has led to the hypothesis that patients with similar ED diagnoses may be heterogeneous vis-à-vis several distinct personality styles, that only imperfectly map onto DSM-IV ED diagnoses (Westen and Harden-Fischer 2001). Several research groups have attempted to cluster ED patients empirically based on personality data, and a convergence across methods has begun to emerge (Goldner et al. 1999; Westen and Harden-Fischer 2001; Espelage et al. 2002; Thompson-Brenner and Westen 2005c; Wonderlich et al. 2005a). Although it is unclear to what extent patients classified using one instrument map onto those classified using a different measure, studies have generally identified three personality styles common among ED patients. The first is a high functioning style, sometimes allied with perfectionism and negative affectivity (Westen and Harden-Fischer 2001, Wonderlich et al. 2005a); this style is most commonly seen in a subset of BN patients. The second is a constricted, emotionally restrictive style, most commonly observed in AN patients, and, with or without bulimic symptoms. Perfectionism and negative affects are often seen in patients with eating disorders (Agras 1999; Crits-Christoph et al. 2000). The third is an interpersonal style, in which, in addition to the eating disorder, higher levels of depression, anxiety, and self-esteem, and low self-esteem. Most recently, patients with eating disorders, and negative affects are often seen in patients with eating disorders (Agras 1999; Crits-Christoph et al. 2000). The third is an interpersonal style, in which, in addition to the eating disorder, higher levels of depression, anxiety, and self-esteem, and low self-esteem.
Whereas Cluster A disorders (such as paranoid and schizoid personality disorders) differ from Cluster B disorders (such as antisocial personality disorder) in terms of patterns of thought and behavior, Cluster C disorders (such as avoidant and dependent personality disorders) are characterized by excessive concerns with interpersonal or social situations, leading to feelings of vulnerability and anxiety. Cluster D disorders (such as major depressive disorder) are characterized by a range of symptoms including depressed mood, loss of interest or pleasure, fatigue, and cognitive impairment. Cluster E disorders (such as bipolar disorder) are characterized by extreme fluctuations in mood and energy levels. Cluster F disorders (such as developmental disabilities) are characterized by impairments in the development of language, social skills, or other abilities.
The dietary-negative affective group (43%) was again characterized by higher levels of personality disturbance. As with personality pathology in EDs more generally, however, some of the elevations observed by Grilo appear somewhat inconsistent. For example, the dietary-negative affect group showed elevations in a set of scales reflecting anxious, avoidant, or internalizing pathology (e.g., inhibition, introversion, deficit) as well as other scales suggesting impulsive or externalizing pathology (e.g., oppositionality, borderline PD) (Grilo 2004). It may be that these apparent contradictions would be resolved by a three-cluster rather than a two-cluster solution, which distinguishes more disturbed patients with negative affectivity who are either constricted and overcontrolled from those who are impulsive and undercontrolled.

Summary of important findings

Personality pathology, whether relatively mild or severe, is nearly ubiquitous in EDs. Patients with EDs tend to have problems with negative affect, whether allied with perfectionism, anxious obsessivity, or the kinds of self-hating, rejection sensitivity, and abandonment fears characteristic of patients with BPD. ED patients also tend to struggle with impulse and affect regulation. Some overregulate their feelings, desires, and impulses; this is the case with many patients with the AN, restricting type. Others under-regulate, or have difficulty putting the brakes on their feelings, desires, and impulses; this appears to be the case with a substantial minority of patients with bulimic symptoms, whether diagnosed with BN, AN, binge-purge type or ED NOS. Data on personality subtypes suggest that we should not assume a one-to-one correspondence between symptoms and personality, and should correspondingly expect that the same disorder (e.g. BN) could be associated with both undercontrol and overcontrol, depending on sample characteristics (e.g. college student samples, where we might expect more high-functioning patients among those with BN than in an outpatient or hospital sample). To put it another way, the heterogeneity of personality with ED diagnoses (e.g. BN, or AN, binge-purge type) may be patterned, not random.

Clinical implications

Although we focus here primarily on treatment implications, an important implication for clinical assessment should be clear: clinicians treating ED patients should comprehensively assess patients’ personality functioning as well as their eating (and other axis I) symptoms. The increasing body of literature linking personality to virtually all the disorders on axis I of DSM-IV suggests the importance of a comprehensive case formulation in treating ED and other patients.

Over the last decade, with the advent of the empirically supported therapies movement, research has focused on specific treatments for specific disorders, particularly cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT) for BN. Data from these treatments are more sparse for moderating role of IPT for BN patients. The majority of studies, including lack of power, differences across studies, and importantly, the fact that severe PDs either are comorbid with abuse and suicidal tendency (Brenner et al. 2003) or are carried by the majority of studies (particularly borderline) (Pfaus et al. 1997). Davis et al. (1997) Wonderlich et al. suggest that trait anxiety (Fredrick et al. 2003) and all the studies suggest that personality also predicts positive outcome. Research on personality in ED pathogenesis (often referred to as DFT for BN, or AN, binge-purge type) may be patterned, not random.

Abridged versions of all patients have been tested with BN (Pfaus et al. 2000, 2001). The focus here is on patients with eating disorders, their judgments and implications. DFT for BN patients can be more difficult, particularly given the role of personality for which eating disorder treatment (e.g. and Harman-Fulik et al. 2005) cases of severe, comorbid BN is an important target for reducing days of eating disorders.
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Research on personality has contributed to three new lines of research on treatment in ED patients. The first is the application of dialectical behavior therapy (DBT) to EDs. DBT is based on the rationale that emotional dysregulation is the core pathology in BPD, causing secondary disorders in identity and interpersonal functioning (Linehan 1993; Linehan et al. 2001; McMain et al. 2001). DBT includes group and individual therapy, crisis intervention, and skills training. Abridged versions of DBT (fewer sessions per week, uni-modal treatment) have been tested with BN and binge-eating disorder (BED) (Safer et al. 2001; Telch et al. 2000, 2001). These reports suggest useful modifications of the DBT protocol for patients with eating symptoms, including expanded diary, cards, nutritional education, and application of distress tolerance techniques to bodily focused judgments and impulses to binge (Wosniowski and Kelly 2003). In one study, DBT for BN produced substantial improvement, although recovery rates were not high relative to trials of CBT for BN (Safer et al. 2001). As several reviewers have suggested, research on DBT for BN and other EDs needs to identify the subgroups of patients who are most likely to benefit from DBT interventions, particularly given that many BN patients have more constrictive forms of personality for which DBT may not be as useful (Kuder et al. 2003; Weslen and Hamden-Fisher 2001). One case series has studied DBT with patients with severe, comorbid BN and BPD (Palmer et al. 2003). The therapy was effective in reducing days of inpatient hospitalization, self-harm, and ED symptoms.
although three of five patients with BN continued to meet criteria for an ED post treatment. Nonetheless, the low drop-out rate and symptomatic improvement in this very severe sample suggest that elements of DBT may be useful for the treatment of disordered BN patterns.

The second line of research in ED treatment relevant to personality is the development of enhanced, flexible, pan-disorder treatment manuals. The development of these manuals reflects the repeated observation that the relatively nonspecific diagnosis of EDNOS is the most prevalent ED in practice as well as the consistent observation of links between many forms of eating pathology and personality traits such as perfectionism, low self-esteem, difficulties with emotion regulation, and interpersonal problems (Fairburn et al. 2003). The basic formulation of BN reflected in the Fairburn et al. (1993) CBT manual (CBT-93) is that overvaluation of shape and weight drives dietary restriction; dietary restriction leads to binge eating; and binge eating leads to compensatory behaviors that in turn produce additional vulnerability to binge eating. The new transdiagnostic treatment proposed by Fairburn and colleagues supplements this formulation, suggesting that several additional deficits may help maintain ED symptoms, including mood intolerance, interpersonal difficulties, low self-esteem, and clinical perfectionism (Fairburn et al. 2003, 2004). Although these deficits are not explicitly described as personality characteristics, they meet most definitions of personality (i.e. patterns of cognition, thought, and affect that persist across time or situation). The CBT-Enhanced (CBT-E) manual, which includes optional modules for each of these four deficits, is currently being tested with a transdiagnostic ED sample. Data collected to date on CBT-E with BN suggest that the treatment produces improvement and recovery in a greater percentage of cases (72%) than CBT-93 has in prior BN samples (approximately 50%) (Fairburn 2004).

The third line of research has begun to use naturalistic data to study the influence of personality on treatments in the community (Thompson-Frederen and Westen 2005a,b,c). In a national sample of BN patients described by their treating clinician, personality subtype (dysregulated, constrained) showed systematic relations to the ways clinicians reported intervening with patients. The two most striking findings were a substantially increased use of intervention strategies associated with psychodynamic approaches among cognitive-behavioral (CBT) clinicians when working with dysregulated patients, and a shift toward more structured CBT interventions among psychodynamic clinicians when working with constriction patients. For CBT clinicians, the extent to which the patient showed evidence of dysregulation was correlated around r=.50 with their endorsement of statements such as the following: 'Helped the patient come to terms with her relationships with and feelings about significant others from the past (e.g. mother, father);’ ‘Focused on similarities between the patient's relationships (and perceptions of relationships) repeated over time, settings, or people;’ ‘Addressed the patient's avoidance of important topics and shifts in mood;’ ‘Focused on the relationship between the therapist and patient;’ and ‘Focused on the influence of unconscious processes on behavior, emotions, beliefs.’ For clinicians who reported a psychodynamic orientation, the extent to which the patient showed a constrained style correlated around r=.30 with the extent to which the therapists reported coping with her issues'. In addition, dysregulation was associated with group treatment for personality styles and ED symptoms, while constriction length found that psychodynamic global functioning. CBT-E clinicians do not use structures for addressing concerns, perhaps as research continues.

Future directions

These are clearly exciting times with present clinical and empirical literature. In some ways, the shift from externalizing and examining internalizing and externalizing (Westen 2002), has taken us up the complex and not be understood in the way we were accustomed to. The research does not yet bridge the construct of maladaptive traits to the behavioral and expressed pathology. The research does not bridge to the patients’ lack of insight, such as regulation or feedback, nor does it reflect the absence of functioning rituals and routines, such as regulation or context. Further research is needed to bridge these gaps.
extensive to which they reported that they 'taught the patient specific techniques for coping with her symptoms' and 'actively initiated the topics of discussion and other therapeutic activities'; and correlated $r = 0.30$ with the item, 'Prefered that the patient, rather than the therapist, initiate the discussion of significant issues'. In addition, for clinicians of all theoretical orientations, patients' dysregulation was associated with use of adjunctive treatments, such as medication, group treatment, and hospitalisation. Multivariate analyses controlling for personality style found that use of CBT was associated with faster change in ED symptoms, while analyses controlling for personality style and treatment length found that psychodynamic therapy was associated with increased change in global functioning. Other recent naturalistic survey research finds that clinicians do not use structured treatment manuals because of their perceived inadequacy in addressing comorbidity (Isaacs and Clopton 2003), something that may perhaps change as research expands on CBT-E.

Future directions

These are clearly exciting times in the study of personality and EDs. What began with prescient clinical observations has become an increasingly sophisticated empirical literature on the relation between personality and eating pathology. In some ways, the study of personality in eating disorders, like the study of interoception and externalising personality spectra in axis i disorders (Krueger 2002), has taken us back to the future, to the idea that symptoms often need to be understood in their charaterological context (Westen et al. in press). This does not mean returning to pre-empirical days of relying exclusively on clinical hunches about character structure or etiology. Rather, we are witnessing a period in which we may find substantial clinical and empirical utility in trying to bridge the chasm between decades-old clinical ideas about the way personality patterns may provide fertile ground for the development and maintenance of certain forms of psychopathology and contemporary research on the structure, behavioral genetics, and molecular genetics of personality and psychopathology.

The research described here suggests multiple directions for the future, of which we note two. First, although data are converging on several key constructs in the study of personality in EDs, we cannot assume that all measures purporting to assess the same construct are in fact doing so or doing so equally well. For example, impulsivity is a multidimensional construct, and measurement can focus on trait aspects associated with externalizing pathology, specific behaviors, or specific behaviors as indicators of latent traits (see Wonderlic et al. 2004). Similarly, although we have emphasized the convergence of different approaches to subtyping personality in EDs, the subtypes are not identical, and we cannot assume that self-report measures are assessing the same constructs as measures that require clinically experienced raters. There is good reason to believe that the assessment of personality pathology can be complicated by patients' lack of insight and by their lack of expertise in assessing constructs such as regulation of emotion, identification and tolerance of affect, and subtle
aspects of interpersonal functioning (e.g. the extent to which the person can form rich and nuanced representations of the self and others) (see Westen (1997). 
Perhaps the best strategy at this point would be to collect data using multiple 
insitutions and observers on the range of personality constructs studied in EDs 
to assess convergence and to conduct analyses across instruments to identify 
common dimensions as in recent research on the major self-report personality 
traits instruments (Markon et al. 2005). 
Second, as a field, we are only beginning to grapple with personality as a 
variable of importance in the treatment of EDs. Preliminary data, described 
above, suggest that CBT-E may prove more effective than standard CBT for BN, 
perhaps because it is addressing personality features not adequately addressed 
in the original model and manual. Suggestive but highly preliminary research 
from our own laboratory suggests that most clinicians in the community attend 
closely to personality in EDs and employ integrative strategies to address both 
personality characteristics and target symptoms, and that these integrative 
approaches tend to yield better global and ED-specific outcomes than more ‘pure’ 
approaches. However, far more questions remain than have been addressed: 
How long is optimal treatment for ED patients with different forms of person-
ality pathology? What is the best mix of symptom-focused versus diathesis-
focused targets in therapy? What is the optimal timing of that mix (e.g. target 
symptoms first and personality diatheses once symptoms are under control, 
or target both simultaneously)? At this point, it would seem prudent for all 
treatment research on EDs to assess personality variables carefully as baseline 
markers of likely response to various treatments (both pharmacological and psychotherapeutic), and as outcome variables.

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This study was notable for the breadth of assessment measures converging on the finding of a consistently inhibited subtype of bulimia nervosa. In a sample with both BN and avoidant PD, the authors tested personality functioning (interpersonal inhibition and avoidance), neuropsychological functioning (forns of inhibition on the Go/No go task), and serotonergic functioning (deficits consistent with inhibited functioning). The study concludes that a distinct subtype exists characterized by inhibition across three major domains.


This keynote address at the AED Annual Conference presented the first data regarding CBT-Enhanced, the new, flexible, transdiagnostic treatment for eating disorders. The presentation emphasized the point that empirically supported treatments exist only for
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Personality and eating disorders


This two-part article presents data from a 145-patient sample with bulimia pathology treated in the community. Results from the community support prior observations that rates of comorbidity are very high and are related to treatment outcome. Results supported the observation of three personality subtypes, with treatment length and outcome associated with subtype. The use of cognitive-behavioral interventions was associated with more rapid remission, whereas the use of psychodynamic interventions was associated with global outcome.


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This study investigated the role of impulsivity as a risk factor for disordered eating. The primary goal was to establish whether risk outcomes depended on the way that impulsivity was measured. The researchers found that trait impulsivity, as measured by traditional personality scales, failed to predict the onset of eating pathology. However, behavioral indicators of impulsivity, such as substance abuse or delinquency, significantly predicted the onset of disordered eating.


This multi-site study combined data on 178 patients with clinical or subclinical BN, including data on ED symptoms, personality pathology, perfectionism, impulsivity,
drug abuse, depression, anxiety, obsessive-compulsive behavior, and genetic information. Latent profile analysis including the variables above (excluding ED symptoms) produced a stable three-cluster solution. Clusters were labeled 'High-functioning,' 'Affective-Perfectionistic,' and 'Impulsive.' The affective-perfectionistic cluster had significantly higher scores on perfectionism, obsessive-compulsive symptoms, trait anxiety, inhibition, and depression. The impulsive cluster had significantly higher scores on impulsive/self-destructive behavior, dissociative behavior, and substance abuse.


This article reviews the extant literature on eating disorders and anorexia nervosa. The major conceptual models of the relationship between personality and anorexia nervosa are reviewed. In addition, the authors review methodological challenges for eating disorder and personality research and suggest more clarity in the conceptual models that researchers apply to their future work.