

# EATING DISORDERS REVIEW®



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## The American Psychiatric Association Practice Guideline for the Treatment of Patients with Eating Disorders

By Joel Yager, M.D.  
Editor-in-Chief

After several years of work, the revised American Psychiatric Association *Practice Guideline for the Treatment of Patients with Eating Disorders* has been published as a supplement to the January 2000 issue of the *American Journal of Psychiatry* (volume 157 no.1).

This revision represents substantial rethinking and updating, and reflects major input by many members of the *Eating Disorders Review* editorial board. The core work group of Drs. Arnold Andersen, Michael Devlin, Helen Egger, David Herzog, James Mitchell, Pauline Powers, Alayne Yates, Kathryn Zerbe, and myself have all been seriously involved with the eating disorders field for quite a while. Initial drafts of the guideline drew hundreds of instructive comments from dozens of national and international consultants and from many professional and advocacy organizations.

While the *Guideline* is in theory authored by and for psychiatrists, it is actually very broadly written and will be useful for clinicians of many backgrounds. Psychologists, adolescent medicine specialists, other primary care physicians, registered dietitians, social workers, and other caregivers have all had substantial input into and influence upon this document.

*The Guideline* fills 30 large two-columned journal pages, has 7 instructional tables, and contains 356 references. Here are some of the more important highlights:

### Choosing the treatment site.

The most significant new feature of the revised guidelines deals with choosing the site for treatment. Table 5, "Level of Care Criteria for Patients with Eating Disorders," offers guidelines for selecting outpatient, intensive outpatient, partial hospitalization/full day programming, residential or inpatient care based on the types and levels of medical complications, suicidality, weight concerns, motivation, co-morbid disorders, need for structure, ability to care for oneself, environmental stressors, availability of treatment facilities, and living situations associated with each setting. These recommendations are much more specific and should be more helpful to patients, families and providers than the broad recommendations of the original 1993 guideline.

**Diagnoses.** The American Psychiatric Association's  
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## Update

### Self-Handicapping Among Women with Eating Disorders

Women may use an eating disorder as an excuse for failure or to avoid taking on new challenges, according to researchers at the Toronto Hospital. Three groups of women, including 40 dieters, 40 non-dieters, and 40 women with eating disorders, were entered in a study that allegedly tested the effects of music on verbal reasoning. Dieters and non-dieters practiced the same amount of time whether or not they expected their test performance would be known. In contrast, women with eating disorders practiced significantly more than non-eating disordered patients when they expected that their performance would not be known, but did not practice when they expected that their performance would be made public. The researchers note that this suggests that women with eating disorders use self-handicapping to protect themselves from negative public evaluation in case of failure. They add that further study is needed to learn whether self-handicapping is a trait that precedes the onset of an eating disorder or if it is acquired after the onset of the illness.

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*Diagnostic and Statistical Manual of Mental Disorders (DSM IV)* is closely followed, but several controversies in current diagnostic schemes are highlighted, and may merit additional attention in the future. For example, since many clinicians see extremely “anorectic” patients who continue to have some menstrual function, should amenorrhea continue to be a requirement for the diagnosis of AN? How does culture influence the appearance and clinical features of eating disorders, and how do these disorders differ across cultures? What is “atypical” anorexia nervosa, in which patients acknowledge that they are too thin and seem not to have much distortion about their body image? The revised *Guideline* recognizes how important eating disorders not otherwise specified (ED-NOS) are in most practices, and provides an expanded discussion of the clinical features and treatment of binge eating disorder, not addressed in the 1993 version.

**Recent epidemiologic data and clinical features.** Several new tables outline the major physical complications and abnormal laboratory test results clinicians are likely to encounter in anorexia nervosa and bulimia nervosa and offer guidelines for routine laboratory workups as well as indications for additional tests.

**Standardized assessment.** The guidelines also discuss the value of standardized eating disorders assessment instruments for clinicians. Major features of representative assessment instruments clinicians might wish to select for use in their practices are reviewed.

**Treatment strategies for anorexia nervosa and bulimia nervosa.** Strategies for anorexia nervosa and for bulimia nervosa are each discussed by major therapeutic domains, i.e., nutritional rehabilitation, psychosocial treatments, and psychopharmacological interventions. These domains are then addressed with respect to selecting and establishing specific goals, considerations of how effective these approaches have

been in research studies and other professional literature, side effects and toxicities that may arise and strategies for managing them (especially regarding medications), and how to implement these various treatment strategies. For example, nutritional rehabilitation issues that are discussed include determining goal weights, calculating initial and subsequent caloric intake, and how to progress after initial implementation. Other issues include dealing with patient reluctance and resistance, as well as side effects, consideration of nasogastric feeding, and what constitutes medical monitoring.

Psychosocial treatment approaches for anorexia nervosa include structured inpatient and partial/day programs, one-on-one psychotherapies, family counseling and therapy, addiction model interventions, and the role of support groups. The medication review stresses recent studies showing that selective serotonin reuptake inhibitors (SSRIs) add little to programs based on good experienced nursing care during hospital-based weight restoration. However, after weight has been regained, some studies suggest that SSRIs (fluoxetine was used in these studies) may be useful in helping patients maintain weight and decrease the risks of depression and the likelihood of rehospitalization. (The guidelines also alert clinicians to the fact that the SSRI citalopram has been associated with weight loss in the treatment of outpatient anorexia nervosa relative to psychotherapy alone. See *EDR* January/February 2000, page 8).

**Cognitive behavioral therapy and interpersonal psychotherapy.** Cognitive-behavioral therapy remains the strongest psychosocial intervention. For persons with bulimia nervosa and for patients receiving psychotherapy and psychopharmacotherapy, SSRIs may be preferred.

Interpersonal psychotherapy also has considerable value. Professionally written guided “self-help” manuals may benefit many patients, those in formal treatment as well as

those who are attempting to deal with the symptoms on their own.

### **Collaborative models of care.**

Collaborative models of care are discussed in greater detail.

**Special considerations.** Special consideration is given to such issues as the chronicity of eating disorders, co-morbid conditions and/or concurrent medical conditions in relation to assessment and management, and special considerations related to demographic/setting features related to male gender, age, culture, athletics, high schools and colleges.

Copies of the *Guideline* may be purchased from the *American Journal of Psychiatry* Circulation Department (202-682-6158). The January issue of the Journal, including the supplement, is priced at \$17.25 for the single issue. If they have all been sold, other copies of the revised guideline (fancier edition, bigger print) are now available from the American Psychiatric Press, Inc. (1-800-368-5777).

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## **BED and Sleep Disorders**

People with obstructive sleep apnea have repeated interruptions of airflow for longer than 10 seconds during sleep. This leads to decreased oxyhemoglobin saturation and increased sleep disturbances. Some patients report choking and daytime sleepiness, fatigue, memory disturbances, and irritability.

Since sleep apnea is 25 times more common among obese persons, Dr. Orna Tzischinsky and colleagues wanted to see if obese persons with binge eating disorder (BED) might be at greater-than-normal risk for the disorder. The Israeli researchers compared obese patients with BED (BED), non-BED obese patients (OB), and normal-weight non-binging women (NW) using mini-actigraphs and self-report questionnaires. The actigraphs were used to monitor sleep-wake patterns.

The actigraphs revealed differences in the quality of sleep between BED and OB subjects compared to NW subjects. Among the BED and OB patients, the quality of sleep was significantly poorer and the patients had more complaints. Weight-related physical discomfort or breathing disorders during sleep are reported by about 30% of obese persons.

# **Eating Disorders High Among Military Women**

A combination of environmental and traditional factors place military women at greater-than-normal risk for developing an eating disorder, according to a recent study by Tamara D. Lauder, MD, and her colleagues.

The 1-year study showed a higher-than-normal prevalence of eating disorders among 423 women on active duty in the Army (*Med Sci Sports Exer* 31:1265, 1999). Thirty-three percent (142) of the women met the screening criteria (Eating Disorders Inventory, or EDI)

for being at risk for abnormal eating behavior. Among 108 women interviewed, 33 were diagnosed with eating disorders: 3% had anorexia nervosa, 9% had bulimia nervosa, 15% had binge eating disorder, 33% had an eating disorder not otherwise specified (ED-NOS), and 39% had what the authors termed a "situational eating disorder." The authors developed this category to describe intermittent behaviors that were consistent with a DSM-IV diagnosis of ED-NOS. Situational eating behaviors occurred in connection with specific events during which the women felt significant pressure about weight and fitness.

The women with eating disorders exercised more, felt more dissatisfied with their weight, and felt more pressure about their weight than the other women in the study. Women with eating disorders also had a greater drive for thinness, used more bulimic behaviors, were more dissatisfied with their bodies, and had higher overall scores on the EDI Symptom Checklist. Army women face regular weigh-ins and army physical fitness testing (APFT) on a regular basis; the women reported that these were particularly high-stress times, and they engaged in abnormal dietary behaviors and

exercise before the weigh-ins. Other studies have shown similar patterns (*Mil Med* 1999; 164:630; *Mil Med* 1997; 162:753).

### **Pressures similar to those in civilian athletes**

Military women face many of the same pressures to be thin and fit as do civilian women athletes in organized sports. For example,

women entering military academies are expected to perform at the same high physical and academic levels as their male counterparts. Women who

become full-time active duty soldiers in the U.S. Army hold physically demanding jobs and also must participate in daily physical fitness programs. They also have to pass tests of fitness and meet weight standards every 6 months. In addition, they face the same societal pressures to acquire a "model-like physique."

The military lifestyle also challenges the soldiers' attempts to maintain weight and fitness standards. For example, soldiers may only have access to high-calorie, high-fat foods. Frequent moves, field deployments, and field time may also make meal planning difficult.

The authors raise some interesting questions about whether eating disorders are being produced by the types of pressures put upon women and men in the military and whether this is the best approach to prepare soldiers for military duty. They suggest that women in the military could benefit from development of educational and preventive measures similar to those from the 1993 Eating Disorders Information and Education Act, which provided information and education about preventing and treating eating disorders.

***The Army lifestyle increases risk of eating disorders.***

## Treatment Contracts

Treatment contracts serve many useful purposes for eating disorders patients, their families, and the treatment team. For example, contracts are helpful when working with patients or family members who are chaotic or who have not been able to collaborate with treatment team members. Contracts can be drawn when treatment has stalled and new therapy options need to be clearly introduced.

***Contracts can be drawn when treatment has stalled and new therapy options need to be introduced.***

For treatment team members with minimal experience with eating disorders, contracts can serve as a guide for monitoring and goal setting. Contracts can also be helpful for conveying treatment plans to health maintenance organizations and insurance companies.

Treatment contracts are particularly helpful for adolescent patients, and with larger treatment teams, and when family members are more involved in treatment. Finally, the detailed information developed with a treatment contract can be very helpful to send to managed-care organizations to document the seriousness of an eating disorder.

### Where to Begin

The health professionals on the treatment team initially draft the treatment contract. Each provider contributes to the document until all team members agree upon the goals and plan of action. The contract is then presented to the patient and family members for review and addition of their goals.

The contract is revised until all involved parties agree on the document. When a consensus is reached, each party signs the final contract.

### What Is Included in a Treatment Contract?

The structure is flexible, but typically includes the following:

*Treatment participation:* A description of the current treatment plan:

- The name and role of each team member and a description of the client's appointments with that practitioner. For example, "Dr. Jones (physician) – vitals check once a week on Mondays, at 4:00 pm. Electrolytes monitored every two weeks." If necessary, the vitals check can be described in detail, such as what and how measurements

will be taken; e.g., "Weight will be taken on office A's scale with the patient wearing a gown and panties."

- How this treatment schedule can change. For example, "The above appointments may be increased or decreased in frequency, as recommended by Dr. Jones. Any change in the treatment plan will be discussed with patient and/or patient's significant others prior to implementation."

- Treatment participation expectations.

"Patient is expected to attend all treatment sessions. Should patient need to reschedule

or cancel an appointment, it is her/his responsibility to contact the provider in advance. A pattern of failed or cancelled appointments will result in a treatment team meeting to evaluate barriers to participation."

*Treatment component descriptions:* As needed, individual treatment components are described in detail to clarify goals and provider/patient interactions.

- Here is an example of a

nutrition component description: "Patient and Tami Lyon will work together to develop a 'safe' and nutritionally adequate meal plan of 1800 calories/day by February 20, 2000. Patient will inform Tami of any substitutions and modifications that she makes to this meal plan by discussing them during nutritional counseling sessions. Patient will complete a food diary that will be reviewed by patient and Tami during sessions."

*Achieving a healthy weight:* All pertinent goal weight ranges are addressed, including hospitalization, medical stability, and exercise and target weight ranges.

- A time line for achieving each weight range is documented. Here is an example for weight gain: "Patient will achieve her exercise weight of 100 lb or more by March 1, 2000."

- The benefits of achieving a weight goal should be based on the patient's requests as much as possible. For example, "The patient may participate in three physical education classes per week as long as she maintains a weight of 100 lb or more. If this weight is maintained for 6 consecutive weigh-ins, then the patient can reduce her vital checks with Dr. Jones to once every other week."

- The providers' response to the patient should she not meet a

weight goal is described in detail. For example, "If patient's weight is less than 100 lb on March 1, 2000, all

extracurricular activities, including all individual and group events that expend energy will be suspended until the goal weight of 100 lb is attained. Vitals checks with Dr. Jones and nutrition appointments with Tami Lyon will increase to twice a week until the weight goal is met."

- The providers' response to weight loss after the weight goal is achieved. For example, "If patient's weight is less than 100 lb for two or

***The final document should reflect input from everyone affected by the agreement.***

more vital checks during a four-week period, the following will occur: immediate restriction of all extracurricular activities, including walking for transportation and pleasure, attendance of any social functions that include any activity and twice-a-week weigh-ins with Dr. Jones.”

*Participation of family members:* The level of involvement of family members is described in detail.

- How family members will communicate with the treatment team. For example, “Patient’s parents will meet with Dr. Hayes once a month for 55 minutes.”

- Treatment recommendations and requirements for family members. For example, “Patient’s parents will start couples therapy by March 1, 2000.”

- Treatment recommendations and requirements for the patient and family members. For example, “Patient and patient’s parents will attend family therapy on a weekly basis beginning March 1, 2000.”

*Effective dates:* The dates that the contract will begin and end are documented. This typically includes a mid-contract review of progress meeting for all those involved in treatment.

A treatment contract documents treatment goals and how the treatment team will support the patient and family members in achieving the goals. The process of drafting the document can take several weeks and may have an impact on the treatment process. It is important that the patient and family members feel included in the creation of the contract, and that the final document contains input from everyone affected by the agreement.

—Tami J. Lyon, MS, RD, CDE

*(Note: For the past 10 years, Tami Lyon has offered practical, real-life solutions to nutrition and eating disorders issues in “Nutrition Notes.” With the next issue, Tami will take a well-deserved rest, and this column will continue with a series of guest contributors. Tami will remain on the Editorial Advisory Board.)*

# The Effects of Tryptophan Depletion

Dieting may promote relapse among women who have recovered from depression, due to depletion of the serotonin precursor tryptophan, according to the results of a recent British study (*Br J Psychiatry* 2000;176:72). And, a second study has shown that persons with bulimia nervosa (BN) may turn to dieting and binge eating to regulate their unstable serotonin system after tryptophan depletion (*Biol Psychiatry* 2000;47:151).

Women who have recovered from depression have an abnormal sensitivity to the mood-lowering effects of acute tryptophan depletion induced by a tryptophan-free amino acid mixture. This suggests that they may have abnormalities in the regulation of brain serotonin (5-HT) function.

## In some, a failure to regulate 5-HT function

In the first study, women with a history of depression showed impaired regulation of 5-HT function in response to dieting. Katharine A. Smith, MRCPsych, and co-workers placed women with and without a history of major depression on a 1000 kcal/day diet for 3 weeks. Just before the study began and during the final week of the diet, the researchers measured fasting plasma tryptophan levels and the prolactin response to an intravenous tryptophan challenge in all women.

Of the 43 women who entered the study, 25 completed the protocol (14 controls, 11 recovered patients). Although plasma tryptophan levels fell by about 10% in both groups after the diet, the prolactin response to tryptophan increased after dieting only among the women in the control group.

The pre-diet response to the tryptophan challenge was similar in both groups. The results suggest that if there is a trait abnormality in women vulnerable to major depression, it may be apparent only when 5-HT function comes under biochemical stress. Although there was only a minimal difference in the mood effects of dieting between the 2 groups, the more marked

neuroendocrine differences among the depressed patients suggest that vulnerability to a relapse to depression may be related to an inability to upregulate brain 5-HT function in response to stress.

## 5-HT and the pathogenesis of BN

In a second study, Walter H. Kaye, MD and colleagues found that women with bulimia nervosa (BN) seem more vulnerable than normal controls to the effects of acute tryptophan depletion (*Biol Psychiatry* 2000;47:151). Numerous studies suggest that a disturbance of 5-HT neuronal function may be trait-related and may contribute to the pathogenesis of BN.

Twenty-two women with BN and 16 healthy controls were studied on 2 separate days during the follicular stage of the menstrual cycle. The participants drank a mixture of essential amino acids and tryptophan on one day and a tryptophan-deficient mixture on the second day, in a double-blind design. Mood/appetite rating were recorded and blood samples were taken at baseline and at hourly intervals of up to 7 hours. The participants were then offered a variety of foods and were allowed to binge and vomit if they wished.

After acute tryptophan depletion, women with bulimia nervosa had a significantly greater increase in peak depression, mood lability, sadness and desire to binge compared to the control group.

Dr. Kaye and colleagues hypothesize that the 5-HT neuronal system is poorly modulated and inherently unstable in persons with BN. Thus, the 5-HT system fluctuates erratically among BN patients, rather than precisely compensating and buffering the effects of diet or stress, as it does in normal women. Because of this, persons with BN may use dieting and binge eating to adjust their unstable 5-HT system.

Conceivably, the findings in depression and those in BN may show some common history and features. Studies in patients recovered from BN with and without past histories of depressive disorders may help clarify the picture.

# Anorexia Nervosa: Taking a Multidisciplinary Approach

Because of the complex nature of anorexia nervosa, severely ill patients have a much better prognosis when they are treated by an experienced multidisciplinary team, according to Dr. Stephan Zipfel of the University of Heidelberg, Germany (*Lancet* 2000; 355:721).

Dr. Zipfel and a team of researchers recently attempted to contact 84 women at least 21 years after their first inpatient treatment for anorexia nervosa. Follow-up revealed that 14 of the 84 patients (17%) had died. Twelve deaths were due to anorexia-related symptoms, including bronchial pneumonia, sepsis, dehydration, and suicide.

Sixty-three of the 70 survivors underwent a psychiatric interview and physical assessment and also completed standardized psychological questionnaires. Of the survivors, the researchers classified 50.6% as fully recovered, 20.8% as having an intermediate outcome, and 26% as having a poor outcome.

## Who had the poorest outcome?

Women with a poor outcome were more likely to have had the disease for a long time before they

were first hospitalized, did not gain adequate weight during hospitalization, and had a low body mass

***Women who did poorly included those who did not gain adequate weight while hospitalized.***

index. In addition, women who did poorly had severe psychological or social problems at the time the

diagnosis was first made.

Dr. Zipfel noted that such patients would greatly benefit from being treated by a team of psychiatrists/psychotherapists, physicians, dietitians, family therapists, and additional therapists experienced in treating patients with body image disturbances. He added that clinicians treating patients with severe anorexia nervosa should focus

on social and psychological symptoms as well as adequate weight gain during treatment.

## BOOK REVIEW

### **Preventing Eating Disorders: A Handbook of Interventions and Special Challenges**

(Edited by Niva Piran, PhD, Michael P. Levine, PhD, and Catherine Steiner-Adair, EdD. Philadelphia, PA: Brunner/Mazel [Taylor and Frances Group], 1999; 347 pp; \$59.95)

This book originally germinated through a special 1996 issue of the journal *Eating Disorders: The Journal of Treatment and Prevention* focusing on prevention. The project leading to this book grew to incorporate and include much of the contemporary field of prevention. It came to provide "snapshots" of and to critically review contemporary programs that show promise, to share curricula and program ideas, and to portray the richness of varied primary and secondary prevention efforts.

Inspired in part by the mission of EDAP (Eating Disorders Awareness and Prevention) to foster and promulgate prevention activities related to eating disorders, a substantial number of talented social scientists have given thought, form, and, increasingly, substance to the considerable challenges posed by such agendas. The editors have asked a large group of these people to tell us what they've been up to.

The 20 chapters divided into four major sections (addressing societal institutions and values; programs for elementary and middle schools; high schools and colleges; and the

special challenges of high-risk populations and secondary prevention) cover much, but not all, that is going on. Several programs are described in enough detail so that school administrators might copy them easily, and a few chapters suggest clear guidelines for what the authors believe constitute good preventive practices (e.g., "10 things coaches can do to help prevent eating disorders in their athletes"). However, outcome and evaluation data are minimal for most programs, and unconvincing for some. We will have to wait for future snapshots to indicate which of these many efforts really pay off.

These chapters are very worth reading and thinking about by educators, coaches and public health personnel. Those particularly interested in this field should supplement this primarily North American experience with a more international and critically balanced book recently reviewed in *EDR* (*The Prevention of Eating Disorders*, edited by W. Vandereycken and G. Noordenbos, Athelone Press, 1999).

—J.Y.

## **Growth Hormone and Weight Gain in African-American Girls**

Researchers have long sought to explain why African-American girls are more sexually mature, taller and heavier, with more muscle mass and body fat than their Caucasian peers. One clue may lie in higher-than-normal levels of a growth hormone (*J Pediatrics* 1999; 135:296).

Researchers at Baylor College of Medicine, Houston, found higher blood levels of a potent growth

*continued next page*

# Parents Take Daughter to Court to Make Her Eat

The parents of an anorectic 16-year-old British schoolgirl resorted to drastic action to persuade their daughter to eat after all other approaches had failed. David and Linda Carter, both 46, obtained a court order for their daughter Vicki to be

hospitalized and force-fed.

Vicki had

adopted a starvation diet that propelled her weight down to 70 lb (her healthy normal weight was 119 lb); her waist was measured at 15.5 in. The family had watched the teen change from a gentle, popular teenager who was an excellent student to a depressed, moody, and withdrawn young woman. After a bout with glandular fever, Vicki became obsessed with her weight. She was crafty in her efforts to hide her starvation, resorting to baggy clothing and obsessive workouts to aerobics videos, often at 6 am, before the rest of the family got up.

## The family decides to act

The parents decided to take legal action when doctors failed in an

attempt to use enteral feeding to help restore her weight. Vicki had initially agreed to force-feeding, but had repeatedly disconnected the nasogastric tube. She also refused all other treatment and attempted to leave the hospital.

The teen decided to fight the court order, and lawyers were appointed to defend her on the grounds that it was her right to refuse food if she chose. When a judge found in favor of the parents, Vicki agreed to start eating. She is

now taking food voluntarily. She and her family agreed that they

***We have no regrets... Without legal action, she would have died.***

***—David Carter***

would publicize the case to help others avoid the downward spiral of anorexia nervosa.

Vicki now weighs 85 lb and is slowly regaining weight. She is studying psychology at the clinic while she recovers. Her father said, "Vicki had a solicitor appointed for her and she said, 'I am going to fight you.' But her mental state at that time was terrible." He added, "It was an unpleasant thing to do to have to fight in the court to get your daughter to stay alive, but we did it and she is recovering now. We have no regrets about taking Vicki to court. Without legal action, she would have died."

*Our thanks to Dr. Walter Vandereycken for this news story.*

## Bright Light Therapy and Binge Frequency

Bulimia nervosa (BN) and seasonal affective disorder, or SAD, have much in common. BN is primarily an eating disorder but it also is accompanied by atypical depression and seasonal variations in symptoms. SAD is primarily an atypical depressive disorder but is often associated with carbohydrate craving and disordered eating. Both syndromes occur primarily in women and both may be associated with dysregulation of serotonin.

### Could light therapy be helpful in BN?

Bright light therapy is an effective treatment for SAD. Could bright light therapy also help patients with BN? To test this hypothesis, Devra L. Braun, PhD, and co-workers treated 34 bulimic female bulimic outpatients with either 10,000-lux bright white light or 50-lux dim red light (controls) (*Comprehensive Psychiatry* 1999; 40:442). The placebo group (n=18) and the bright-light group (n=16) were matched for age, degree of seasonality of symptoms, and concurrent depression. The light sessions involved 3 weeks of morning light for 30 minutes a day.

### Binge eating decreased significantly with light therapy

Binge eating decreased significantly more during treatment with bright light therapy than during placebo treatment. However, depression decreased during the study in both groups and did not decrease significantly more among women who had the bright light therapy.

The authors note that their results show the need for further studies of the effects of light therapy. For example, bright light therapy might be useful for augmenting the effects of drug therapy or cognitive behavioral therapy among patients with BN.

### **GROWTH HORMONE** continued

hormone, free IGF-1, in African-American girls than in their Caucasian peers. The study examined hormonal levels of 136 healthy African-American and Caucasian girls of normal weight between the ages of 9 and 17. The results raised the question of whether higher levels of free IGF-1 may be accelerating growth in African-American girls, and whether the higher levels might be a factor in excessive weight gain if the hormone levels remain high once an individual's growth is complete.

Insulin may also be involved in the degree of free IGF-1 in circula-

tion in the body. Insulin inhibits production of one of the binding proteins that inactivate IGF-1. According to the authors, this connection is significant because healthy, normal-weight African-American children have higher blood insulin levels than Caucasians. High insulin is thought to predispose people to adult-onset, or Type 2, diabetes. Even when diabetes doesn't develop, higher than normal insulin levels might contribute to high cholesterol, weight problems, and hypertension. All of these problems are more prevalent among African-Americans.

## Questions & Answers

### Binge Eating Following Dieting

**Q.** Does binge eating always follow a pattern of prior dieting? (*V.K., Boise, ID*)

**A.** In contrast to some previously held notions, more recent research has shown that binge eating doesn't always follow restricted eating (*J Psychosomatic Res* 44:367, 1998). In fact, for a substantial proportion of women who binge eat, especially those who meet the criteria for binge eating disorder (BED), binge-eating behavior often starts long before dieting. These researchers uncovered two distinct patterns in the development of binge eating among a group of 106 overweight women between 18 and 55 years of age. The first pattern was an early-onset form, in which binge eating began by early adolescence without prior restrictive intake. The second form begins in early adulthood after a number of years of dieting. The early-onset form, or binge eating before dieting, may be tied to a higher rate of BED (or at least a higher rate of BED by mid-life) and possibly a higher rate of Axis II disorders. Those who started to binge eat before dieting started to diet earlier and more often than those in whom binge eating was preceded by dieting. No differences between the two groups were found in the patterns of weight gain throughout the teenage years or

high and low weights in adulthood. This research is consistent with an earlier study in which only 8.7% of 31 binge eating obese patients reported having been on strict diets before they started to binge eat. (*Int J Eat Dis* 13:25, 1993). At the same time, there are shades of gray. Some degrees of undereating meals, e.g., at breakfast or lunch, without strict dieting per se, may predispose to some exaggerated increases in neuropeptide Y and the nighttime binges that result.

—J.Y.

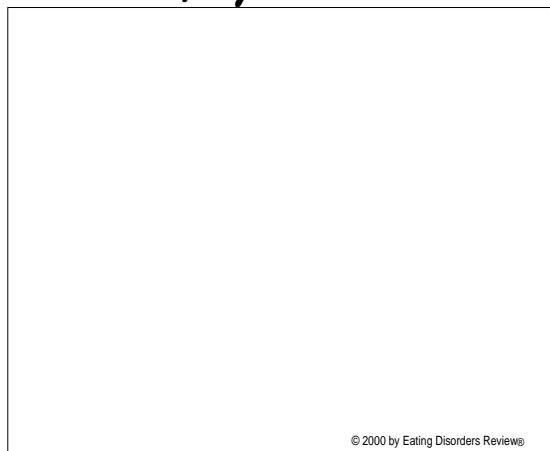
### One of Beauty's Drawbacks

Physical beauty has many benefits; however, it may also have at least one serious drawback. According to results of a recent study, beautiful women may be at increased risk for disordered eating (*Int J Eat Disord* 2000; 27:67).

A group of 203 female university students (mean age: 21 years) were first rated on facial attractiveness; these data were then added to self-report measures of perfectionism, neuroticism, and weight preoccupation. The hypothesis was that weight and diet concerns would be greater among beautiful women than their less-attractive counterparts.

Just as the authors predicted, the more attractive women in their study reported a significantly greater degree of preoccupation with their weight than did the less-attractive participants. The study also confirmed earlier evidence that the relationship between general perfectionism and disordered eating only occurs when combined with an underlying tendency to be anxious and hypercritical.

### Nibbles, by Hunter



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"Hunter" worked on the APA Practice Guidelines.

## In the Next Issue

### The Economic Costs of Eating Disorders

By Ruth Striegel-Moore, PhD

The growth of managed care has limited care for some patients, due to lapse of insurance coverage. Some practical strategies can make a big difference in patient care.

#### PLUS

- Fluid restriction in anorexia nervosa
- Dieters and the "false hope syndrome"
- High-protein diets and renal function
- Patient Information Sheet: How to Find Coverage for Eating Disorders Treatment

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