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Involuntary Treatment of Patients with Eating Disorders

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Involuntary legal commitment for the treatment of eating disorders is a controversial issue. Although most patients with eating disorders are not globally incompetent, some have such impaired thoughts, perceptions, judgment and behavior, along with reduced capacity to care for themselves, that they are good candidates for commitment.¹ (See "Requirements for Legal Commitment, page 3.)

Some have suggested that coerced treatment is counterproductive and adversely affects the therapeutic relationship. Hiday found that two hypotheses guide outcome studies of involuntary commitment.² The first is that patients who are hospitalized involuntarily will be angry and negative about their hospitalization and treatment. As a result, they will be less likely to cooperate with inpatient and outpatient treatment and will have to be rehospitalized. The second hypothesis predicts that involuntary patients will become positive toward hospitalization and treatment after their initial anger and negativism subside and after they are treated. Their symptoms will become minimized and functioning maximized, which will help them avoid rehospitalizations.

Some researchers have reported that involuntary patients tend to hold more negative views of hospitalization than voluntary patients and when discharged

report that little or no benefit has occurred.^{3,4,5} In contrast, others have found that most involuntary patients who initially objected to their commitment later reported they would want to be hospitalized in the future if they became dangerously ill again.^{6,7} These contradictory results could be due to patients expressing negative attitudes toward certain parts of their hospitalization, even while appreciating the help they received.²

Few Empirical Studies Exist

Given the controversy about involuntary treatment in psychiatry and in law, it is surprising that so few empirical studies have addressed involuntary commitment of persons with eating disorders. Ramsay, Ward, Treasure, and Russell have reported that involuntary commitment of patients with anorexia nervosa leads to satisfactory short-term results, but found increased morbidity when they followed patients for a mean of 5.7 years after the first admission for treatment.⁸ The mortality rate at follow-up for detained patients was 12.7%, compared to 2.6% for voluntary patients.

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Update

Body Image Disorders Among Preteens with Type I Diabetes

Eating disorders are more common among teenage girls with type I diabetes mellitus than among their age-matched peers, and can lead to poor metabolic control and vascular complications. In a study reported at the recent Eating Disorder Research Society meeting in Prien am Chiemsee, Germany, 35% of 90 girls 9 to 13 years of age with Type I diabetes were found to have mild to moderate weight and shape-related body image disturbances. Patricia A. Colton, MD and colleagues also reported that the disturbances were severe in 13% of the girls. Ten percent of the girls had recently used markedly restrained eating and intense exercise to control their weight; 3% reported binge-eating, and 1% manipulated their insulin dosage. Girls with BMIs in the top 25% for age were most likely to report severe body image disturbances and disturbed eating behavior. None of the girls met the criteria for an eating disorder. The long-term goal of the study is to determine whether these disturbances are only transient or early signs of more serious eating problems.

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In Sullivan's review of 42 studies, the aggregate annual mortality rate from AN averaged 0.56% per year—more than twice that of female psychiatric patients with other diagnoses.⁹

A Study of Voluntary and Involuntary Patients

We designed a study to compare 66 involuntary and 331 voluntary eating disorder patients who were consecutively referred for treatment at the University of Iowa Hospital and Clinics Eating Disorders Program from July 1991 to June 1998. Pertinent information was taken from the patients' clinical charts retrospectively and recorded on a coding sheet. For those who were admitted more than once, only information from the first admission was recorded.

Body weights were calculated by body mass index (BMI), kg/m², and as a percentage of mean matched population weight (MMPW).¹² BMI has the advantage of being reference-free and standardized by height and weight. MMPW has a reference population standardized by weight, height, and gender.

All diagnoses were made by reference to the DSM-IV. Chart reviewers then independently confirmed the diagnoses. The code sheet information was double entered into an ACCESS database. Statistical analysis was performed using SAS software.

Of the 397 patients admitted, 16.6% (66 of 397) had been referred by involuntary legal commitment. Involuntary patients were not different from voluntary patients in age, gender, marital status, diagnostic distribution, or psychiatric comorbidity. Within the involuntary population, 28.8% had a history of substance abuse (alcohol and drug abuse were combined), compared to 23.6% of the voluntary population. The proportion of patients who had a history of substance abuse was similar for commitment status, diagnosis, gender, and depression. Both of the populations also had a similar proportion of depression: involuntary, 47% (31/66)

and voluntary, 42% (138/331).

Both groups had begun dieting at weights above their MMPW. On admission, involuntary patients were 81.8% of their MMPW, while voluntary patients were 86.2% of their MMPW. Involuntary patients' mean BMI was 17.4 on admission, compared to 18.4 among voluntary patients. The involuntary group had also been ill longer than the voluntary group (a mean of 96.8 months vs. 83.7 months, respectively) and had more prior hospitalizations than the voluntary group. The number of past hospitalizations was skewed. Most of the study population, 52%, had no previous hospitalizations. About 2% had more than 10 past hospitalizations. Among the study population, 95% had 5 or fewer past hospitalizations; involuntary patients had a mean of 3 prior hospitalizations compared to 1.4 among the voluntary group.

Results

Both involuntary and voluntary patients responded well to the refeeding program. Involuntary patients gained a mean of 18.8 lb during hospitalization, whereas voluntary patients gained a mean of 13.9 lb. Involuntary patients gained 2.6 lb per week, while voluntary patients gained 2.2 lb per week. Although the rate of weight restoration was not significantly different between the two groups, it took involuntary patients longer to restore their weight, which was related to the fact that they were thinner to begin with. Involuntary patients stayed in the hospital for a mean of 58 days, compared to 41 days for voluntary patients. Even though the involuntary group remained in the hospital 17 days longer than the voluntary patients, the proportion of patients in the involuntary group above 85% MMPW (or a BMI greater than 18) at discharge was 78.8% (52/66). This was not significantly different from the 80.6% (267/331) reported in the voluntary group.

Upon discharge, involuntary patients had a slightly lower MMPW than the voluntary group (96.6% vs.

97.2%). Discharge BMI was also similar in the involuntary and the voluntary groups—20.5 and 20.7, respectively.

Psychological Test Results

At admission, involuntary and voluntary patients were similar on most standardized psychological tests. There was no difference in the EAT-26, EDI, and MMPI-II admission scores for patients in either group above 15 years of age. On the Wechsler Adult Intelligence Scale (Revised) involuntary patients' verbal IQ (VIQ), full-scale IQ (FSIQ), and performance IQ (PIQ) were significantly lower than those of the voluntary patients.

We found that involuntary patients were similar to voluntary patients in virtually all aspects, except for their lack of willingness to seek treatment for their life-threatening form of eating disorder. The frequent past hospitalizations of the involuntary patients indicated that they were more resistant to treatment than the voluntary group.

Despite the significantly longer length of hospitalization for the involuntary patients, this group responded well to treatment over the short term. About 80% were discharged at weights above 85% of MMPW. Seventy-five percent of involuntary patients were discharged at weights greater than 85% MMPW, compared to 73% MMPW among voluntary patients. This suggests that legal detainment for treatment does not necessarily prevent the development of clinical improvement.

After discharge from inpatient care, often the involuntary patients' legal commitment was transferred to outpatient follow-up to maintain their weight and prevent future hospitalizations. The longer hospitalization of involuntary patients (54 vs. 41 days) is proportional to their lower BMIs on admission. The impact of comorbid diabetes on involuntary treatment outcome could not be determined due to the low prevalence in our study population.

Anecdotally, many of the invol-

Requirements for Legal Commitment (IOWA)

Iowa's requirements for legal commitment for involuntary treatment of a psychiatric disorder are similar to those of many states:

- Evidence that a psychiatric disorder is present.
- Evidence that the disorder threatens the life of the patient because of self-harm or neglect of vital care caused by the disorder.
- The patient refuses treatment.

Multiple safeguards are built into the legal process of involuntary patients to protect the rights of the individual. For example, a petition to the court by the family or health care professional must precede all commitments. Also, an evaluation by physicians unrelated to the petitioners is required to determine the presence, severity, and life-threatening nature of the illness.

A legal hearing, with a court-appointed legal examiner with counsel provided for the patient, takes place within 48 hours. Periodic review of the involuntary status is scheduled during the hospitalization.

untary patients reported to the treatment team at the time of discharge that they now recognized and endorsed the need for treatment. Not a single patient entered a legal complaint or complained to a medical society after discharge

about the inappropriateness of the involuntary commitment or even informally complained that the treatment was unnecessary. This change in attitude suggests that the initial negative attitude might have resulted from the patient's illness or unrealistic appraisal of the usefulness of treatment.⁷ It also supports the need to treat some seriously ill patients against their will.

The VIQ, PIQ, and FSIQ scores on the WAIS-R were lower for detained patients than voluntary patients. This suggests that detained patients may have slightly less capacity to recognize the severity of their condition and to seek treatment.

Legal, Moral, and Philosophical Issues Remain

Our study did not address or resolve important philosophical, legal, or moral issues about whether any person should be involuntarily committed for treatment of a psychiatric disorder. Nevertheless, there appear to be selected cases of eating disorders that are life-threatening and associated with core features of denial of illness or thinness to a degree that the use of involuntary may be appropriate.

At times the comorbid depressive illness or personality disorder or both that often accompany an

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Is It Possible to Control Weight?

Can anyone really successfully control his or her weight? The results of a 3-year community-based study were not too encouraging (*Int J Obesity* 2000;24:1107).

Fifty-four men and women from 20 to 45 years of age were assigned to one of three treatments. Half were placed in a group who had no contact with the researchers; a fourth received educational materials through monthly newsletters, and a fourth were given educational materials and an incentive for participating in the study. The intervention groups received the same educational and behavioral messages, including monitoring their weight, eating 2 servings of fruit and 3 of vegetables daily, reducing intake of

high-fat foods, and walking for at least 20 minutes 3 times a week.

Only 1 in 4 Avoided Weight Gain

More than half of the subjects gained weight over the first 12 months, and only 1 in 4 (24.5%) successfully avoided gaining weight over the 3 years. Fewer than 1 in 20 (4.6%) successfully lost weight and maintained the loss.

General public health efforts to prevent weight gain are extremely important, according to the authors. Their findings suggest that without much greater public health efforts to promote and support weight control, most people won't be able to avoid weight gain and very few will manage to lose weight.

Christian Weight Loss Programs

During the last decade, there has been a surge in religious—especially Christian—weight loss and fitness programs. Thousands of churches across the country have sponsored such programs as Gwen Shamblin's Weigh Down Workshop, First Place (whose curriculum is published by the Southern Baptist Convention in Dallas), and 3D (for Diet, Discipline, and Discipleship).

As R. Marie Griffith of the Center for the Study of Religion at Princeton University has noted, these groups have taken the model of support groups from Weight Watchers and Overeaters Anonymous and have added their own strong dose of spiritual discipline and uplift. Meetings generally include Bible study, prayer, and sometimes devotional music, as well as the usual instruction and therapeutic check-in times with group members. First Place offers workshops and rallies. Another, and decidedly unique, group, the Temple Remodelers, meets only on the Internet, and uses virtual reality tools, such as a virtual ocean cruise on the "S.S. Slim 4 Him," to promote health and weight loss.

The use of religion to promote weight loss is not new, according to Dr. Griffith. In 1957, a well-known Presbyterian minister and writer published his book *Pray Your Weight Away*. Many other authors followed this trend in the 1960s and 1970s, resulting in books such as *I Prayed Myself Slim*, *Devotions for Dieters*, *God's Answer to Fat*, *Slim for Him*, and (perhaps the most evocative title of all) *More of Jesus, Less of Me*. Some of these books sold more than a million copies worldwide and spawned mid-sized industries of diet products, exercise videos, and low-calorie cookbooks. Authors and purveyors of these products agreed that, as one insisted, God "wants us aware that sloppy fat, hanging all

over the place (or even well girdled) is not a good Christian witness."

That message persisted into the 1980s and 1990s, attracting thousands of new adherents to the gospel of diet with the claim that authentic religious faith would result in the "promised land" of a thin body. One former bulimic, Stormie Omartian, showed somewhat more caution by urging

Success for many, but also risks for women with body obsessions and/or eating disorders

readers to love their bodies no matter what shape they were in; ironically, her own perfectly chiseled body on the cover of her books and exercise videos set an unrealistically skinny standard. Today's most popular Christian diet guru, Gwen Shamblin, a registered dietitian, teaches that thinness is a matter of religious obedience, so that even five extra pounds upon an otherwise lean body is a sign of sin.

The Weight Down Diet

Shamblin's 1997 book, *The Weigh Down Diet* (published by Doubleday) sold well over a million copies within a year and is still found in larger bookstores across the country. Shamblin, a charismatic speaker, travels across the country giving seminars that urge Christians to lose weight for God. In her new book, *Rise Above: God Can Set You Free from Your Weight Problems Forever*, Shamblin promises to deliver readers from the "bondage" of food with motivation and heart-changing cultivation. Her message that fat equals sin is reaching a very receptive audience. In a typical convention held in Nashville last July, scores of formerly obese women and men lined the stage to witness tearfully to the pounds Shamblin's program had helped them lose, while audience mem-

bers of all body types sat enraptured by those testimonies.

Some critics have noted that the second book goes over familiar territory, but has new and harsher doctrines as well. One troubling necessity promoted by the book is submission, particularly wifely surrender to a husband, as well as employees' submission to their employers.

Dr. Griffith points out that while programs such as Shamblin's may have some success in helping the obese to reach and maintain

healthier body weights, the impact upon women who may already be prone to body obsessions and eating disorders seems mixed at best and dangerous at worst. Because the most successful religious diet programs are fundamentalist or evangelical, they maintain strict norms of right and wrong that can be highly conducive to guilt and shame. Especially since the 1980s, thinness has been a crucial element of "true Christian womanhood" in that religious culture, which is part of the explanation for the growing popularity of these self-designated Biblical diet programs.

Malnutrition Has a Primary Role in Bone Loss

Women with anorexia nervosa can develop bone loss as rapidly as 6 months after the disease begins, and the effects can remain even after weight is restored. Researchers at the Massachusetts General Hospital, Boston, and the Wilkins Center for Eating Disorders, Greenwich, CT, recently demonstrated the high prevalence and profound degree of site-specific bone loss in a group of women with anorexia nervosa (*Ann Intern Med* 2000;133:790). They also reported

that malnutrition has a primary role in anorexia-nervosa-related bone loss, independent of estrogen deficiency. (See also September/October *EDR*, p.1).

The researchers recruited 130 women with anorexia nervosa for the study through ads and physician referrals. Dual-energy x-ray absorptiometry was used to determine bone mineral density (BMD) at numerous sites, including the anterior-posterior lumbar spine, lateral spine, left total hip, femoral neck, and greater trochanter. Women were also asked about use of exogenous estrogen.

Half of patients had osteopenia

More than a fourth of the group (34 patients, or 26%) had a history of fractures. Osteopenia and osteoporosis, respectively, were seen at the anterior-posterior spine in 50% and 13% of patients, at the lateral spine in 57% and 24%, and at the total hip in 47% and 16% of patients. Only 37% of patients had normal bone mineral density at the anterior-posterior spine; normal bone density at the lateral spine was noted in only 19% of patients, and of the total hip in 37% of patients. BMD was reduced by at least 1 standard deviation (SD) at one or more skeletal sites in 92% of patients.

Weight predicted BMD

Weight was a significant independent predictor of BMD at all sites. The authors also found that estrogen exposure had a minimal effect on BMD. They hypothesize that the effectiveness of estrogen in increasing or preserving BMD in women with anorexia nervosa may be undermined by continued undernutrition, which may act to uncouple bone formation and resorption. Twenty-three percent of patients were using supplemental estrogen, but current or prior use of estrogen was not associated with bone mineral density at any site. Time since the last menstrual period and the age at menarche were also significant predictive factors for BMD at the anterior posterior spine.

BOOK REVIEW

Comparative Treatments for Eating Disorders

(Katherine J. Miller and J. Scott Mizes, eds. Springer series of comparative treatments for psychological disorders. New York: Springer Publishers, 2000; 368 pp; \$47.95; ISBN: 0-8261-1358-3)

The unusual pedagogical format of this series successfully engages those of us who enjoy learning in a clinical setting. It's as if you're at a clinical grand rounds, where the same patient is presented to a number of authorities, each of whom is an advocate for a particular clinical approach.

After an introductory chapter in which the major problems of eating disorders are overviewed, "Kristin's" clinical case is presented. The overview chapter summarizes clinical features, course, and a history of the treatments that have been employed for anorexia nervosa and bulimia nervosa, including controlled treatment research on bulimia nervosa (behavioral, cognitive-behavioral, interpersonal and pharmacological).

After the case presentation, authors of subsequent chapters—many of whom are prominent researchers and clinicians familiar to *EDR* readers—respond to a series of specific questions about this patient posed by the case report. For example, if you were treating this patient, what specific or special techniques (including the use of homework) would be implemented, which other professionals would be brought in, and which significant others would be involved (and how)? How would medical and nutritional issues be handled? What potential pitfalls and types of resistance would be anticipated in the therapy, and how would they be handled? How would termination and relapse prevention be addressed? In addition, the ensuing well-referenced chapters also variably address treatment goals, the nature of the therapeutic relationship, how the case would be conceptualized and formulated, and anticipated time-line and course of treatment.

The specific approaches presented include cognitive behavioral therapy (CBT), psychoanalysis, interpersonal psychotherapy, developmental-systemic-feminist therapy (a specific integration of

these three approaches), and self-psychology. In addition, they include an Adlerian approach; the "elementary pragmatic model" (a therapeutic model evolving since the 1960s starting at the University of Bari in Italy, based on the pragmatic communication models of Bateson et al, which posits 16 interactive styles of interpersonal interaction); and the integrative cognitive therapy model being developed and tested at the Universities of North Dakota and Minnesota (which expands traditional CBT by more specifically incorporating attention to cultural, interpersonal and affect regulation issues). And there is more: the cognitive-analytic therapy and transtheoretical framework being grown and tested at the Maudsley and other centers in England (which includes elements of motivational interviewing now widely applied in the treatment of alcoholism and substance abuse).

A final chapter summarizes, contrasts, and compares all these treatments, focusing on the treatment models, the therapist's skills and attributes, assessment (including the amount of time given to assessment and the specific assessment instruments and tools employed), therapeutic goals, the time-line for therapy, how the case was conceptualized, the therapeutic bond, roles in the therapeutic relationship, techniques and methods of working, and answers to the specific questions posed above. As might be expected, many areas of overlap exist, but there are also significant and deep differences in treatment philosophies, techniques, and anticipated mechanisms of change. It's a pity that the various authors weren't given a chance to question and discuss each other's approaches.

In summary, this recent collection offers a broad, up-to-date, case-based review of a variety of psychotherapeutic approaches. Some have been around for years and have proven useful in clinical trials; some have been around for years but remain untested; and others are theoretically appealing and newly evolving. Every chapter will be informative and many will be thought-provoking, and even experienced clinicians will feel that they've been introduced to some new approaches.

—J.Y.

Establishing a Therapeutic Alliance with Clients

For the last few months, the tables have been turned on me. Instead of playing the familiar and comfortable role of dietitian, I have been the patient. Broken bones forced me to take a time-out from my professional life to focus on my own health.

Those who know me well knew how much I did *not* want to have orthopedic surgery. I would have done anything to avoid it. But the truth was I had to have it. I felt trapped and, quite frankly, scared. Thoughts of potential postoperative complications and rehabilitation were troubling.

However, something happened that significantly changed my perspective. I was referred to an orthopedic surgeon, and we quickly developed a rapport. By the end of our first session I felt I could trust this person and to do what so many times I have encouraged my own clients to do, take a leap of faith.

Over the years of working with eating disordered clients, I have come to understand the importance of establishing rapport and trust. Yet, it wasn't until my own experience that I fully appreciated the power of a therapeutic alliance.

The Importance of the Therapeutic Alliance

A collaborative relationship, or therapeutic alliance, between the client and all members of the eating disorders treatment team is essential in order for the patient to move forward in recovery. In the client-dietitian relationship, a therapeutic alliance supports the client with behavioral change and enables her to express emotions, describe behavior, and explore irrational thoughts related to food and eating. The patient can engage in nutritional counseling without fear of being judged or ridiculed.

Strategies for Developing a Therapeutic Alliance

My recent health dilemma prompted me to look at my own clinical practice. I was curious to identify the strategies that I use to develop a therapeutic alliance with clients. I realized my approach is a compilation of lessons learned from colleagues and my experiences with patients.

Establish Boundaries with Patients

Compared to some other team members, the dietitian may have greater difficulty establishing a therapeutic alliance with patients. Clients are typically very aware that the dietitian deals concretely with their symptoms, namely, their eating behaviors and low body weight. Often, clients begin nutritional counseling with assumptions about the dietitian's intentions. These preconceived ideas can tap into some of the patient's worst fears, making a trusting relationship elusive.

When I meet a client for the first time, I explore the possibility that the patient has misconceptions about my role. I ask the client how she felt about coming to the nutrition session, and whether she has seen a dietitian or any other "nutrition specialist" in the past. If she has already had nutritional counseling, I try to understand what that experience was like for her. Clients who have had bad experiences need an opportunity to discuss what went wrong and how their time with me can be different.

At this point, I also talk with clients about my role and responsibilities as a dietitian. I let them know that I am the team member responsible for conducting a nutritional assessment and designing a care plan according to their specific nutritional and educational needs. While I gather medical information such as physical signs and symptoms of the eating disorder, I don't provide medical advice. I also inform clients that I don't conduct therapy during the nutrition sessions because I have

not received the necessary training and certification in psychotherapy. I tell clients in advance that I will direct them to the most appropriate team member when medical or psychotherapy issues arise.

I define my professional boundaries in more detail by telling clients that expressing emotions about food and eating and discussing the meaning behind their eating disorder symptoms is appropriate during nutrition sessions, even though a thorough exploration of the latter is done with the patient's therapist.

Identify Limits of Confidentiality

Communicating with other team members (e.g., therapist, physician, social worker) is another of the dietitian's responsibilities. During the initial nutrition session, I identify the team members who will be privy to the information the client shares with me. Dietitians in private practice will need to have clients sign "Release of Information" documents in order to communicate with other health care providers. It is important that clients understand that the dietitian's contact with other team members increases their chances of receiving comprehensive treatment.

Dietitians who work with children and adolescents will need to identify the family members who will participate with the client in nutrition sessions. The family's involvement needs to be well defined for the patient before nutrition counseling gets underway.

Clarify the Client's Expectations of the Dietitian

In the early stages of nutritional counseling, clients need to hear how the dietitian will work with them. Explaining to patients what they can expect may help them feel more at ease.

At a conference in 1998, I heard Leah Graves, RD, LD, dietitian at the Laureate Eating Disorders Program, Tulsa, describe how she develops trust with patients. Leah's approach emphasizes honesty and integrity with clients. She tells her patients that she will not keep

secrets from them and will be honest if miscalculations or errors occur. She explains her role to clients by stating she will not do things to them. Instead, she will take the journey [toward recovery] with them in helping them accomplish their goals.

On numerous occasions, I have seen both rapport and trust enhanced when I have helped the client set goals based on her ability to change. Accomplishing realistic and self-articulated goals empowers patients to continue making changes with greater confidence. But, at the same time, I am clear about the goals I will not support (e.g., weight loss and/or medical instability). I let my clients know that, under these circumstances, they may not be involved in deciding how their treatment progresses. I inform clients that my nutritional counseling philosophy emphasizes personal health and overall quality of life. The focus is not on weight, although it will be monitored as an indicator of nutritional health.

Express Your Beliefs About the Client's Dilemma

So often patients presenting for treatment are embarrassed about their eating disorder behaviors and ambivalent about their ability to make changes. I believe it is important to let clients know that you will not pass judgment on any information they disclose. I tell clients that I understand and respect the function the eating disorder has served in their life—it has kept them alive.

A few years ago I heard Tami Lyon, MPH, RD, CDE, currently a dietitian in private practice in San Francisco and previous author of "Nutrition Notes," speak at an international eating disorders conference. She shared a message that she uses with clients in her practice: "I realize that at some point in your life you were distressed and needed to cope. An eating disorder helped by providing you with a set of tools that worked, but it didn't tell you that using

these tools would be so costly in the long run. I would like to work with you in slowly replacing these tools with new ones. Together, we can fill a new toolbox with tools that will enhance the quality of your life, not take away from it." Tami's message communicates how she views the clients' dilemma, and articulates, in a non-intimidating manner, her role in their treatment.

The client may believe that the dietitian has expectations about the client's recovery (e.g., that it will take a certain amount of time or it will look a particular way). An open discussion can help the dietitian identify these beliefs along with the client's own expectations about recovery. I let patients know that I see recovery as a process, not an event. Eating behavior changes take time, energy, and a commitment on behalf of the client and the dietitian.

Demonstrate an Interest in the Client's Life

As a health care provider, I feel it is crucial that I see my client as a person, and not simply as a patient with an eating disorder. Early in the relationship I try to connect with the client and to discuss an aspect of her life that is unrelated to her eating disorder. Mindful of personal and professional boundaries, I try to get to know the client in at least one of these areas: pets, hobbies, school, or vocation. I believe that touching on these topics throughout future nutrition sessions can strengthen the therapeutic alliance between client and dietitian.

Linda M. Watts, MA, RD

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eating disorder may have added to the denial of illness and unwillingness to seek treatment. A relatively small proportion of the eating disorders population—16.6% in our study, for example—are ill enough to be detained for treatment.

It could be argued that all eating-disordered patients could be treated effectively as outpatients. Several well-designed and controlled studies comparing the effects of hospitalization and outpatient treatment of the mentally ill show

that the outpatient treatment was as good or better than inpatient care and usually less costly.¹¹ However, studies on the outpatient treatment of life-threatening forms of eating disorders are limited.

Our study suggests that these severely ill eating-disordered patients who do not recognize their need for treatment do reasonably well in short-term treatment. However, a longer-term follow-up study is needed to determine the lasting effects of involuntary admission. Ramsay and colleagues confirmed that short-term treatment of involuntary and voluntary commitment is comparatively effective, but is more problematic for the involuntary patients.⁸

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Questions & Answers

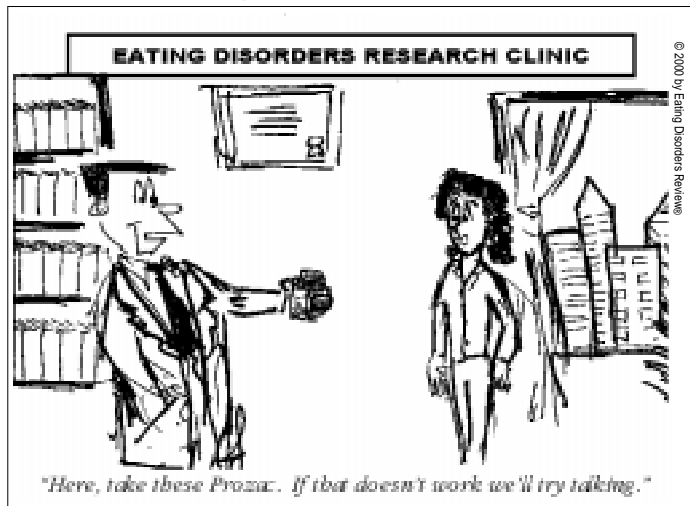
A Patient Who Resists Treatment

Q. I've been treating a young patient with anorexia nervosa who needs an inpatient program. But, she refuses to accept this recommendation. Her family has asked me about having her hospitalized against her will. What are the odds that she'd gain any benefits from hospitalization if she's so resistant? (*L. Reynolds, Houston*)

A. Without knowing the specifics of this patient's case, it's impossible to even speculate on what the impact of involuntary treatment might be. Decisions to hospitalize patients involuntarily can never be undertaken lightly, and legal jurisdictions vary widely from place to place. The problem you're confronting certainly isn't rare. A substantial minority of patients with severe eating disorders receive care only when involuntarily committed. Coincidentally, the study described in this month's lead article (*see page 1*) sheds some light on what may happen to involuntary patients, but the report addresses only what may happen during the period of acute hospitalization.

Of course, this study should be followed up to see if and how the weight gains achieved during hospitalization endure. Nevertheless, the results suggest that even patients who are involuntarily hospitalized

Nibbles, by Hunter



can make substantial initial progress. The caveat is that such successes may require treatment units in which well-developed and well-tested eating disorder programs exist, and where staff are trained and experienced to conduct these treatments.

— J.Y.

Charting Cerebral Blood Flow in Anorexics with Binge-Purge Behavior

Tetsuro Naruo, MD, and co-workers at Kagoshima University, Japan, have used single-photon emission computed tomography (SPECT) to chart distinct changes in cerebral blood flow among patients with anorexia nervosa (*Am J Psychiatry* 2000; 157:1520).

They studied 21 female patients: 7 with restricting AN, 7 with AN and habitual binge-purge behavior, and 7 healthy controls. The women were asked to visualize a piece of custard cake for 10 seconds and then to imagine themselves eating the cake for 5 minutes. SPECT scans were made before and after the women visualized eating the cake.

After visualization, women with habitual binge/purge behavior had the greatest apprehension about food intake and a significantly higher percentage of increased cerebral blood flow in the inferior, superior, prefrontal, and parietal regions of the right brain than the others.

The neural pathways involved in the recall of events may have an important role in binge eating and purging among anorexic patients. Their findings also suggest a close association between

neural network activation and episodic memory retrieval. The fact that specific activation of cortical regions of the brain plays an important role in perception and memory suggests an association between habitual binge/purge behavior and the cerebral recognition process.

In the Next Issue

Detecting Infection-Triggered Anorexia Nervosa

by Mae Sokol, MD

Streptococcal infection can trigger this unusual type of anorexia nervosa, also called PANDAS (Pediatric Auto-Immune Neuropsychiatric Disorders Associated with Streptococcus). Seven essential laboratory tests will help make the diagnosis. A Patient Information Sheet on PANDAS will be included.

PLUS

- **Assessing Readiness to Recover in Anorexia Nervosa**
 - **Internalized Stigma and Binge Eating Among Overweight Women**
 - **A Comparison Study of Two Types of Family Therapy**
 - **A New Tool for Studying Weight-related Self-Evaluation**
- and much more...

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