

EATING DISORDERS REVIEW®

Current Clinical Information for the Professional Treating Eating Disorders



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UPDATE

Negative Images and Automatic Thoughts Can Trigger Vomiting

Patients with emotional disorders often experience negative imagery that can be traced to core beliefs and memories of childhood trauma. At the annual meeting of the Eating Disorders Research Society, in Charleston, SC, last November, British researchers reported that negative automatic thoughts (related to core beliefs of defectiveness/shame) and recurring negative visual images may play important roles in triggering vomiting in bulimic patients. Thirty bulimic women were interviewed about their thoughts before vomiting; in addition, the women completed two self-report questionnaires of core beliefs and post-traumatic cognitions. Dr. Hendrik Hinrichsen and colleagues found that just before vomiting, most bulimic patients reported having thoughts relating to a core belief of defectiveness and felt shame and anxiety. Most reported that the feelings triggered vomiting. In addition, the women reported having visual images that were recurrent and linked to early traumatic memories. Finally, women who reported visual images prior to vomiting reported having more post-traumatic thoughts and beliefs than those who did not. It remains to be seen if this information can be translated into possible therapy to help reduce purging behaviors.

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Nutrition Care for Clients with Diabetes and An Eating Disorder

By Nancy L. King, MS, RD, CDE, and Linda M. Watts, MA, RD

Adolescents with Type I diabetes have a higher-than-normal prevalence of eating disorders. In fact, although roughly 1% and 4%, respectively, of patients in the general adolescent and college-age populations have Type I diabetes, nearly 7% of patients with anorexia nervosa (AN) and bulimia nervosa (BN) have it. In one study, 16.9% of 89 adolescent females with Type I diabetes had "disturbed eating behavior."¹ There is also greater body dissatisfaction and an increased drive for thinness in among females with Type I diabetes. Interestingly, an increased drive for thinness has been observed in males one year after the diagnosis of Type I diabetes.²

Early Warning Signs of an Eating Disorder

How can clinicians detect early warning signs of the development of an eating disorder among clients with Type I diabetes? By maintaining an open dialogue with patients about body image, self-esteem, and a sense of self-efficacy as these relate to diabetes. For example, you might ask the client, "How do you feel about your body's demand for food when your blood sugar drops below 60 mg/dl?" Or, "Do you feel differently about your body when you're wearing your insulin pump?" This may give her a chance to disclose that she is struggling with eating disorder thoughts or behaviors.

A good beginning in nutrition education is to ask the client what she already knows about diabetes.

ging with eating disorder thoughts or behaviors.

Blood glucose levels that are difficult to control or erratic, or don't seem to match food intake, stress levels, or physical activity, could be the result of disordered eating. Skipping insulin doses or scaling back on the prescribed regimen to make weight loss easier or to prevent

weight gain, can also be associated with an eating disorder. This particular behavior is extremely important to monitor because insulin omission is the

primary cause of recurrent diabetic ketoacidosis (a potentially life-threatening biochemical event triggered by unusually elevated blood glucose levels) in adolescents. Some other warning signs are trying to eat "perfectly," expressing disgust when glucose levels are elevated, self-berating one's body, excessively exercising to bring glucose levels back to normal, and binge eating.

Over time, disordered eating will cause hemoglobin A1c (glycosated hemoglobin; see also table below) levels to rise. In one study, adolescents with an eating disorder and Type I diabetes had a mean A1c of 9.4%; non-eating-disordered teens had a mean A1c of 8.6%; and subclinical eating-disordered adolescents had mean A1c of 9.1% (the ideal is approximately 4%-6%).³ Even though these values indicate elevated blood glucose levels over time, the client's erratic eating, and exercise, and insulin patterns can create a much higher risk for severe

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and unanticipated hypoglycemic events. Poor diabetic control can lead to long-term consequences among persons with diabetes and an eating disorder.

One overall approach to management of this population is to anticipate that the relationship with a client will be long term, open, process-oriented, and supportive. See yourself as a guide and advisor who “comes alongside” the client in a supportive way rather than as the authority on diabetes and eating disorders. This approach may be crucial for individuals, especially adolescents, who are struggling with an eating disorder because of underlying control issues and the daily demands and decision-making associated with diabetes management. Empowering the client to control what is in her primary “circle of influence” is a primary focus. But, it is equally important that she identifies and accepts the facets she cannot control and learns how to live with these limitations.

Important Nutrition Goals

Clients should be able to: (1) eat a wide variety of foods and manage the impact on their glucose levels; (2) eat in a way that adequately nourishes their body daily and preventively for future needs and challenges (i.e. growth, pregnancy, illness, aging); (3) identify and respond to their body's cues of hypo- and hyperglycemia; and (4) take more responsibility for their dietary choices, physical activity, and insulin/medication.

A good beginning in nutrition education is to ask the client what she already knows about diabetes. For example, does she know someone who currently has or had diabetes? What did they observe? What concerns do they have today? Who is in her life to support her? It's also helpful to cover the basic physiology of digestion (with diagrams and drawings), including the biochemical and mechanical aspects. This provides a natural lead-in to the glycemic impact of food and physical activity and the relevance of the body's cues (i.e., hypo/hyperglycemia, hunger, fullness, appetite, satiety, satisfaction). Later, you can weave in the micronutrient value of foods such as calcium, iron, and folic acid, for example. The initial goals are to inform and equip the client so she can normalize glucose levels as soon as

possible, or at least prevent severe hypo- and hyperglycemic episodes.

Promoting Healthy Eating

Most of the time, clients can expect to finish a meal or snack and be sustained by protein, energized by carbohydrates, and satisfied by dietary fats and sweets. The degree to which clients are ready to experience this depends on the reasons for their eating disorder. For example, if denial of pleasure or tolerance of inadequacy are the primary motivations for engaging in eating disordered behaviors, then don't expect clients to be ready to eat in a way that brings satisfaction or satiety. But, if they are ‘tired of feeling tired’ or depressed, explore the role and the amount of carbohydrates that can make them feel energized and promote a healthier brain “marinade,” a term first used by Dr. Joel Yager.

As clients become more open to feeling sustained, energized, and satisfied, they begin to experiment and discover foods from the respective groups that produce these outcomes, and are able to track their glycemic responses. This framework can be effective because it puts clients in the driver's seat. It's not focused on what they should do (a moralizing term), but rather on what outcomes they can and want to produce. At some point, clients discover this is the same dynamic that guided their eating disorder behaviors, but now the outcomes are supporting health. This shift depends upon each client's readiness to transition from expressing life issues through eating disordered behaviors to acknowledging, accepting, and meeting the body's needs through a nourishing eating style.

Meal Planning Tools

Carbohydrate counting is useful for many clients with diabetes, whether they have an eating disorder or not. Carbohydrate counting is a glucose management method that was used in the Diabetes Control and Complications Trial.⁴ With this method, clients are taught the carbohydrate content of each food group and given carbohydrate goals for each meal and snack to match their insulin regime (e.g., 62 g of carbohydrate at breakfast). Clients are encouraged to eat a variety of foods as long as the carbohydrate total for the meal/snack is within 3 g of their goal.

However, emphasize that they do not have to aim for perfection. In the same way most of us wouldn't stop to pick up a penny on the sidewalk, our bodies do not count pennies ("pennies" being 1 g of carbohydrate, or 5-15 kcal over or under what is anticipated). But, some individuals might need to care about the nutrition nickel, dime, or quarter. Explain to the client that one of our jobs as partners in the nutrition work is to discover what her body cares about using her self-monitoring blood glucose (SMBG) values. Of note, equating glucose monitoring with taking one's temperature is helpful to portray a nonjudgmental, but concerned and caring response to glucose values.

Carbohydrate counting can help clients with eating disorders see foods in a more neutral way, rather than as "good or bad." This encourages them to expand their "safe foods" list and to rediscover the pleasure in eating. The meal planning technique can empower them to make their own food choices, and by using the nutrition information on food labels, predict their blood glucose results. This tends to motivate clients to shift the responsibility of glucose management from their parents, or treatment team, to themselves.

Interestingly, carbohydrate counting can also help clients access the anger, injustice, frustration, and disappointment they feel, by making the limitations and the exceptional daily demands of their bodies more concrete. Ironically, although many clients with an eating disorder truly believe their bodies process food differently, or have different requirements than others, in the case of diabetes and eating disorders, facets of these beliefs are quite true. As clinicians, it is important to validate any accurate beliefs and the accompanying thoughts and feelings.

Then there are some clients for whom more "counting" approaches are not helpful. In this case, one can generalize portions by handful, fist-size, or hand-size as much as possible. If glucose values are predictable using this manner of meal planning, it is adequate for glucose management. The Willett pyramid may be helpful as a general nutrition guide. (It can be found at <http://www.hsph.harvard.edu/nutritionsource/pyramids.html>.)

Patients Who Purge

It is particularly challenging to work with clients who struggle with purging. Without SMBG, it may be nearly impossible to work safely and effectively with these clients. Complications such as delayed gastric emptying, coupled with purging through laxatives, vomiting or excessive exercising, can make medication adjustments difficult and can result in unstable and/or unsafe glucose levels. So, in the interest of clients' safety, one may see them three times a week and have phone contact with them between appointments. This dual diagnosis may require making a recommendation for inpatient treatment sooner for these clients than for clients without diabetes.

Insulin Regimens

Insulin regimens are determined by the client's ability and readiness to eat and engage in physical activity in a consistent and adequate way. With consistency and adequacy, blood glucose fluctuations occur within a narrower range. When the client experiences few serum glucose fluctuations, the risk of hypoglycemic episodes is lowered and her goal range can be moved closer to what is considered normal. But the more a client has an erratic and an inadequate eating style, the higher her serum glucose goal range will need to be above normal to prevent severe hypoglycemia. One approach is a combination of medium-/long-acting insulin, with short-acting insulin to accommodate eating according to hunger and fullness cues. Some clients who have a more consistent eating style find they prefer an insulin pump. Just like the other facets of an individual's treatment plan, insulin is tailored and adjusted in a way that meets the client's needs at any given point during recovery from the eating disorder. ■

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A FEW TERMS

Type I diabetes (once termed insulin-dependent or juvenile-onset diabetes) is beta cell destruction, which results in total dependence on exogenous insulin.

Type II diabetes includes insulin resistance with or without endogenous insulin deficiency or insulin deficiency with or without insulin resistance.

Hemoglobin 1Ac is a useful measure of metabolic control among diabetics with chronic hyperglycemia. The glycohemoglobins circulate within red blood cells, which have a life span ranging up to 120 days. Thus, the glycohemoglobins (1a, 1b and 1c) reflect the state of glycemia during the preceding 8-12 weeks, and provide an improved method of assessing diabetic control. The higher the prevailing ambient levels of blood glucose, the higher the levels of glycosylated hemoglobin. The standard hemoglobin H1Ac measurement is an average of all three glycohemoglobins.

Hyperglycemia: Abnormally high levels of glucose in the circulating blood. A relative or absolute lack of insulin secretion leads to higher than normal levels of circulating stress hormones and inappropriate blood glucose levels and changes in lipid metabolism.

Hypoglycemia: An abnormally small concentration of glucose in the circulating blood.

February 23-March 2

Eating Disorders Awareness Week 2003: Look for PBS Documentary

The National Eating Disorders Association is working with the Public Broadcast System (PBS) and television station KCTS Seattle to promote a new documentary film addressing eating disorders in the family. The film will be one highlight of Eating Disorders Awareness Week 2003, from February 23-March 2.

The film, "Perfect Illusions: Eating Disorders and the Family," will air at 10:00 pm (EST) on February 24 on PBS stations across the country. The film focuses on four families whose lives have been impacted by eating disorders. Viewers will meet 16-year-old Suni, who has recent-onset bulimia nervosa, 26-year-old Marya, who describes her 15-year struggle with anorexia nervosa and bulimia nervosa, and 20-year-old Annie, who became bulimic during a bout with clinical depression in high school. A fourth patient, Anna Westin, who developed anorexia nervosa at the age of 17, kept a diary during her battle with anorexia nervosa, but died from a fatal overdose of painkillers at the age of 21. Excerpts from her diary are included in the film.

"Perfect Illusions" goes beyond the women's experiences to describe the role family issues can play in eating disorders, including pressure to live up to high

expectations, and the traumatic impact of eating disorders upon family members. The film also explores the problem of insurance coverage for treatment. Anna's parents believed their insurance company's denial of treatment contributed to her death and this led to a landmark settlement against the company. The parents are using their \$1 million award to establish a residential treatment center for eating disorders.

2 million persons reached during Eating Disorders Awareness Week 2002

The major element of Eating Disorders Awareness Week is a nationwide screening and education program, aimed at educating students, parents, and teachers about eating disorders. Last year, more than 500 Eating Disorders Awareness Week coordinators helped reach more than 2 million people across the country, including elementary, middle school, high school, and college students, as well as parents and teachers.

In addition to the documentary film, the National Eating Disorders Organization will provide an online chat room for coordinators to share ideas and information, an educational video, new handouts, presentations, and promotional materials.

Leptin Secretion Linked to Severity of Disease in Bulimia Nervosa

Leptin is a hormone, produced by adipose tissue, which is thought to affect some of the many factors that influence satiety and to regulate body weight by adjusting feeding behavior and energy use. Factors other than size of fat cells and fat content influence the production of leptin, and thus the macro- and micronutrients in the diet have an important effect upon leptin production.

Work by a group at the University of Naples may help explain why lower leptin levels have been reported in some patients with bulimia nervosa (BN), but not in others. This group has tied decreased leptin secretion to more

chronic disease and greater binge eating/vomiting behavior among a subgroup of patients with chronic BN (*Psychosomatic Med* 2002; 64:874).

Palmiero Monteleone, MD, and colleagues measured plasma leptin levels and other hormone levels among a group of 127 women, including 33 patients with anorexia nervosa (AN), 56 women with BN, and 38 healthy controls. All the women were evaluated with the Eating Disorders Inventory, the BITE (Bulimic Investigation Test Edinburgh), and the Hamilton Depression Rating Scale, and had morning blood samples taken.

Decreased leptin levels reported

Compared with the healthy controls, underweight AN and normal-weight BN patients had decreased plasma levels of leptin, prolactin, and 17-beta estradiol. Cortisol levels were increased among AN patients but not BN patients. Among the bulimic patients, plasma leptin levels were inversely correlated with the duration of the disease and the frequency of binge eating/vomiting. In addition, 29 bulimic women had anorexic-like plasma leptin concentrations; the other 27 women had circulating leptin levels similar to that of the normal controls.

Thus, a subgroup of BN patients apparently secreted lower-than-normal levels of leptin despite having normal body weight. Therefore, something other than current body weight was involved in reducing leptin production in these patients. One contributing factor, according to the authors, might be a history of substantial weight loss—sustained weight loss has been shown to lead to a persistent reduction in circulating leptin in humans (*Horm Metab Res* 1996;28:698). Other researchers, such as Jimerson et al. (*J Clin Endocrinol Metab* 2000;85:4511) have also identified a relationship between decreased leptin levels and increased frequency of binge eating.

Can nutrition affect leptin levels?

The Italian scientists believe that the association between leptin levels and binge eating/vomiting frequency and the correlation between leptin and the duration of the illness, reflect changes in the subjects' nutrition and/or eating patterns and that this then affects leptin synthesis. They point out that in spite of the large number of calories bulimics ingest during a binge, these patients vomit a relatively large amount of calories and then engage in calorie restriction. A caloric intake below the normal requirements, even with no loss of fat mass, may have an impact on leptin synthesis. In addition, although BN is not characterized by lack of nutrition and cachexia, as in AN, incorrect selection of foods may lead to the lack of certain macro- and micronutrients in the diet that may then affect the production of leptin. Finally, experimental binge eating dramatically flattens the leptin diurnal rhythm even when the total calories are appropriate for weight. ■

Portion Power

It's well known that ever-increasing portion sizes have paralleled an increase of obesity in the U.S. Nutritionist Barbara J. Rolls and her colleagues at Penn State have added another element to the literature on food and portion sizes (*Am J Clin Nutr* 2002; 76:1207).

For 4 weeks, 51 men and women were served lunch one day a week. At each meal, the subjects were presented with 1 to 4 portions of macaroni and cheese. One group received the meal on a plate, and could choose the portion they wanted, and a second group got it in a serving dish and could take as much as they wanted.

The subjects consumed 30% more when offered the largest portion than when offered the smallest one. The amount consumed was not affected by who determined the amount of food on the plate—nutritionists or subjects—or by the participants' body mass index, gender, or scores of dietary restraint or disinhibition (Eating Inventory and Eating Attitudes Test). Five persons in each group were identified as "plate cleaners." When this subgroup was excluded from the analysis, the effect on portion size remained—subjects in both groups consumed a significantly greater amount of food as portion size increased. In addition, the ratings of hunger and fullness after the meal did not vary, although intake increased with the amount of food that was presented, suggesting that portion size influences the development of hunger and satiety.

Learning about appropriate portions

The authors note that many people are often not aware of what constitutes an "appropriate portion" (*J Am Diet Assoc* 1998;98:458). Since this is a factor that can be easily modified, it should be addressed in the efforts to prevent obesity. One approach would be designing better educational materials about appropriate portions and how to read nutrition labels. Other suggested strategies are encouraging people to eat at restaurants that offer smaller portions, or to set aside part of the food at the beginning of meal, or to serve smaller amounts of food at home. ■

BOOK REVIEW

Integrative Group Treatment for Bulimia Nervosa

(Helen Riess and Mary Dockray-Miller, New York, Columbia University Press, 2002. 260 pp; \$39.50)

A number of studies have shown that Cognitive-Behavior Therapy (CBT) and Interpersonal Therapy (IPT) are each effective, in both individual and group therapy formats, for reducing symptoms of bulimia nervosa and symptoms of depression. These authors describe a form of therapy that integrates key elements of both of these approaches into a single modality that has been offered in a 12-week-long, once-a-week, 90-minute format, conducted by one or two group leaders, at the Massachusetts General Hospital. Based on data from half a dozen completed groups involving women 21-40 years of age, this method appears, at least at the end of the 12 group sessions, to result in about 60% reduction in binge and purge episodes (and, in some cases, has led to abstinence). It has also been followed by a substantial reduction in symptoms of depression as assessed on the Beck Depression Inventory. The treatment employs strategies that directly affect eating behaviors as well as strategies that focus on the interpersonal and relational context in which the disordered eating evolved and persists. The authors are clear at the outset about criteria for patients selected into the group, excluding those with anorexia nervosa, severe personality disorder or psychosis,

suicidality and/or chemical dependency problems. The essence of the book provides a detailed session-by-session treatment manual, complete with log sheets and some handouts, for therapists who may want to use this approach. The first three sessions are devoted to psycho-education and the second three to the cognitive behavioral phase. Session 7 concerns cognitive-experiential issues and sessions 8-12 involve the interpersonal/relational phase with some experiential components woven through. In the 11th session, discussions regarding possible referrals for additional ongoing therapy are addressed. Techniques incorporated range from essay writing homework through assigned readings, psychodrama exercises and group meals.

No mention is made of whether any of these patients simultaneously participated in individual therapies or used psychiatric medications, so from my reading it's difficult to know whether the gains are entirely attributable to the patients' work in these groups. As the authors indicate, additional research will be needed to show the longer-term impact (e.g., 1-5 years), the need for additional treatment to sustain and facilitate further improvements, and the effectiveness of this approach in relation to other modalities. In the meantime, this manner of integrating CBT and IPT approaches makes intuitive sense clinically. Therapists contemplating running treatment groups for the types of bulimia nervosa patients addressed here will do well to consult this book.

— J.Y.

Binge Eating Disorder: More Common than Suspected?

Community-based studies have generally shown that about 2% of the general population, or 1 to 2 million adults, have problems with binge eating. A recent study among women seeking treatment for binge eating suggested that binge eating disorder, or BED, may be more common than suspected (*Eating Behaviors* 2003;3:295).

Nearly 85% of 592 women seeking treatment for binge eating or weight loss reported binge eating (consistent with the DSM-IV definition of a binge). The women were recruited through advertise-

ments and then interviewed by telephone. The women were from 19 to 67 years of age (mean age: 44.7 years). Most were Caucasian, college-educated, and married. Seventy-four percent were obese (BMI >30), and 0.2% were underweight (BMI <18.5). Most reported becoming overweight before they were 19-years-old.

Thirty-three percent of the women (200) met the DSM-IV criteria for BED, 11% (65) met criteria for non-binge eating disorder (NBED), and 55% (328) met criteria for subclinical binge eating

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disorder (SBED). Among those with SBED, 8.7% tried to control their weight with self-induced vomiting; 24.7% used diuretics, 12.2% used laxatives, and 12.2% regularly used diet pills.

How did those with BED differ?

According to the authors, women diagnosed with BED had higher BMIs, had become overweight at an early age, and reported more unhealthy methods of trying to control weight than did non-BED women. Women with BED also reported more current and past depression and suicidal ideation than did NBED women. Mothers of women with BED also were more often overweight than were mothers of NBED women, but there were no differences in weight of fathers or parental eating disorders between the two groups.

Two characteristics required for a binge include consumption of a large quantity of food in a short time and feelings of loss of control. Two situations seemed to precede binge-eating episodes: stress and boredom. However, a large number of women could not explain why they binge-ate.

Limitations of the study

The authors point out that their study results might be limited by the fact that

the women were interviewed by telephone only, and suggest that future studies could be improved by adding a second phase of assessment to confirm the diagnosis of BED. The results may also be limited by the inherent bias that exists in recalling retrospective information about age overweight, number of pounds overweight and parental weight status and psychological makeup. In addition, the participants responded to ads for a treatment study of binge eating or weight loss, and the recruitment advertisements may have influenced the subjects. The authors note that the

Two situations seemed to precede binge-eating episodes: stress and boredom.

prevalence of BED was more similar to samples of clinic-based treatment samples than community-based samples. Finally, the authors admitted that they weren't able to accurately categorize women in the SBED group as having BN or subthreshold BN because they failed to ask the relevant diagnostic questions to all of the women in the sample.

The authors note that their findings highlight the need to further investigate the relationship between binge eating and depression among women, to better understand whether depression precedes or follows binge eating. This information might be helpful in the development of interventions to target both binge eating and depression among women in treatment and community settings. ■

Fluoxetine Shows Promise For BED

A wide range of antidepressants, including the selective serotonin reuptake inhibitors (SSRIs) have been effective for people with bulimia nervosa (BN). Fluoxetine (Prozac®), the only drug currently approved for the treatment of eating disorders, has been effective for treating BN. Could it also be helpful for BED?

Lesley M. Arnold, MD and co-workers assessed the safety and effectiveness of fluoxetine among 60 outpatients with a DSM-IV diagnosis of BED. The participants were randomly assigned to receive either fluoxetine, 20-80 mg/day (30 patients), or placebo (30 patients) in a 6-week, double-blind, flexible-dose study (*J Clin Psychiatry* 2002; 63:1028). The dosage was begun at 20 mg, increased, as tolerated, to 40 mg/day for 3 days, and then increased to 60/mg/day. After 2 weeks, the dosage could be increased to 80 mg/day.

Results

The group treated with fluoxetine had a significantly greater reduction in frequency of binges, greater weight loss, and lower CG-S and HAM-D scores than did the placebo group. The mean dosage was 71 mg/day. At week 6, the estimated mean difference between groups in frequency of binges was 1.1.

Although fluoxetine was generally well tolerated, 24 people withdrew from the study—17 from the placebo group and 7 from the fluoxetine group. The most common reasons for this were: sedation, hand and foot swelling, palpitations, diarrhea, nausea and apathy. The most common effects reported by those treated with fluoxetine were dry mouth (11), headache (9), fatigue (6), and sedation (5).

It is still not known how fluoxetine acts to treat BED. Although side effects such as anorexia, dyspepsia, and nausea may have helped reduce binge eating, in this study the incidence of these effects was not different in each group. Fluoxetine may act by correcting abnormal serotonin neurotransmission, according to the authors. ■

Ballet Dancers and Familial Risk

Ballet dancers are known to be at high risk for developing eating disorders based on the demands on appearance and high levels of physical activity. They may have an additional challenge—an underlying familial risk for eating disorders.

Dr. Kelly L. Klump and colleagues recently compared the rates of eating disorders in ballet dancers with and without a family history of psychopathology. Eating disorders and other Axis I disorders were assessed in 32 ballet dancers and 90 of their first-degree relatives, using structured clinical interviews.

Dancers with at least one relative with an Axis I disorder were twice as

likely to have an eating disorder than dancers without any affected relatives. When family histories of eating disorders alone were compared, ballet dancers with family histories were 13 times more likely to have an eating disorder than dancers without a family history of eating disorders. Thus, there is preliminary evidence that there is a familial and possibly a genetic risk that underlies development of an eating disorder among ballet dancers. The group reported their study at the recent Eating Disorders Research Society annual meeting in Charleston, South Carolina. ■

Measuring Body Image's Effects on Quality of Life

A new questionnaire, the Body Image Quality of Life Inventory (BIQLI), can effectively measure effects of body image on feelings about the self and life in general, according to Dr. Thomas F. Cash and Emily C. Fleming (*Int J Eat Disord* 2002;31:455). Dr. Cash is well known for his research on body image and for his workbook, *The Body Image Workbook. An 8-Step Program for learning to Like Your Looks* (New Harbinger Publications, 1997).

The authors report that even though many studies have emphasized the increasing prevalence of negative body image, discontent with one's body doesn't always lead to problems. For some, unhappiness with weight, height, hair or facial features may not lead to a negative body image, while for others the impact is much more serious. Although research confirms that body image can affect many aspects of psychosocial functioning, until recently there was no direct way to measure its effect upon quality of life.

Dr. Cash and colleagues developed the BIQLI by studying 116 college women at a large mid-Atlantic university. The mean age of the study group was 21.3 years, and 86% were single. The sample included 55% Whites, 33% African-Americans, 5% Asians, and 7% from other minorities. The average body mass index (BMI= k/m^2) was 24.7, and ranged from 15.7 to 49.2. Dr. Cash and colleagues selected 3 subscales of the Multidimensional Body-Self Relations Questionnaire. To check the validity of the results, the women re-took the test 2 to 3 weeks later.

Results: More positive than negative

The assessment was consistent and stable over the 2- to 3-week period. Women in the study group reported more positive than negative consequences of their perceived body image. As expected, having a higher score was significantly associated with higher body satisfaction, less body shame, less preoccupation with or fear of becoming "fat,"

In 1944, the Swiss psychiatrist Ludwig Binswanger published an elaborate case history of a patient he diagnosed as having a form of schizophrenia. In fact, it is a poignant example of anorexia nervosa of the bingeing-purging subtype. After it was translated into English, the case became well known and is often quoted as one of the classic case histories of bulimia. I personally have studied the case from a clinical point of view and published a Dutch translation with comments. But at the time we commented on the case, the original files were not available, so we had to rely on Binswanger's publication. In the meantime, the hospital files and Binswanger's personal archives are now at the University of Tuebingen in Germany.

A collaborator of the Institute for the History of Medicine, Albrecht Hirschmueller, has studied the original reports as well as Binswanger's own notes in detail [Ellen West – a pseudonym – was treated at his private hospital in 1921] and has also found new documentation obtained from Ellen West's family (including correspondence between her husband and Binswanger). Hirschmueller organized a conference in October 2002 on Binswanger's hospital with a special section on the case of Ellen West. The papers will be published soon (others can be found on the website: http://w210.ub.uni-tuebingen.de/portal/binswanger_tagung/).

and less over-concern with appearance.

An additional analysis tested the hypothesis that women with higher BMIs would report a poorer body image quality of life, independent of their level of body satisfaction. More of the women reported a positive rather than a negative impact on body image. ■

New documentation on the famous case of 'Ellen West'

To those who can read German, I recommend the detailed report by Hirschmueller recently published in a German journal on the history of psychoanalysis. It is a most fascinating story because you will read about the treatment failures (from Ellen's viewpoint), interwoven with the psychoanalysts' countertransferences, and also that Binswanger and the husband have "arranged" or "prepared" Ellen's suicide!! In fact when I was studying the case ten years ago (and published in Dutch about it) I was puzzled that Binswanger had missed a 'neurotic' diagnosis (anorexia nervosa) and defended a 'psychotic' one (the 'incurable' schizophrenia). I hypothesized that he needed this interpretation to get rid of his responsibility (guilt) and feelings about Ellen's suicide (Binswanger's own son committed suicide...). The new documentation confirms this assumption in a most dramatic way!

Binswanger, L. (1944/translation 1958). The case of Ellen West. In: R. May et al. (eds.), *Existence: A new dimension in psychiatry and psychology*. New York: Basic Books.

Hirschmüller, A. (2002). Ludwig Binswangers Fall "Ellen West". Zum Verhältnis von Diagnostik und Übertragung. *Luzifer-Amor* 15 (29):18-76 (publisher: <http://www.edition-diskord.de/>).

Vandereycken, W. (1992). *Ellen West; Een klassiek geval van anorexia nervosa en boulimie*. Amsterdam: Candide.

— Walter Vandereycken, MD, PhD

Correction

In the May/June 2002 issue, the citation for the article, "Weight Teasing: The Long-Term Effects," was confusing. The study by Dr. Diane Neumark-Sztainer et al. appeared in the *International Journal of Obesity and Related Metabolic Disorders* 2002; 26:123.

QUESTIONS & ANSWERS

Growth Stunting in Anorexia Nervosa

Q I know that one of the risks of anorexia nervosa in adolescents is stunting of growth. To what extent can patients catch up to their expected growth if they're treated early with adequate nutrition? (L.B., Kansas City)

A You're certainly correct about short stature in adolescents with anorexia nervosa. Several groups have observed that anorexia nervosa presenting prior to menarche is associated with growth retardation. Some research has shown that patients who have had anorexia nervosa for at least six months manifest arrested growth, and that after good nutritional intervention, catch-up growth occurs (*Isr J Med Sci* 1994; 30:581). However, it appears that even with good treatment these adolescents don't catch up to their expected theoretical heights (estimated

on the basis of their pre-illness pediatric growth curves). In a recent prospective study, 16 pre-menarchal females were followed from presentation at an average age of 12.6 years through nutritional rehabilitation (average: 4.6 years). In this group, the average age of menarche was delayed to about 15.5 years (U.S. average: 12.88 years). Although some degree of catch-up occurred in the majority of patients, despite aggressive treatment 13 of 16 (81%) did not achieve their theoretical heights. Averaged together, the group achieved "near final adult heights" that were 97% of the expected heights. The average height deficit was about 4.1 cm. Contrary to the investigators' starting suppositions, the final height outcomes were the same for subjects presenting in early- or mid-puberty (*J Adolescent Health* 31:162, 2002). The take-home message is that although these patients did not catch up to their theoretical heights, without early and aggressive nutritional treatment their final height deficit would have been even greater.

— J.Y.

ON THE CALENDAR

February 23-March 2: Eating Disorders Awareness Week

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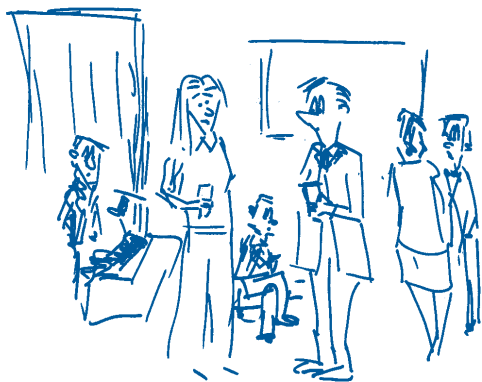
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Nibbles by Hunter



"For me, FAT is bioterrorism."

IN THE NEXT ISSUE

Recent Advances in the Eating Disorders

Arnold Andersen, MD,
James Mitchell, MD,
Marsha Marcus, MD and
Michele Levine, MD

Find out what's new in diagnosis and treatment for three major eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder.

PLUS

- False Hopes of Self-Change
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