

# EATING DISORDERS REVIEW®

Current Clinical Information for the Professional Treating Eating Disorders



Published by Gürze Books,  
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publications and education since 1980.

ISSN 1048-6984

SEPTEMBER/OCTOBER 2003 • VOL. 14 / NO. 5

## UPDATE

### Baring Truths About Women's Bodies

In an effort to counteract the unrealistic and sometimes harmful portrayal of women in ads and other media, a pilot project is bringing real-life images and stories of women to sites across the country. "The Century Project," a collection of nude photographs and personal stories of women from birth to 100 years of age, is now touring the U.S. The exhibit is designed to counteract media images of unrealistic female shapes with real-life images. Women have responded positively to the exhibit, according to the authors, and often describe the exhibit as having a "therapeutic effect" upon their own body image. As Janet Murray and Stacey Tattleff-Dunn of the University of Central Florida reported at this spring's Academy for Eating Disorders meeting in Denver, modest but positive effects occurred after a test group of 56 undergraduates (41 females and 15 males) viewed the exhibit. After seeing the exhibit, the men and women rated their reactions on several dimensions, using a scale from 1 (changed negatively; unimportant) to 5 (changed positively; very important). After the exhibit, the students' views of their own bodies were slightly more positive. Women reported more positive changes than did men.

## Treatment Transitions: Improving Patient Recovery Through Effective Collaboration

By Kari B. Wolfe, MS, CPC  
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Treating a person with an eating disorder can take many years and many cycles of care before recovery occurs. Research suggests that the course of illness for anorexia nervosa may be 7 to 10 years<sup>1</sup> and possibly less for bulimia nervosa<sup>2</sup>. As professionals, we often see patients who have received treatment, but for whom the continuum of care has been broken, leaving us without access to critical information. Between 20% and 30% of eating disorder patients drop out of treatment<sup>3</sup>. Due to denial and cognitive impairment secondary to malnutrition, there are significant impediments, including denial of the severity of illness. Thus, patients may not fully understand the issues raised during previous treatments. The same ground is therefore covered and recovered, unnecessarily prolonging the illness.

and when inpatient and outpatient providers have established ties to one another. Shared knowledge, trust and common language, and the responsiveness of self-identified colleagues all prove beneficial.

**Treatment recommendations from unified teams are difficult for insurance companies to dispute.**

In 2002, our center mailed a treatment transitions survey to 100 randomly selected outpatient eating disorders professionals. Sixty-five percent responded. Their feedback is integrated into the recommendations below.

### Team Collaboration

Nearly all our respondents agreed that severe eating disorders, such as low-weight anorexia nervosa, are best treated with a multidisciplinary team, including a primary care physician, a dietitian, a psychiatrist, and a psychotherapist. This approach is believed to be superior for many reasons, such as medical comorbidities that pose serious risks, including death, and eating disorder complexities that require skills in nutrition science and psychopharmacology. Uncomplicated bulimia nervosa is an exception. In our survey, professionals who were not working with a team nevertheless recognized its importance and wanted to develop one.

Team success requires that all members have a general knowledge of the other

### Collaboration to Improve Recovery

Collaboration across the continuum of care, improved communication, and synergy of treatment approaches may improve recovery. Collaboration and communication are enhanced when outpatient providers work together frequently as a team,

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**Eating Disorders Review®** (ISSN 1048-6984) is published bimonthly by Gürze Books, PO Box 2238, Carlsbad CA 92018. 760/434-7533, fax 760/434-5476, e-mail [gurze@aol.com](mailto:gurze@aol.com). Prior indexes and more information at [www.gurze.com](http://www.gurze.com).

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disciplines and that they communicate regularly. Eating disorder patients often minimize symptoms, failing to talk about essential issues. A team is better able to gain the information necessary to adequately treat patients. Teams' unified treatment recommendations are more effective with families, insurance providers, and patients.

**Developing a treatment team.** The first step in developing a team is finding professionals who are knowledgeable about eating disorders or who are willing to learn about them. Here are some suggestions for those willing to learn: (1) Send them a copy of the *American Psychiatric Association Practice Guidelines*. (2) Suggest they join eating disorders associations, such as the Academy for Eating Disorders. (3) Recommend that they subscribe to relevant journals and attend relevant conferences. (4) Suggest that they host a monthly eating disorder consultation group with other professionals.

Close communication is often difficult, given the busy schedules of many professionals. However, effective communication can be achieved with confidential voice mail and faxes. Letters work as well, and might be more confidential. Teams should determine the information that is relevant to the group. Critical information may include: changes in medical status, including weight changes, problems with follow-up, missing appointments, and changes in meal plans. If higher level of care criteria are met, a conference call is needed to plan for the transition. One team member can act as a point person for the team, the family, and the patient. Appropriate information releases must be secured at the beginning of treatment, so providers can discuss important issues with other members of the team. When patients fail to cooperate, it may be a sign of therapy-interfering behavior. In such cases, the therapist and patient may need to negotiate a workable solution.

### Outpatient-to-Inpatient Transitions

Our survey indicated that professionals recognize level of care needs according to the severity of illness.<sup>4</sup> Treatment failures, including treating patients unsuccessfully for an extended time, may

also indicate the need for a higher level of care in order to handle patient resistance and provider countertransference.

**Managing change.** Outpatient providers have the major responsibility for coordinating the patient's care and for assessing their levels of care. To manage changes, outpatient providers must know that patients may need higher levels of care from professionals in their region. Therapeutic rapport can be pivotal when convincing a family or patient that a higher level is necessary. Transitional teleconferencing prior to and after a higher-level admission can ease concerns and build confidence. Outpatient providers have a great deal of influence with insurance companies and recommendations from united teams are difficult to dispute. Experts can also help educate insurance companies about industry standards for appropriate levels of care with eating disorders.

Because eating disorder patients are often reticent, a telephone call to gather information about the patient is essential for the inpatient providers before a treatment plan can be formulated. An agreement should be made between inpatient and outpatient providers regarding communication during the inpatient stay.

During longer lengths of stay, it is standard practice for outpatient therapists to disengage from therapy with their patients so that patients may switch to a new treatment setting and develop trust with the new treatment team. However, it is optimal for inpatient and outpatient providers to communicate at least twice during the patient's stay, to keep outpatient providers abreast of patient progress and to help with interventions if the patient begins to talk about leaving inpatient treatment prematurely. For shorter lengths of stay, good judgment will be needed to help both groups decide the outpatient provider's degree of disengagement.

Inpatients may say that the outpatient providers were not helpful to them. This may simply mean that such patients are displeased with the recommendation for a higher care level and the outpatient provider(s) who made it.

### Inpatient-to-Outpatient Transitions

A teleconference prior to discharge is

essential. This conference should include the patient. Treatment progress and issues to address in the lower level of care should be discussed and agreed upon. There may also be times when the inpatient team may need to communicate information to the outpatient treatment team that would not be said in the same way with the patient present. For patients with more severe illness or those who have been inpatients for a longer time, transitional care or "step-down" programs may be indicated for one to three months. These patients benefit from the structure of such programs, which enable them to practice new skills and to gain confidence while facing typical stressors of everyday life. Once patients are ready to return to outpatient care, inpatient/transitional providers should coordinate this hands-off with their outpatient colleagues by scheduling appointments for the patient during the first week following discharge.

All pertinent medical records should be forwarded to the appropriate outpatient providers, preferably prior to the first appointment with that provider. Inpatient treatment centers have a wealth of information available to the outpatient providers, often including psychological testing results and family therapy notes that are sometimes difficult to gather on an outpatient basis. According to those surveyed, most outpatient providers want clear and specific treatment recommendations from inpatient providers. They also believe that the discharge plan should contain specific criteria for readmission, such as body weight or other indicators of relapse.

Outpatient providers want to know the specific interventions and program content of the inpatient facility in order to continue with similar language, tools, and skill building. This helps the patient to internalize the inpatient experience. Inpatient and outpatient treatment goals should be discussed and aligned as much as possible. This also sends a congruent message to patients, and less time will be wasted on therapy-interfering behaviors such as splitting between providers.

**A patient's own manual.** During inpatient discharge planning, it's helpful for the patient to create a "User's Manual" to share with the follow-up

treatment providers. In the manual, the patient writes down behaviors, events, and perceptions that might cause trouble in the future. These are often called Red Flag Warning Signs<sup>5</sup>. Involved families can also be alerted by the patient to these warning signs of relapse.

In our survey, one outpatient professional wrote, "...follow-up communication prior to discharge is the most essential piece." Patients should be aware that collaboration exists and that outpatient providers expect their return on a specific date.

### Getting Patients Back Into Treatment

Although most providers agree that communication and complementary approaches to care are essential, it is unfortunate that when patients fail to follow through with outpatient appointments, many healthcare professionals, inpatient and outpatient, do not try to bring patients back into treatment. Patients may need help with their motivation to change. We cannot assume that patients who reach a particular level of motivation at one point in treatment will maintain this level of motivation<sup>6</sup>. Changes in environment or relationships, along with fear, can affect patients, even those with the best intentions.

We urge providers to make a commitment to improve the recovery process for eating disorder patients and to try to go the extra mile when patients don't follow through. Preventing relapse and keeping patients in treatment can save lives.

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## BMI and Diet Groups

A higher-than-normal body mass index, or BMI, has been identified as a risk factor for shortened lifespan and development of diabetes, heart disease, and some cancers. Cancer researchers at Oxford University have expanded upon this to make a connection between BMI and specific eating patterns (*Int J Obesity* 2003; 27:728).

Dr. Elizabeth Spencer and her colleagues compared the BMIs of 37,875 healthy men and women aged 20 to 97 years who are participating in the European Prospective Investigation Into Cancer and Nutrition (EPIC-Oxford), a long-term, ongoing study of lifestyle and dietary factors. The participants were classified in one of four groups of eating patterns, according to their main dietary preferences: as meat-eaters, fish-eaters, vegetarians, or vegans (people who choose to eat no meat, fish, eggs, or dairy foods).

### Meat-eaters had highest BMIs

The mean overall BMI (kg/m<sup>2</sup>) was 23.81 for men and 23.05 for women. There were considerable differences in mean BMI among the four diet groups. The fish-eaters and vegetarians had lower mean BMIs than the meat-eaters, but had higher mean BMIs than the vegans. Mean (unadjusted) BMI was highest among meat-eaters, at 29.49 for men and 23.69 among women, and lowest among vegans, at 22.34 for men and 21.75 among women.

Among men 5'11" tall, meat-eaters were a mean of 13 lb heavier than vegans. For a woman 5'6", the corresponding difference in mean BMI represented a difference in weight of about 11 lb between vegans and meat-eaters. Eating a diet of high protein and low fiber was the factor most strongly associated with low BMI.

# Family Therapy for the Teen with Bulimia Nervosa

A three-phase approach using family-based treatment may be a helpful option for adolescents with bulimia nervosa (BN), according to an ongoing study at the University of Chicago (*Am J Psychotherapy* 2003;57:237).

## Still uncharted territory

Although much information is available about the causes and treatment options for *adults* with BN, much less is known about effective treatment for adolescents diagnosed with BN. For example, although cognitive behavioral therapy (CBT) and interpersonal therapy (ITP) have been helpful for adults, no clinical trials of CBT or IPT have yet been designed for teens.

Dr. Daniel LeGrange and colleagues at the University of Chicago have had good preliminary results with a family therapy approach for adolescents with BN.

There are several strong arguments for including the family in treatment of teens with BN, according to the researchers. For example, information about BN can be shared with the parents and their child, and issues about meals and the impact of the eating disorder on family relationships can be addressed. Additionally, the intrinsic denial of the alarming nature of bulimic symptoms makes many teens incapable of appreciating how serious the disorder may be. This makes it necessary for the parents to become involved to make certain that the teen gets adequate treatment.

## A manualized approach for BN

Based on an earlier manual developed for family treatment for anorexia nervosa (AN), the researchers developed a manual for BN that reflects three clearly defined phases of treatment. Whereas in AN the first and main focus of treatment is empowering the parents to succeed in refeeding their starving daughter or son, the treatment focus for adolescents with BN is helping parents help their son or daughter regain control over eating and preventing the child from turning to binge-eating and purging. Just as in AN, it is only after the eating disorder has been successfully addressed that parents can hand control over eating back to their child.

**Phase 1. Regulating food intake (sessions 1-10).** In the first phase, treatment is almost entirely focused on the eating disorder, in order to enable parents to help their child to regulate eating and stop purging. A family meal with the therapist early in treatment starts the process of parental involvement, and lets the therapist directly observe the family's interactions to eating. The therapist helps parents relieve their guilt, so they stop thinking that they caused the eating problem. The emphasis is on the positive aspects of parenting. Families are encouraged to work out for themselves how best to stabilize the bulimic child's eating. The initial session also helps educate the family about the nature and challenge of treating bulimia, especially the secretiveness and shame associated with binge eating and purging.

**Phase 2. Negotiating a new pattern of relationships (sessions 11-17).** The second phase can begin once the patient has agreed to her parents' demands that she normalize food intake and abstain from binge eating and purging, and when the therapist detects a change in the mood of the family (e.g., relief after taking charge of the problem). Although symptoms are the center of discussions, regular, stress-free meals are now encouraged. This second phase also marks the return of control over eating to the adolescent. Parents monitor eating but allow the teen to make her own food choices. Other family issues can now be brought forward for review.

**Phase 3. Adolescent issues and termination (sessions 18-20).** Once the patient maintains a stable weight and binge/purge symptoms have disappeared, the therapist and family work to establish a healthy adolescent or young adult relationship with the parents. In this relationship, the illness is not the center of attention. This stage also involves working toward increased personal autonomy for the adolescent, more appropriate family boundaries, and addressing the need for independence.

According to the authors, their manualized treatment approach is still in the preliminary stages, but family therapy for adolescents with BN may enable patients to recover without pro-

tracted outpatient treatment or hospital admission.

## Racial Teasing and Its Effect on Body Image Among South Asian-American Women

Acculturation and loss of ethnic identity have been proposed as risk factors for eating and body image disturbances among women of color. Now two researchers have added another risk factor: being teased about racial or ethnic features (*Int J Eat Disord* 2003; 34:142).

Drs. Dana Sahi Iyer and Nick Haslam report that women from South Asian backgrounds have been overlooked in studies of minority women and eating disorders. This is unfortunate because these women are culturally, economically, and historically distinct from women in other ethnic groups and have markedly different cultural practices, including arranged marriages and religion.

### What is racial teasing?

In typical childhood teasing, the comments are directed at children thought to be different or who are disliked. In contrast, "racial teasing" focuses on the target's ethnically distinct attributes. In a 1988 study by Kelly and Cohn, racial teasing was the most prevalent form of teasing among 10- to 17-year-olds in England. Both forms can have long-lasting and detrimental effects upon the target child. Researchers have shown the connection between being teased and development of aggressiveness, depression, low self-esteem, eating problems and body image dissatisfaction.

Racial teasing might also adversely affect body image because it selects appearance-related features. By drawing hurtful attention to their distinct features, racial teasing might lead minority women to adopt the beauty norms of the dominant culture, misidentify with their host culture, and experience identity problems, distress and self-denigration, all of which can promote eating and body image problems.

### The study

Participants in this study included 122 American undergraduate women (mean age: 20.6 years) of South Asian descent who were recruited from 5 states. Most (89%) were Asian Indian-Americans and most came from affluent families (67% had family incomes above \$60,000 per year). All the women completed seven self-report questionnaires and a demographic information sheet

### Results

In this group, only a history of hurtful racial teasing, but not acculturation or loss of ethnic identity, was associated with disturbed eating behavior and body image dissatisfaction. Racial teasing, which was reported by 86% of the women, was not correlated with ethnic identification, and only weakly correlated with acculturation.

### Associations are still unclear

Just how and why racial teasing is associated with disturbed body image and disordered eating is still unclear. The authors hypothesize that being teased about visible signs of being ethnically different might make some girls dissatisfied with their appearance, and they may then turn to disordered eating in an attempt to change it. Another possibility is that racial teasing may create or deepen a sense of not belonging in the surrounding culture.

The results of the study strongly support the role of racial teasing in disordered eating behavior and body image problems. This indicated that racial teasing might be an important but neglected factor in eating and body image disturbance among minority women.

Researchers and theorists interested in studying eating disturbances among ethnic minorities may need to look beyond women's relations to the dominant culture and their culture of origin. If a history of being cruelly taunted about one's ethnic appearance is associated with eating and body image disturbances, then it may be the majority culture's response to the minority individual, not just her accommodation to it or estrangement from her own ethnic origins, that plays a role in the development of these disturbances.

### *The Psychology of Bulimia Nervosa: A cognitive perspective*

(By Myra Cooper, PhD. Oxford University Press; 2003. 337 pages, \$49.50)

Although \$49.50 may seem a lot to spend on a paperback book, this informative review and synthesis nicely delivers what it promises—a very scholarly introduction to psychological aspects of bulimia nervosa, primarily cognitive theoretical and treatment approaches. I suspect that it developed from an advanced seminar for psychology graduate students at Oxford. For someone new to the field, this book will provide an excellent way to step into the current scene. For those who've been in the field for a while, this book offers a careful review, and contains interesting discussions from which even veterans can learn something new.

At the very outset, I was grabbed by the historical introduction, in which Dr. Cooper resurrects “kynorexia” (a term from antiquity and the Middle Ages referring to “insatiable hunger like that of a dog”) and “bulimia emetica,” from Cullen's 1780s classification of three types of bulimia, in which vomiting followed excessive eating.

Next, after a detailed review of the status and controversies concerning nosology and key clinical features, Dr. Cooper turns to her main focus, thorough discussions of psychological issues. In each area, she presents and critiques the evidence, pointing out difficulties in interpretation, gaps in knowledge, the need for future research, and treatment implications. She begins with internal states

and their cognitive associations, involving self-esteem, body image, impulsivity, sexuality and perfectionism. Then, she turns to external and developmental factors, including abuse, attachment, emotional regulation, development of the self, family issues, life events, coping, and social support.

There are reviews of epidemiology, cultural issues, and a brief but helpful survey of non-cognitive psychological theories, including psychodynamic (ego-psychology, object relations, self-psychology and relational theories), sociocultural, feminist, family/systems, and behavioral theories.

When we finally get to cognitive theories, about halfway through the book, we've been well prepared for an in-depth discussion. Her review of the basic assumptions offered by major theorists in the field is focused and edifying – Garner and Bemis; Fairburn; Young; Vitousek and Hollon; Guidano and Liotti; Cooper et al, etc. She then addresses some of the newer ideas in cognitive theory, associating cognition with attention and memory, cognitive-affective interactions; and others.

The final sections perceptively analyze treatments based on these various psychological models. I particularly appreciated the discussions of outcomes, future issues in systems of care (such as self-help, manualized care, and stepped care), new topics on the horizon such as schema-focused theory and therapy, and an examination of what might actually be the effective elements in treatment.

—J.Y.

## BMI and Length of Disease Predict Bone Turnover in AN

Long-term anorexia nervosa (AN) and a low body mass index (BMI) lead to a breakdown of the essential balance of bone formation and resorption (*European J Clin Nutr* 2003; 57:1262), according to the results of a recent case-controlled study. University of Bonn scientists discovered this pattern after evaluating 51 women with AN and 51 control subjects matched for age, sex, and height.

AN patients had lower BMIs, lower fat mass, lower fat-free mass, and lower muscle mass than women in the control group. In addition, serum levels of osteocalcin (a marker of bone formation) were lower, and serum levels of C-

telo peptide (CTx, a marker of bone resorption) were higher in patients than in controls. Finally, a ratio of these two markers, which provides an index reflecting the balance of bone formation and remodeling, was elevated among patients but not controls. The AN patients had enhanced serum calcium and cortisol levels, and reduced serum levels of several hormones, including thyroid hormones, insulin, and leptin.

BMI and duration of disease were independent predictors of the CTx/osteocalcin ratio in the patients with AN. Use of oral contraceptives had no effect upon the ratio in patients or controls.

# Weight 'Cutting' Waning Among College Wrestlers

Five years ago, after three collegiate wrestlers died while trying to "cut," or lose, weight, the National Collegiate Athletic Association (NCAA) developed new rules designed to curb extreme weight loss efforts among college wrestlers. The new rules added 6 lb to every weight class, moved weigh-ins closer to the start of each competition, and established a minimum wrestling weight based on body fat composition at the beginning of the season. In addition, each wrestler had 3 months to meet his competitive weight.

The NCAA's weight-control rules seem to have had a slight but positive effect upon extreme weight measures among collegiate wrestlers, according to the results of a recent survey (*Int J Sport Exerc Metab* 2003; 13:29). Drs. Robert A. Opplinger, Suzanne A. Nelson-Steen and James R. Scott of Iowa City, IA, conducted a survey among 47 Division I, II, and III schools to determine if the rules had made an impact upon harmful weight-cutting methods. The results were based on the extent of weight loss, information on weight-cutting methods, and assessment of eating behaviors related to standard criteria for bulimia nervosa.

## Results: Some Improvement Seen

From the 741 survey responses they received, the authors determined that the most weight lost during the season was 5.3 kg, or 6.9%, of body weight. Weekly weight losses averaged 4.3% of body weight. The most common methods used for taking off pounds included gradual loss through dieting (27.6%), and increased levels of exercise (75.2%). Unfortunately, the authors found that some of the old extreme weight loss methods were still being used by wrestlers: 55% fasted, 28% used saunas to steam weight off, and 28% used rubber/plastic suits to sweat off pounds. Five of the 741 wrestlers who responded met the criteria for bulimia nervosa.

Coaches and fellow wrestlers were credited with changing harmful weight-loss practices, and 40% of the wrestlers said they were influenced by the NCAA rules. Compared with high school stu-

dents, the collegiate wrestlers still showed more extreme weight control behaviors, but less extreme measures than were common among collegiate wrestlers during the 1980s.

## Why do wrestlers use extreme methods to lose weight?

According to the American College of Sports Medicine, athletes often believe that losing weight will improve their chances of winning. Ironically, weight-cutting may impair their performance and endanger their health. The combination of food restriction and fluid deprivation creates an adverse physiologic effect on the body, often leaving the wrestler too weak to compete. Wrestlers also may justify their choice of weight class with the belief that they need to lose excess body fat. However, studies show that in the off-season, high school wrestlers have body fat levels in the 8% to 11% range, well below that of their peers, who average 15% body fat. In the wrestling season, wrestlers typically have body fat levels of 6% to 7%.

Dehydration caused by sweating in a sauna or rubber suit, use of laxatives, and forced vomiting contribute to loss of electrolytes as well as water. Wrestlers hope to replenish body fluids, electrolytes and glycogen in the brief time between weigh-ins and the competition. However, replenishing body fluids may take 24 to 48 hours, muscle glycogen replenishment may take 72 hours, and replacing lean tissue may take even longer. The American College of Sports Medicine recommends that male athletes 16 years and younger with body fat below 7% and those over 16 with a body fat lower than 5% get medical clearance before they are allowed to compete.

The NCAA and the American College of Sports Medicine both urge greater cooperation among coaches, exercise scientists, physicians, dietitians, and wrestlers to use research and education to determine the best medically sound system for selecting a weight class. Their hope is that harmful weight loss methods will one day be a thing of the past among collegiate wrestlers.

# Making Connections Between Anger and Eating Disorders

The connection between overt and suppressed anger and disordered eating has been the focus of research for some time. Recently researchers in London and Scotland compared two groups of women to determine if facets of anger are related to an individual's core beliefs.

The two groups included women who met DSM-IV criteria for eating disorders and a control group. The authors also hoped to learn whether levels of different types of anger differ across individual eating disorder diagnoses and behaviors (*Int J Eat Disord* 2003; 34:118).

The study group included 20 women with anorexia nervosa of the restricting subtype, 39 with anorexia nervosa of the bulimic subtype, 68 with bulimia nervosa, and 13 with binge eating disorder. The 50 women volunteers in the control group were all undergraduates and none had a history of eating disorders. All the women filled out two self-report questionnaires that measure anger levels (State-Trait Anger Expression Inventory) and unhealthy core beliefs (Young's Schema Questionnaire).

## Higher anger levels reported in those with eating disorders

The study results showed that women with eating disorders had higher levels of state anger and anger suppression than did the control group, particularly when the eating disorder diagnosis included bulimic symptoms. Different aspects of anger were associated with specific bulimic behaviors. If women used binge-eating or vomiting, they had significantly higher levels of trait anger. In contrast, women who exercised excessively had significantly higher state anger scores. Those who used laxatives had significantly greater levels of suppressed anger than did the control group.

## Suppressed anger was characteristic of bulimic patients

In contrast to earlier studies, this study suggests that suppressing anger is characteristic of patients who use bulimic behaviors. The study also reiterates re-

search showing that bulimic attitudes are associated with anger suppression rather than with externally directed anger.

The authors note that it may be useful to examine anger as a multifaceted problem. They hypothesize that bulimic behaviors serve different emotional functions, and can be divided between the elements of anger that are influenced by “fast-acting” behaviors, such as binge eating, vomiting, and exercise, and those influenced by “slow-acting” behaviors, such as laxative abuse.

These findings suggest that high levels of state anger, trait anger, and anger suppression may need to be addressed during therapy. Treatment approaches may help patients replace emotion-focused coping strategies with a more adaptive problem-focused approach.

Among women without eating disorders, bulimic attitudes and behaviors have been specifically correlated with state anger and anger suppression, rather than with trait anger. This suggests that binge eating and vomiting behaviors may serve different functions with regard to anger. In an earlier study by Drs. R.J. Mulligan and G. Waller, of the University of London, Southampton, bulimic attitudes and behaviors appeared to reduce immediate anger states, particularly when the individual had a strong tendency to avoid expressing anger (*Int J Eat Disord* 2000; 248:446).

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## Amenorrhea and Weight Criteria for AN Are Questioned

Currently, the diagnostic criteria for anorexia nervosa (AN) include amenorrhea and weight loss to below “healthy weight.” Results of a recent study at the University of Iowa have challenged the usefulness and validity of these criteria (*Acta Psychiatr Scand* 2003;108:175).

Drs. T. L. Watson and Arnold E. Andersen compared the records of two groups of women. The first met current International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> revision (ICD-10) and DSM-IV criteria for AN. The second group met the essential psychopathological criteria for AN and used significant self-starvation, but did not have either amenorrhea or

weight loss below 85% of healthy weight. The researchers used retrospective examination of the medical charts of 588 patients consecutively admitted to an inpatient treatment program. All the diagnoses conformed to ICD-10 and DSM-IV criteria.

### Few differences noted

Of the 588 admissions, 297 females had some form of AN: 77.4% (230 of 297) met the current criteria, while 22.6% (67 of 297) with core psychopathology and self-starvation were classified as having eating disorders not otherwise specified, or were put into an “atypical” category because of some menstrual function or being above 85% of healthy weight. There were few significant differences in demographics, history of illness, treatment response, psychopathology, or bone density.

The authors concluded that amenorrhea may not be a useful diagnostic criterion for AN. Also, using a criterion of a weight below 85% of healthy weight needs to be better defined.

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## Hidden Costs: Caregivers and Girls with Eating Disorders

Although there is widespread information about the overall cost of treating a person with an eating disorder, until recently there was little data about the physical, emotional, and financial cost to a family member caring for a girl with anorexia, bulimia, or an eating disorder not otherwise specified (EDNOS). In an ongoing study, Cheryl A. Dellasega, of Penn State University, and Margaret Marino, Middletown, PA, are exploring the impact of care-giving for a girl with an eating disorder.

The researchers used the Caregiving Information Form, a questionnaire they developed that contains 30 questions designed to assess stressors related to caring for an ill family member. Questionnaires were mailed out to 153 volunteers recruited through organizations and referred by therapists specialized in the treatment of eating disorders. Most of the caregivers who responded were middle-aged, married, female professionals caring for a young woman aged 20 (patients

ranged in age from 12 to 44 years). The authors note that their study is ongoing, and thus far 29 questionnaires (13%) have been returned.

Most of the daughters have anorexia nervosa and have been ill for nearly 6 years. The main stressor the researchers have identified thus far is the mothers’ fear their daughters may die. Most of the mothers have had significant decreases in both physical and mental health since their daughters developed an eating disorder.

The caregivers reported spending an average of \$112 per week (range \$0-\$850) on care for their daughters related to their eating disorders. They also reported missing nearly a day of work per month because of their caregiving responsibilities. Dellasega and Marino reported their findings at the Academy for Eating Disorders meeting in Denver this spring.

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## Measuring Gastric Complaints

Patients with eating disorders may complain of a variety of gastrointestinal symptoms, sometimes in an effort to justify reduced food intake and vomiting. According to Italian gastroenterologists, tests show that some of these patients have valid complaints.

When 18 patients with anorexia nervosa, 10 with bulimia nervosa, and 16 healthy volunteers underwent electrogastroscopy and/or gastric emptying scintigraphy, the test results revealed that those with bulimia had significantly different gastric electrical system patterns and different gastric emptying times than those with anorexia or control subjects. Patients with anorexia nervosa and the control subjects had similar gastric emptying times and similar gastric electrical patterns.

The researchers, who did the testing at Bambino Gesù Hospital in Rome, theorize that the significantly longer gastric emptying times and greater gastric activity reported among bulimic patients, in contrast to normal patterns among anorexic patients, may be due to the longer length of illness among patients with BN. It is still unclear whether these changes in gastric function were a cause of, or a consequence of, eating disorders.

## QUESTIONS & ANSWERS

### Vegetarianism: Does It Contribute to Eating Disorders?

**Q** We work with adolescent women and have noticed an increasing number who are professing various forms of vegetarianism. Does vegetarianism predispose girls or young women to eating disorders? (A.D., Chicago)

**A** Your question is actually quite involved. First, there are numerous cultural complexities to vegetarianism. Although I'm unaware of research specifically addressing this issue, my overall sense is that vegetarianism does not predispose to eating disorders among cultural subgroups that subscribe to vegetarianism as a whole, for example among some Hindus, Jains, Sikhs, Seventh Day Adventists or individual families, where it's generally practiced by most family members in conjunction with various philosophical and health beliefs. More interesting to me is whether "spontaneous vegetarianism" among young women indicates an elevated risk of eating disorders. Here, too, the question is complicated because many young women identify with contemporary peer groups in which vegetarianism is becoming increasingly prominent for philosophical and/or health reasons. Clearly, vegetarians may be as healthy, if not healthier, than non-vegetarians.

That being said, a recent survey of 143 college women conducted at Cal Poly, San Luis Obispo, CA, revealed that median EAT scores (Eating Attitudes Test)

among the 30 self-reported vegetarians were significantly higher than among the 113 non-vegetarians, and that 38% of vegetarians had EAT scores greater than 30 (indicating eating disorder risk), compared to only 8% of non-vegetarians. Of note, 23 of these "vegetarians" were actually "semi-vegetarians", at least willing to consume chicken and/or fish but no red meat. The rest were lacto-ovo-vegetarian; there were no strict vegans in this sample. Nearly 19% of the vegetarians chose vegetarianism for weight control purposes in the first place, and this may skew the results. (Klopp SA et al, *J Am Dietetic Association* 2003;103:745)

For clinicians, the important point is to assess the origins and intentions of vegetarianism, and to see how much the patient's initial goal in changing eating behavior was primarily to restrict calories and food choices. But, remember, vegetables are good for you, and you should all eat your vegetables.

—J.Y.

## ON THE CALENDAR

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### Nibbles by Hunter



"The only place I'd agree to gain weight is in my fingernails."

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## IN THE NEXT ISSUE

### An Update on Family Therapy

By Walter Vandereycken, MD

## PLUS

- Weight Recovery in Teens with AN
- An Integrated Approach to Preventing Obesity and Eating Disorders: Will It Work?
- Changes in Brain Structure from Anorexia Nervosa
- How Effective Are Antidepressants for Binge Eating Disorder?
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