

EATING DISORDERS REVIEW®

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UPDATE

TV and the Internet: Fattening for Teens?

Can a steady diet of watching television and using the Internet increase a teen's risk of becoming overweight? Dr. Susanna Kautiainen and colleagues at the University of Tampere, Finland, surveyed a nationally representative sample of 6,515 teens 14 to 18 years of age to see if the time they spent on the Internet was tied to obesity or overweight. Of the 70% who responded, 35% of the boys and 22% of the girls used the Internet. Internet use per se was not associated with overweight in either sex. However, overweight was slightly more common among girls who spent at least an hour daily using the Internet, compared to other girls who did not use it (14% vs. 11%). "Internet addiction" (the inability to avoid going online at least once a day) was associated with overweight among boys but not with girls. In a second study, Dr. P. Iacovazzo and co-workers studied patterns of TV watching among 721 boys and girls 11 to 14 years of age. Those who spent more time in front of the TV were more often overweight and obese than those who spent less time watching TV. Both studies were reported last September at the 13th European Obesity Group Workshop in Mesagne, Italy.

Eating Disorders at Middle Age, Part 1

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Until recently, the problem of eating disorders among middle-aged women was largely overlooked in psychiatry and medicine. The definition of middle life is somewhat arbitrary and in current flux, due in part to the increased longevity of people in the U.S. and Western Europe. This article focuses on increasing the knowledge of eating disorders in this population, which we define as the period of life between 35 and 65 years of age.

Individuals may develop an eating disorder for the first time at middle life, but to date most patients described in the literature have had the problem for at least 10 years. While the manifest problem may be understood as a pathologic means of coping with changes in body image due to aging, the clinical course and motivation behind this maladaptive mechanism lead to different clinical presentations.

We want to increase awareness of this neglected clinical problem, to offer some recommendations for treatment, and to encourage others to augment the knowledge base by describing how eating disorders in middle life are both similar to and different from eating problems at other periods in the life cycle.

Introduction

Despite the overall increased awareness of the negative effects of being overweight, as well as a greater than \$15 billion diet indus-

try, Americans are getting larger more quickly than the rest of the world. Nations like France, where people consume a diet rich in fatty foods such as cheese, cream and whole milk, manage to maintain an obesity rate of slightly over 6%. Americans, despite many "low-fat" and "no-fat" foods, maintain an average national obesity rate of over 40%. Current data argue that this disparity is related to larger portion sizes, higher stress levels, and lower levels of regular exercise, not to food itself. Our attitudes towards food govern the way in which we consume food and help explain why we eat so much. Likewise, a combination of physical, interpersonal, and cultural factors determine our body image at any given point in the life cycle. Americans measure self-worth by appearance and make pejorative comments about their bodies despite objective measures to the contrary. How we will use or abuse food as we age is only one factor in how we alter that image to sustain a sense of self or of self-esteem.

According to a 1997 *Psychology Today* poll, which is the largest study on body image and eating disorders to date (involving more than 3,400 women and 500 men between 13-90 years of age), gaining weight is at the top of the list for negative influences on body image in both men and women.¹ This was true even though most were of normal weight. Two-thirds of the women and a third of the men said that gaining weight produced the greatest detriment to their self-image. Nearly half of the women

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polled reported being preoccupied with weight and finding displeasure with their weight regardless of age. In contrast, the poll found that men of all ages were much less dissatisfied with their appearance. Those from 30-39 and 50-59 years old were most dissatisfied. Another large-scale survey, which included women up to age 75, found that more than 70% of women aged 30-74 were dissatisfied with their weight even though they were of normal weight.² As women age, body dissatisfaction increases.

Biological Bedrocks

Physiologic aging has various effects on the human body that also alter body image, particularly in women. Until age 60, women tend to gain 5-10 lb per decade of life. Body shape changes, skin loses its elasticity (i.e., crows' feet), and hair turns grey and thins. These normal lifecycle changes are likely to be particularly problematic for women because body fat deposition tends to increase with each developmental milestone, for example, puberty, pregnancy, and menopause.³

Body image can also be threatened by any medical problem, chronic illness, restriction in social activity, and change in relationships with family and friends (i.e., divorce, or becoming a grandparent). This gender-based finding likely contributes to the "normative discontent" women feel about their bodies, and may contribute to the initiation and/or maintenance of eating disorders and exercise addiction in middle life.⁴

In clinical practice, we educate women that these biological facts about midlife transition are likely genetically based because females are: (1) born with more fat cells than males; (2) have slower metabolic rates than males; and (3) have different hormonal influences than males (i.e. estrogen, progesterone), which increase the likelihood of weight gain throughout the life cycle. Women may also feel worse about their bodies with age because of lowered energy levels and other sensory and motor changes.

While all body systems change with age, it appears that women worry most about their weight and skin. For example, skin changes can be the most devastating for women because they are the most visible and also are the target of increas-

ing media pressure for change. Women are bombarded with suggestions about defying their age and urged to "lie about [their] age," leaving them with the impression that aging is bad and that they should not be satisfied with themselves when they see "crows' feet" or other signs of aging developing. The overall message is that aging is bad and wrinkles are worse, and that the only solution is to use products, reconstructive surgery, or virtually anything in order to achieve a younger, more ideal look.

Herein lies the difficult assessment that women must make about themselves in order to age successfully: Do they accept society's message that younger is better and strive for unattainable or unnatural ideals, or allow themselves to become internally self-worthy and maintain a positive body image despite some noticeable and possibly inevitable physiological shifts?

The Scope of the Problem

Body image derives from conscious and unconscious processes, a manifestation of internal and external promptings that have been shaped over the years by life experience, media images, and feedback from other people. Separating out the potential developmental antecedents of the body image disturbance that has led to and helped nurture the eating disorder allows the patient to better understand herself, her life, and the struggles that have shaped her into who she is today.

As a whole, 89% of the women polled by *Psychology Today* wanted to lose weight. The average woman is 5'5" tall and weighs 140 lb, but would like to weigh 125 lb, a desire that 15% of women said would be worth sacrificing more than five years of their lives to achieve. Another 24% of the women surveyed would sacrifice three years of their lives to achieve their desired weight.¹

It is no surprise that preoccupation with body image affects a woman's sense of herself. For over 56% of women in our society, being a woman entails preoccupation and dissatisfaction with her overall appearance and body size. This desire to diet runs deeper than just a willingness to restrict calories and to exercise. Instead, it goes far beyond, to a pathological "I'll do anything" mindset to lose

weight. This mentality is most commonly associated with women in their adolescent or young adult years. Thus, it is not surprising that 62% of females 13-19 years old are dissatisfied with their weight. What has been neglected and unrecognized is the larger percentage of older women who are dissatisfied with their body weight. This dissatisfaction with body weight rises to 67% in females over the age of 30.¹ Today's young women are being initiated to feelings of body dissatisfaction at a young age; these attitudes about their bodies stay with them and later prevent a normal transition into middle life.

Because middle-life is usually viewed as that time when men and women have achieved identity and a personal sense of power, one begins to wonder why a focus on body image is so pervasive in this age group. Body dissatisfaction is not only higher than in past years, it has been accelerating—from 25% in 1972 to 38% in 1985 to 56% in 1997.¹

Diets leave women unsatisfied with the results. In 2001, over 93% of liposuction patients were women between the ages of 17 and 74 years old, but 98.7% were within 50 lb of their ideal chart weight. While the procedures have been improved and significant medical complications (e.g. bleeding, pulmonary emboli) have decreased, the success of liposuction does not address the increasingly negative body image of millions of women who believe that weight reduction or body fat removal will make them happier and healthier human beings. It seems as though the alternative of liposuction only addresses part of the problem, namely the female desire to come closer to the slender ideal, while it fails to resolve the negative body image that fuels the self-defeating dieting that often precedes and follows such procedures. Consideration of these facts makes clinicians wonder if women who seek plastic surgery at middle life should be screened for an eating disorder.

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(In Part 2, in the next issue, the authors address clinical presentations of these disorders and outline recommendations for treatment.)

Waist Circumference: Better Than BMI for Predicting Health Risks?

Body mass index (BMI, kg/m²) has long been used as a predictor of morbidity and mortality from several chronic diseases, including diabetes, heart disease, and stroke. Evidence from a recent study indicates that when waist circumference (WC) is added to BMI, the two measurements more accurately predict health risk than BMI alone. According to Dr. Ian Janssen and fellow epidemiologists at Queen's University, Kingston, Ontario, Canada, WC may be a stronger marker of health risk than is BMI (*Am J Clin Nutr* 2004;79:379).

Data from a large study

To compare the efficacy of both measures, Dr. Janssen and his colleagues used data from the third National Health and Nutrition Survey (NHANES III). The NHANES data was taken from 14,924 adults, who were grouped into categories of BMI and WC in accordance with National Institutes of Health cutoff points. Men and women with WC values less than <102 cm (40 inches) and 88 cm (35 inches), respectively, were considered to have normal waist circumference, while men and women with WC values above >102 and 88 cm, respectively, were classified as having high waist circumference.

Subjects were placed in one of three categories on the basis of BMI: normal weight (BMI 18.5-24.9), overweight (BMI 25.0 to 29.9), or class I obese (BMI 30.0 to 34.9). Odds ratios for hypertension, dyslipidemia, and the metabolic syndrome were compared for overweight and class I obese BMI categories and the normal-weight category before and after adjustment for WC. BMI and WC

were also included in the same regression model as continuous variables for prediction of the metabolic disorders.

Results

According to the authors, their results provide compelling evidence that BMI coupled with WC does not predict an increase in obesity-related health risk better than WC alone, when the two values are examined on a continuous scale. Thus, overweight and obese persons have a health risk that is comparable to that of normal-weight persons with the same WC value. However, when WC is dichotomized as a normal or high-risk value according to the NIH obesity guidelines, BMI remains a significant predictor of metabolic health risk. This suggests that the obesity classification advocated by the NIH is misleading and can be improved.

Thus, obesity-related health risks are explained by WC and not by BMI, say the authors. And, for a given WC value, overweight and obese persons have a health risk that is comparable with that of normal-weight persons. Future studies are required to determine whether WC can be used alone as an indicator of health risk.

A dissenting opinion

According to Dr. George A. Bray, of Pennington Biomedical Research Center, Baton Rouge, LA, there is still far too little evidence that waist circumference can be substituted for body mass index as a measure of health risk. In an editorial in the same issue (*Am J Clin Nutr* 2004; 79:347), Dr. Bray urges clinicians not to consider using WC alone as an indicator of health risk. Instead, he notes that height and weight, the main components of BMI, are important indicators of health status and are easy for health care workers to measure. In addition, he points out that the National Heart, Lung, and Blood Institute clearly recognizes that measuring BMI is only the first step for a clinician making an assessment of health risk and that central adiposity should also be measured. Dr. Bray added that the most practical criteria for measuring central body fat are WC and WC divided by hip circumference, or using a waist-to-hip ratio.

Family Environment and Childhood Feeding Problems

A strong relationship exists between children's feeding problems and eating disorders among their mothers. Several studies have noted that intrusive and inconsistent parenting, especially during mealtimes, might be important in the development of food-related disorders (*Psychol Med* 1996; 26:569; *BMJ* 1995; 299:777).

Two environmental aspects are suspect

Peter J. Cooper, PhD and co-workers at the University of Reading, Reading, UK, report that two aspects of family environment are strongly associated with the development of feeding problems among children (*Br J Psychiatry* 2004;184:210) The two suspected causes are chaotic, disorganized mealtimes and a disharmonious child-mother relationship, particularly when the mother is controlling. The researchers' study included three groups: children with feeding problems (35 children), children who were shy, fearful, or had behavioral problems (58 children), and a control group with no feeding problems (23 children).

Dr. Cooper's group used a self-report version of the Behavior Screening Questionnaire (BSQ), along with a questionnaire on child shyness. The teachers completed the Pre-school Behavior Checklist of all the children. Children with feeding problems were identified by their mothers' responses on the BSQ. The mothers were assessed with the Eating Disorder Examination and the Anxiety Disorders Interview Schedule

Taking the study into the home

Fifty-six children were identified with feeding problems, and 43 children entered the study. The mothers and children were assessed in their own homes with a series of standardized questionnaires and also with direct observation. The in-person mealtime observations served two purposes—the first was to validate the children's assignment to the feeding problem category and the second was to observe the mother-child relationship during a meal. The mothers were asked to give their child his or her normal midday meal and if the two

normally ate together, to do that also.

The meal was recorded by video camera, with the researcher in another room to allow a normal meal. The researchers studied the tape for food refusal and fussiness, the amount eaten and any abnormal eating behavior, such as spitting. The videotape was also used to rate the mother's overall child management style at the meal. The mothers and children were also filmed interacting in a situation not related to eating—the children were instructed to explore the contents of a dangerous-looking box and the mother was instructed to help them.

Clinical implications

According to the authors, given the high incidence of eating disorders among mothers of children with feeding problems, it is essential to look at the mother's eating history as well as the child's. In addition, a family meal should be evaluated. Reorganizing family meals and using measures to improve the quality of the mother-child relationship will improve the success of treating childhood eating problems, according to Dr. Cooper and his colleagues.

Treating Bulimia Nervosa with Topiramate

Along with repeated episodes of uncontrolled binge eating and purging, patients with bulimia nervosa must deal with an obsession with food and body weight, distorted body image, low self-esteem, high anxiety, and depression. They struggle each day with the psychological impact of the illness, and binge-eating and purging may give temporary relief of the emotional pain.

Recent treatment approaches have included a multimodal approach with tricyclic antidepressants and selective serotonin reuptake inhibitors, as well as cognitive behavioral therapy and interpersonal therapies. Dr. Dawson W. Hedges and colleagues report that in a

recent industry-supported study of outpatients with bulimia nervosa, use of the antiepileptic agent topiramate improved binge-purge behaviors and led to improved self-esteem, eating attitudes, and body image, while diminishing anxiety and depression (*J Clin Psychiatry* 2003; 64:1449).

Study design

Thirty-five outpatients received topiramate, starting at a dosage of 25 mg/day; this dosage was titrated by 25 to 50 mg/week to a maximum dosage of 400 mg/day. A control group of 34 patients were given a placebo. All patients were tested with the Eating Attitudes Test (EAT), the Eating Disorders Inventory (EDI), and the Hamilton scales for anxiety and depression (HAM-A and HAM-D). All but one patient were female (1 male was included in the topiramate group), and the mean age (29.6 years) was similar in both groups.

Antiepileptic agent led to improvements on the EAT and EDI

On the EDI, patients treated with topiramate showed a greater change in mean score in 5 scales than patients treated with placebo; those in the topiramate group also had a statistically greater change in mean score on the bulimia/food preoccupation and dieting subscales of the EAT than did patients in the placebo group. Those treated with topiramate had significantly greater reductions than those in the placebo group in HAM-A and HAM-D scores and in both binge and purge behaviors. The mean number of days on which patients binged and/or purged fell 44.8% in the topiramate group, compared with 10.7% in the placebo group.

The authors report that baseline EDI scores for ineffectiveness, interpersonal distrust, interoceptive awareness and maturity fears were already at normal levels in both groups, which may explain why these values did not change significantly with treatment.

The most common side effects reported among the topiramate group were fatigue in 32% (versus 24% in the placebo group), flu-like symptoms in 29% (18% in the placebo group), and paresthesias in 24% (6% in the placebo group).

A therapeutic effect beyond slowing binge eating and purging

According to Dr. Hedges and colleagues, improvements in the two eating disorder scales suggest a therapeutic effect that goes beyond moderating binge eating and purging behaviors. They feel that the results on the EAT test suggest relief from obsession with food, while the EDI results show a lessening of obsession with food and body weight.

A New Cognitive Model for Bulimia Nervosa

Three British researchers have recently developed a new cognitive model for bulimia nervosa (BN) that highlights the development and maintenance of the disorder, and also explores some reasons why binge eating is so persistent (*Br J Clin Psychol* 2004;43:1).

Dr. Myra J. Cooper, of Warneford Hospital, Oxford, UK, and two colleagues developed their model based on recent developments in cognitive theory, particularly Beck's general schema and schema-based avoidance and compensatory behaviors. They also followed the idea that conflicting and interacting beliefs and unhelpful coping strategies are involved in maintaining some disorders.

The researchers initially conducted detailed semi-structured interviews with 12 female patients with DSM-III-R diagnoses of BN, assessing each patient's most recent episodes of binge eating. They recorded the patient's thoughts and feelings before, during, and after bingeing, and questioned the women about compensatory behaviors and dieting. Dr. Cooper and colleagues continued the interviews using Burns's downward arrow technique (Burns, 1980) to identify underlying assumptions and core beliefs as well as any schema-driven processes and early experiences that might have contributed to the development of BN.

Negative experiences and development of BN

Negative or traumatic experiences in early childhood, such as neglect or indifference by parents, and, in extreme cases, sexual, physical, or emotional abuse, may lead to dysfunctional beliefs,

especially negative self-beliefs, according to the authors. Experiences in adolescence may also give rise to negative self-beliefs. A person may then try to compensate for these negative self-beliefs. Dieting is the most common compensatory method. The person may believe that dieting will ensure that they will be accepted by others ('If I lose weight, others will like me more') and that they will be more acceptable to themselves ('If I lose weight, it means I'm successful'). Usually, however, there are negative counterpoints to these positive assumptions ('if I gain weight, then I have failed.')

Maintaining bulimic behaviors

According to the authors, four specific types of cognitions are active in the vicious circles that maintain episodes of binge eating: (1) positive beliefs about eating, (2) negative beliefs about weight and shape, (3) thoughts of having no control, and (4) permissive thoughts.

An episode of binge eating may be preceded by the activation of negative beliefs about the self as an 'acceptable' person. Events that trigger binge eating may be related to eating, weight and shape—for example, this could be a remark about the person's weight or how much they are eating, or catching sight of oneself in a mirror—or may be unrelated to weight or appearance. Some examples of this are an argument with a partner or making a mistake at work. The trigger then activates a negative self-belief ('I'm unlovable' or 'I'm a failure'). People with eating disorders learn to manage negative self-directed emotions such as these by eating, for eating and the associated preoccupation with food gives them a distraction from the negative emotions. It also produces changes in cognition and through direct physiologic pathways and changes in interoception (including emotional states and sensations of hunger and satiety, according to the researchers.

Eating is commonly linked to a generally lowering of arousal and a general decrease of arousal and in the intensity of emotional states. At first these are interpreted positively and eating is thus linked to positive beliefs. However, eating behavior cannot help the patient restructure negative self-beliefs; thus, for those with BN, eating, especially over-

eating, is also linked with negative beliefs about the potential consequences. Thus, the person with BN is placed into a state of conflict in which both positive and negative beliefs about eating coexist.

The authors believe their model can be helpful for explaining changing and alternating patterns of behavior in which the individual binges and then uses other behaviors, including purging, to compensate for it. The dissonance between these two conflicting sets of beliefs is resolved by permissive thoughts and/or by thoughts of having no control. Once permissive thoughts and thoughts of no control are activated, eating takes place. After eating, negative self-appraisals and associated negative emotions activate negative beliefs about eating once more, completing the vicious circle.

Triggering binge eating

There is much evidence that binge eating in BN is preceded by considerable emotional and cognitive distress. Anxiety is the most commonly reported emotion that precedes binge eating. Higher-than-average levels of depression have also been reported in these patients. There is also some suggestion that negative cognitions, especially thoughts or feelings of loneliness may also precede or trigger bingeing. Bodily sensations, particularly feeling hungry or feeling full, may also trigger the binge cycle. Feeling full may make a patient feel she lacks control over eating.

Clinical implications

The new model has a number of implications for treatment using cognitive therapy; mainly, according to the authors, it suggests that both maintenance and developmental processes will need to be addressed in each case. Each of the different types of cognitions that maintain episodes of binge eating will need to be tackled, perhaps with verbal restructuring and graded behavioral experiments. For beliefs involved in the development of BN, a useful approach might be standardized techniques, including both verbal restructuring and behavioral experiments (in which the individual tests his own underlying assumptions to see if they stand up to realistic challenges). Schema-focused techniques might also be helpful.

Treating Bulimia Nervosa in a Primary Care Setting

Both cognitive behavior therapy (CBT) and antidepressants have been helpful for treating patients with bulimia nervosa. CBT is ideally given by a specially trained professional with advanced training, but there is currently a shortage of such therapists. Another drawback is that some patients cannot complete the recommended course of treatment, which can include twenty 50-minute sessions over 4 to 5 months.

As a result, self-help programs based on CBT principles have been developed in special books targeted at lay audiences. "Guided self-help" adds a number of short visits (4 to 8) with a therapist, who encourages the patient to follow the treatment program described in the book. The other major intervention, use of antidepressants, has been studied in more than a dozen randomized, placebo-controlled studies. The only selective serotonin reuptake inhibitor most commonly examined in these trials has been fluoxetine; however, nearly all of the data on the use of this agent has come from studies conducted in specialty clinics. Both treatment approaches seem suitable for use in primary care settings.

Treatment groups

B. Timothy Walsh, MD and colleagues at Columbia University studied the benefits of the two treatment approaches in a study of 91 female patients treated in two primary care settings (*Am J Psychiatry* 2004; 161:3). The women were randomly assigned to receive fluoxetine alone, fluoxetine plus guided self-help, or a placebo and guided self-help.

At the baseline visit, patients were assessed with an abbreviated version of the Structured Clinical Interview for DSM-IV, a shortened version of the Eating Disorder Examination interview, and several self-report questionnaires, including the Beck Depression Inventory. Subjects were given fluoxetine, in a dosage of 60/mg/day or a placebo. Patients assigned to the guided self-help group met with a nurse, who gave them a copy of the CBT self-help book and instructed them to read certain sections. In addition to their monthly visits with a physician, these patients were scheduled to see a nurse for 6 to 8 sessions.

The first four guided self-help visits were designed to occur weekly during the first month of the study; the fifth session was scheduled in the second month, the sixth session in the third month, and two optional sessions in the third or fourth months. These sessions were about 30 minutes long and focused on encouraging patients to work through the self-help program.

The mean age of the patients was 30.6 years and 83.5% (76) of the 91 patients met full DSM-IV criteria for bulimia nervosa. The mean reported duration of bulimia was 12 years, and 28 (32.2%) of the 87 patients had previously been treated for eating disorder symptoms.

High dropout rate

Less than a third of the 91 patients (28 patients) completed the full course of treatment. Twenty-three of the patients who did not complete treatment indicated that the treatment offered was either too demanding or not demanding enough. Others gave no reason or complained that important life events interfered with attendance. Eight patients, or 12.7%, including one receiving placebo treatment, felt their symptoms were not improving and one dropped out because she felt she was "cured." Physicians withdrew 4 patients because they had concerns about the level of depression.

The dropout rate was considerably higher than the 20% to 35% rate of dropout of patients with bulimia in comparable trials, and guided self-help had no outward effect on either retention or symptomatic improvement. Fluoxetine was beneficial. Compliance with mental health treatment given in a primary care setting is also problematic for other psychiatric disorders. The authors point out that approximately one-third of depressed adults being treated in primary care settings stop complying with antidepressant treatment (*Eff Clin Pract* 2000; 3:170).

Treatment best given in specialty settings

According to the authors, the problems of noncompliance, the lack of evidence for usefulness of guided self-help, and the

limited impact of fluoxetine suggest that early referral to a specialty clinic that treats eating disorders should be strongly considered for patients with bulimia first seen in primary care settings.

Can Walking 15 Minutes a Day Keep Obesity Away?

Some have recommended that even slight increases in daily physical activity might help prevent weight gain among adults. However, it hasn't been known how much daily walking is needed to counteract weight gain. The typical basal metabolic rate of a Western adult is 4.2 kilojoules (kJ)/minute and walking slowly expends 3.1 times one's basal metabolic rate. Thus, walking slowly for 15 minutes uses 197 kJ (100 kcal is 420 kJ).

Two Swiss clinicians used data from the Bus Sante' survey, an ongoing, community-based surveillance project in Geneva, Switzerland. The survey is designed to monitor chronic disease risk factors among the city's approximately 100,000 female and 100,000 male, nonhospitalized residents 35 to 74 years of age. Since 1997, the Bus Sante' survey has included a validated, self-administered quantitative physical activity frequency questionnaire to measure total and activity-specific energy expenditures, with special attention on light- and moderate-intensity activities.

Epidemiologists Alfredo Morabia, MD, PhD, and Michael C. Costanza, PhD, of Geneva University Hospitals, used data from the 1997 to 2001 physical activity frequency questionnaire data to estimate the potential effects of a hypothetical public health campaign to persuade all adults in Geneva to walk at least 15 minutes per day at various recommended intensity levels on the total energy expenditure (*Am J Public Health* 2004; 94:437).

According to the authors, if the goal is increasing the energy use by 100/kcal per day, the duration of moderate or risk walking should be increased to 30 minutes per day and slow walking should be increased to 60 minutes per day. In ad-

dition, to meet the goal of a 100 kcal increase per day would require that at least 50% of the eligible adult population walk briskly each day.

Long-term Nutritional Follow-up is Essential for Anorectic Patients

Even though patients have completely recovered from anorexia nervosa, they may need continued nutrition surveillance and support throughout their lifetimes, according to the results of a recent study (*Acta Diabetol* 2004;41:18).

Dr. S. Bertoli and colleagues at the International Center for the Assessment of Body Composition at the University of Milan, Italy, investigated the time course of body composition during and after refeeding in 32 female patients with anorexia nervosa. The patients were enrolled in the study when they were at their lowest weight, then re-examined after they achieved a 15% weight gain over a mean of 3 months. They were then re-examined after they had had stable weight recovery for 3 years. Beginning at 3 months, the patients were compared to a control group of 8 healthy females matched for age and body mass index. All participants in the study underwent dual x-ray absorptiometry at each visit.

At the initial visit, the 32 subjects were at 61% of their ideal body weight (IBW) and had severe reductions in fat mass (+7.1%+ to -4.5%), fat-free mass and bone mineral content. At 3 months, 8 subjects had gained 40% of their initial weight but still were 85% of their ideal body weight, with a percentage of fat mass comparable to that of controls and an absolute fat-free mass that was still deficient. Bone mineral content did not improve at 3 months, and remained 79% of that of the healthy controls.

The depletion of fat mass was more severe in the limbs than in the trunk, and at 3 months the trunk/limb ratio remained greater than that recorded in the controls. The authors feel these data strongly suggest that continued nutritional surveillance and support should continue throughout anorectic patients' lives, even after the psychiatric illness and severe underweight are corrected.

Successful Weight Maintainers: Recovery from Relapse

One of the major challenges of obesity treatment is that most patients regain their weight once treatment ends. About 3 to 5 years after treatment at least 50% of patients are back at their baseline weights. To find ways to prevent this pattern of weight regain, Dr. Suzanne Phelan and researchers at several medical centers studied weight regain and recovery among 2400 people in the National Weight Control Registry (*Am J Clin Nutr* 2003;78:1079).

The National Weight Control Registry is an ongoing longitudinal study of persons 18 years of age and older who have lost at least 30 lb and kept the weight off for at least 1 year. Participants provide information about their lifetime maximum weight, and current weight and the approximate dates at which they were at these weights.

Results

Dr. Phelan and colleagues found that, on average, the 2400 individuals gained about 3.8 kg between the baseline and two years. Most were above their baseline weight when reassessed at year 2. However, 99.6% of the subjects remained well below their maximum lifetime weight, and 96.4% of the participants remained at least 10% below their maximum lifetime weight.

Of the people who gained weight between the baseline and year 1, only 11% returned to their baseline weights or below at year 2. This represented 7% of the entire sample. Even small amounts of regained weight were rarely lost—of those who gained between 1% and 3% of their initial body weight at year 1, only 17.5% were able to return to their baseline weight or below at year 2. Larger weight gains reduced the chances of recovery even more.

The researchers also found that 25.5% (575) of the participants relapsed, (defined as gaining at least 5% of the lost weight) between the baseline and year 1. Of those, only about 13% re-lost at least half of the weight gained during year 1 gain by year 2. Only 4.7% of the participants returned to their baseline weights at year 1.

Could relapse and recovery be predicted? The only significant predictor of recovery was the amount of weight regained from baseline to year 1. Recovery was also related to a smaller overall increase in depressive symptoms from baseline to year 1.

Still a success

Despite the fact that small weight gains were common and that few persons recovered from even minor lapses, the authors feel the findings should not overshadow the overall success of those in the program. Even though many gained weight over the course of the 2 years, the weight gains were small, such as 3.8 kg. Furthermore, after 2 years, nearly 97% of the sample remained more than 10% below their maximum lifetime weight and the average percentage weight loss from the maximum weight was 26.6%. The authors point out that this very positive result is 2.5 times what is considered successful by current obesity treatment standards.

The strongest predictor of outcome was the amount of weight regained at year 1—those who regained the most weight at year 1 were the least likely to re-lose weight the following year. Identifying ways to prevent minor lapses from turning into relapses should be a focus of future research.

The only other predictor of recovery, according to Dr. Phelan, was smaller increases in depression in the year before weight regain. The authors did not specify whether subjects were enrolled in weight loss programs when they were studied, or had lost the weight on their own.

The clinical implications of these results underscore the importance of helping patients avoid even seemingly small lapses in weight maintenance, even as little as 2 lb, and halting further weight gain. Healthcare professionals may need to encourage patients to react immediately to reverse even seemingly small lapses and, even more important, to identify specific strategies for help patients avoid gaining even small amounts of weight.

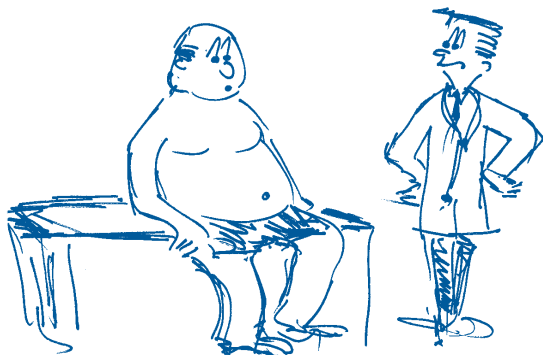
QUESTIONS & ANSWERS

Warning Signs of a Developing Eating Disorder?

Q Before frank anorexia nervosa or bulimia nervosa appears in children, are there any other “softer” eating disorders to look out for? (N.M., Houston)

A Several other eating disorder spectrum phenomena have been described in young children, including food avoidance emotional disorder, selective eating disorder (picky eating), functional dysphagia and pervasive refusal syndrome (*Int J Eat Disord* 2000; 28:317), as well as rumination disorder and “infantile anorexia.” However, their relationship to subsequent anorexia nervosa and bulimia nervosa is uncertain. For example, in a series of 147 children and adolescents aged 5 to 20 with rumination disorder, 16% were thought to have a psychiatric disorder whereas only 3.4% were diagnosed with anorexia nervosa or bulimia nervosa (*Pediatrics* 2003; 111:158). Similarly, for children who show picky eating and “food neophobia” at young ages, most of the pickiness relates to vegetables, and children often outgrow at least some of their fussy habits (*J Am Acad Child Adolesc Psychiatry* 2003; 42:76; *J Am Diet Assoc* 2003; 103:692). While these syndromes are definitely worth noting, and parents understandably seek guidance for their management, further longitudinal studies are needed to ascertain the actual relationships between these early feeding difficulties and subsequent adult eating disorders.

Nibbles by Hunter



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A Bout with Blisters

Q One of my patients with anorexia nervosa recently developed a severe blistering rash on the palms of her hands and on the soles of her feet. Her dermatologist wondered if this might be related to her eating disorder. (P.R., Hartford)

A A condition known as “acrodermatitis enteropathica” has been described in association with anorexia nervosa – and has the dermatologic appearance you’re describing. In addition to large blisters (“bullae”) on the palms and soles, blistering is often seen in the perineal area. Eczema may affect the face and pressure areas. This disorder is usually associated with zinc deficiency, which is why it has been seen in some cases of anorexia nervosa (as well as in patients with bulimia nervosa, alcoholism, and various malabsorption syndromes). The hallmark features of this condition often also include diarrhea and alopecia or dry, brittle, lackluster hair (symptoms certainly seen in cases of anorexia nervosa). Other vitamin and mineral deficiencies, such as lower-than-normal levels of iron, copper and vitamin

C, often seen in association with zinc deficiency, may contribute to some of the clinical features (*JAMA* 2002; 288:2655). Oral zinc supplements, along with other vitamins and minerals, and general nutritional rehabilitation should help considerably.

—J.Y.

IN THE NEXT ISSUE

Eating Disorders at Middle Age, Part 2

By Kathryn Zerbe, MD, and Diana Domnitei, BS

Part of the challenge in treating women with eating disorders at midlife is effectively educating them about the normal process of aging. Here are some steps to help them come to terms with the fact that the thinness they enjoyed as younger women is probably an unrealistic goal in middle age.

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