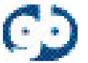
Now available, CE credits...quiz inside!

EATING DISORDERS REVIEW®

Current Clinical Information for the Professional Treating Eating Disorders



Published by Gürze Books, specializing in eating disorders publications and education since 1980.

ISSN 1048-6984

JULY/AUGUST 2005 • VOL. 16 / NO. 4

UPDATE

Inpatient Treatment: From the Patient's Viewpoint

Inpatient treatment for anorexia nervosa can evoke many emotions among patients, according to the results of a small British study. Recently seven young patients were encouraged to reflect upon their experiences both while they were hospitalized for treatment of anorexia nervosa, and after discharge. As reported at the recent International Conference on Eating Disorders, in Montreal, the patients reported feeling a sense of being removed from reality and disconnected from "normality." In addition, the patients felt the staff did not always address their needs. The young patients also reported that their needs were not always addressed and stressed the value and importance of the supportive relationships they shared with fellow patients. According to Hannah M. Turner, DClinPsych, and colleagues from the University of Southampton, Great Britain, when clinicians take an authoritative approach to treating inpatients, this will only compound patients' feelings of ineffectiveness and isolation. According to the researchers, feedback from patients provides a rich source of information that should be used to guide inpatient care.

ALSO IN THIS ISSUE

Study Sheds Light on Crossover Patterns 3
A Dangerous Comorbidity: Eating Disorders and Substance Abuse . . 4
Media Images of Women: Size Counts 5
Review: ***The Clinical Handbook of Eating Disorders*** 5
Inpatient Care and Insurance Coverage 6
Friendships and Body Image Among Teens 6
Body Fat Pattern After Weight Gain in AN 7
Risk of Obesity and Overweight Among Vegetarians 8
Q & A: Can a Head Injury Help an Eating Disorder? 8

Attachment to Life in Anorexia Nervosa

By Yael Latzer, DSc • Director, Eating Disorders Clinic, Rambam Medical Center, Haifa, Israel
Zipora Hochdorf, PhD • University of Haifa, Haifa, Israel

Anorexia nervosa (AN) usually follows a prolonged course, with morbidity and high mortality.[1] According to the *DSM-IV,*[2] one of the diagnostic characteristics of AN is denial. These patients tend to view their low weight as an accomplishment rather than as an affliction and as a result have little motivation for change. Their drive for thinness is considered egosyntonic.[3,4] Thus, one should raise the question, What kind of dialogue do AN patients have with life and death?

Differing Viewpoints

Various authors have dealt with this issue. Some refer to the denial of AN patients from a psychodynamic perspective, claiming that these patients play with the idea of death like a child in a game, pretending that they can disappear through death and return in a mystical way.[5,6]

Other authors relate to the dialogue of AN with life and death from an interpersonal theory perspective.[7,8,9] According to this viewpoint, AN patients are not attracted to death so much as they are seeking control over their life and a sense of identity. The symptoms represent a latent suicidal act as a result of feeling depressed for not achieving such control and thereby serve as a way to achieve false control.

Lifton described the AN patient as an individual who is too afraid to live fully, yet too afraid to die.[10] The paradox is imprinted in the psychopathology of an AN patient in that she refuses to eat in order to have a meaningful life and to fight against death, as if she is "dying to live." Dally and colleagues. also referred to the close link between eating and death imagery, claiming that the aversion to food among AN patients reflects "a horror of eating" rather than a fear of gaining weight per se.[11] Similarly, Strober argued that rather than being a flirtation with death, AN actually represents the struggle to exist within the narrowest parameter.[12] Roea and co-workers relate to the illness itself as giving the meaning of life, rather than as being a threat.[13] As such, the AN symptoms serve as a source of life in a sea of misery, and provide meaning to an otherwise meaningless life.

This theoretical point of view is in line with recent empirical findings. Bachar and colleagues used the differentiation between the attraction to and repulsion by life and the attraction to and repulsion by death as independent factors in order to clarify the perceptions of life and death among ED patients.[14] They found that AN patients are characterized by a rejection of life rather than a contemplation of death or an attraction to it.

This point of view is also in accordance with the attachment theory. According to this theory, AN patients do not dare express their interests or needs, but rather feel insecurely attached to others by dependency or avoidance.

continued on page 2

EATING DISORDERS REVIEW®

Editor-in-Chief
Joel Yager, MD
University of New Mexico, Albuquerque

Managing Editor
Mary K. Stein

Associate Editor
Russell David Marx, MD
University Medical Center at Princeton, NJ

Editorial Board
Arnold E. Andersen, MD
University of Iowa, Iowa City

C. Wayne Callaway, MD
George Washington School of Medicine, Washington, DC

Tami J. Lyon, MPH, RD, CDE
BestSelf, Inc., San Francisco, CA

James E. Mitchell, MD
University of North Dakota School of Medicine, Fargo

Pauline Powers, MD
University of South Florida, Tampa

Cheryl L. Rock, PhD, RD
University of California, San Diego

Walter Vandereycken, MD, PhD
University of Leuven, Belgium

B. Timothy Walsh, MD
Columbia University College of Physicians and Surgeons, New York City

Linda Watts, MA, RD
St. Paul's Hospital, Vancouver, BC

Stephen Wonderlich, PhD
University of North Dakota School of Medicine, Fargo

Alayne Yates, MD
University of Hawaii School of Medicine, Honolulu

Kathryn Zerbe, MD
Oregon Health & Sciences University, Portland

Publisher
Leigh Cohn, MAT

Copyright © 2005 by Gürze Books. All rights reserved. Reproduction, photocopying, storage or transmission by electronic means without permission from Gürze Books is strictly prohibited by law. Violation of copyright will result in legal action, including civil and/or criminal penalites, and suspension of service.

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. Prior indexes and more information at www.gurze.com.

Missing issues will be replaced without charge if the publisher is notified within 60 days of publication. Otherwise, replacement and back issues are available for $10.00 by contacting Gürze Books.

Editorial questions should be addressed to Joel Yager, MD or Mary K. Stein c/o MD Communications, 302 S. Pinto Place, Tucson AZ 85748-6902, 520/296-6400, fax 520/296-6464; marykaystein1@aol.com.

CE credits—see insert.

Online archives—A free service to subscribers. Contact Gürze Books for password access.

Subscriptions—see page 8.

continued from page 1

They lack confidence in the world and the ability to cope with negative emotions. Rather than relying on human beings to fulfill their secure base needs, they resent food and in doing so fulfill those needs.

The Drive to Attachment

Bowlby postulated a drive that is separate from and more powerful than hunger in its effect on the mother-child relationship: namely, the drive toward attachment.[15-17] Adult attachment representations are believed to be internalized working models of infantile drives and associated behaviors. Since Bowlby developed the attachment theory, there has been some suggestive evidence linking Hilde Bruch's theory of abnormal mother-child interactions and eating disorders with insecure attachment styles later in life.[7] Results of several recent studies support this link and find that attachment processes are abnormal among persons with eating disorders. This is particularly true in reference to these patients' insecure attachment styles.[18-20]

Thus, one may assume that those insecure feelings may lead to a low sense of mastery and self-worth, to hopelessness and helplessness, and as a result to a repulsion to life. As such, AN symptoms may create a false sense of security by providing control over a seemingly meaningless life. This conceptualization is in line with recent empirical findings.[21]

The association between attachment style and the sense of meaning in life might shed further light on family issues and AN. According to this conceptualization, the question arises as to how clinicians may assist AN patients in feeling secure enough to be attached to life without needing the symptoms, that is, to be attracted to life from a real base of security rather than a false one.

The clinical implications of this theoretical conceptualization may suggest that creating an internal sense of security and a security-based environment should be the focal point of the therapeutic relationship, rather than focusing the attention and dialogue on death and/or food preoccupation.

Family Therapy

In light of the importance of familial factors in the etiology of ED, family therapy may be a critical aspect of treating AN patients and helping them to develop a sense of internal security and autonomy of the self. Family therapy is recommended as a framework for changing family attachment styles through exposure of the beliefs and rules that dictate and influence family functioning, as well as through the introduction of new ways of interacting that promote family stability and a securely based environment. New emotional experiences that occur as a result of transformed interactions with attachment figures may be a powerful way to affect intrapsychic and interpersonal change.[22] Sexson, Glanville, and Kaslow recommended modifications of interpersonal communication with adolescents, particularly those that address attachment issues within the context of various constellations of family members.[23]

The desired change may be achieved by giving parents access to round-the-clock acceptance, support, and containment during the first three months of treatment (during which time the parents also receive instruction regarding the feeding of their children). This viewpoint is based on the assumption that if the parents themselves feel a sense of safe communication with the therapist, they will be able to transmit this feeling to their children. When the parents feel that they are contained and supported, rather than guilt-ridden and insecure, they may become more aware of their own strengths and abilities and feel better equipped to take more initiative with their child. In addition, warm and empathic interactions with the therapist may act as a "healing experience" for the parents themselves, thereby helping them achieve a more secure attachment style.[24-27]

This approach is in line with the Emotionally Focused Therapy (EFT) model, which addresses attachment issues in the therapeutic process by shifting negative cycles to cycles characterized by affiliation and trust, thereby fostering the creation of a secure attachment bond.[22, 28] Hopefully, with this approach AN patients will start to feel secure

enough in life to become attached to it once more.

Acknowledgment: We would like to acknowledge and thank Galia Golan for her valuable assistance.

References

1. Le Grange, D. Family therapy for adolescent anorexia nervosa. *J Clin Psychol 1999; 5:* 727.
2. *Statistical and Diagnostic Manual of Mental Disorders* (DSM-IV). Washington, DC: American Psychiatric Association, 1994.
3. Garfinkel PE, Garner, D M. *Anorexia nervosa: A Multidimensional Perspective.* New York: Brunner-Mazel, 1982.
4. Yager J, Landsverk J, Edelstein, CK, Jarvik M. A 20-month follow-up study of 628 women with eating disorders: A course of associated symptoms and related clinical features. *Int J Eat Disord* 1988; 4:503.
5. Jackson CC, Davidson G P. The anorectic patient as a survivor: The denial of death and death themes in the literature on anorexia nervosa. *Int J Eat Disord* 1986, *5:* 821.
6. Sours J. *Starving to Death in a Sea of Objects: The Anorexia Nervosa Syndrome.* New York: Jason Aronson, 1980.
7. Bruch H. *Eating Disorders: Obesity, anorexia nervosa, and the person within.* New York: Basic Books, 1973.
8. Bruch, H. *The Golden Cage: The Enigma of Anorexia Nervosa.* New York: Vintage Books, 1979.
9. Russell J, Halasz G, Beumont PJ. Death related themes in anorexia nervosa: A practical exploration. *Journal of Adolescence*, 1989: 13, 311.
10. Lifton R. *Death in life: The Survivors of Hiroshima.* London: Wiedenfeld & Nicolson., 1969.
11. Dally P, Gomez J, Isaacs A. *Anorexia Nervosa.* London: William Heinemann Medical Books, 1979.
12. Strober, M. Disorders of the self in anorexia nervosa: An organisemic-developmental paradigm. In C.L. Johnson (Ed.), *Psychodynamic Treatment of Anorexia Nervosa and Bulimia* (pp 354-373). New York: The Guilford Press, 1991.
13. Roea D, Rott S, Fenining S. Narrowing the insight in anorexia as an ambivalent relation to recovery. *Sichot*: *The Israeli Journal of Psychotherapy* 2003; 17: 247 [Hebrew].
14. Bachar E, Latzer Y, Gur E, Bonne O et al. Rejection of life in anorexic and bulimic patients. *Int J Eat Disord* 2002; 31:43-48.
15. Bowlby J. *Attachment and loss: Vol. 1. Attachment.* New York: Basic Books, 1969.
16. Bowlby J. *Attachment and loss: Vol. 2. Separation: Anxiety and Anger.* New York: Basic Books, 1973.
17. Bowlby J. *Attachment and Loss: Vol. 3. Loss.* New York: Basic Books, 1980.
18. Latzer Y, Hochdorf Z, Bachar E, Canetti L. Attachment style and family functioning as discriminating factors in eating disorders. *Contemporary Family Therapy* 2002*;* 24:581.
19. Ward A, Ramsay R, Turnbull ,. Benedettini M, et al. Attachment in eating disorders: past in present. *In J Eat Disord* 2000; 27*:*279.
20. Ward A, Gowars S.Attachment and childhood development. In: J Treasure, U Schmidt, E Van Furth (eds). *Handbook of Eating Disorders.* John Wiley & Sons, Chichester, Great Britain, pp 20-103), 2003.
21. Hochdorf Z, Latzer Y, Canetti L, Bachar E. Attachment styles and attraction to death: Diversities among eating disorders patients. *Am J Fam Ther* 2005; 33: 237.
22. Johnson S M, Maddeaux C, Blouin J. Emotionally focused family therapy for bulimia: changing attachment patterns. *Psychotherapy* 1998; 35: 238.
23. Sexson SB, Glanville D, Kaslow N J. Attachment and depression: Implications for family therapy. *Child and Adolescent Psychiatric Clinics of North America* 2001; 10: 465.
24. Byng-Hall, J. (1995). Creating a secure family base: Some implications of attachment theory for family therapy. *Family Process, 34,* 45-58.
25. Byng-Hall J, Stevenson-Hinde J. Attachment relationships with a family system. *Infant Mental Health Journal* 1991; 12: 187.
26. Dallos R (2001). ANT attachment narrative therapy: Narrative and attachment theory approaches in systemic family therapy with Eating Disorders. *Journal of Family Psychotherapy* 2001; 12: 43.
27. Liddle H, Schwartz S J. Attachment and family therapy: The clinical utility of adolescent – family attachment research. *Family Process* 2002; 41: 455.
28. Mihikin J W, Johnson S M. Telling tales: disquisitions in emotionally focused therapy. *Journal of Family Psychotherapy* 2002; 11:75.

Study Sheds Light on Crossover Patterns

Anorexia nervosa (AN) and bulimia nervosa (BN) have overlapping clinical features as well as characteristics specific to each individual disorder. For example, the course of AN often includes the appearance of bulimic symptoms and a crossover to the full syndrome of BN. Even so, clinicians are still not able to predict which patients will develop BN. Even less is known about crossover from BN to AN.

Several differences in personality traits associated with the two disorders might influence crossover. For example, individuals with restricting-type AN tend toward rigidity and over-control, whereas those with BN tend toward impulsivity and affective deregulation. Persons with the binge-purge subtype of AN tend to fall between the two previous groups, particularly with regard to the degree of impulsivity.

A study to chart crossover

Pamela Keel, PhD, and 19 other clinicians recently designed a study to examine patients' crossover from AN to BN and from BN to AN. The subjects were participants in the International Price Foundation Genetic Study of Bulimia Nervosa (*Am J Psychiatry* 2005;162:732). The researchers used two types of analyses. First, they explored patterns of crossover from AN to BN by comparing 56 individuals with persistent restricting-type AN and 32 individuals with an initial diagnosis of restricting-type AN who developed BN. Next, to study crossover from BN to AN, they compared 257 individuals meeting the criteria for a diagnosis of persistent normal-weight BN purging type and 93 patients who initially had normal-weight BN followed by the development of AN, purging type.

General patterns of crossover

For most individuals, crossover occurred by the fifth year of illness, and the crossover rate was higher from AN to BN than from BN to AN. The authors found that the proportion of persons with BN who eventually developed AN (27%) was substantially higher than rates reported in previous studies (*Psychol Med* 1992; 22:951; *Psychosom Med* 1987; 49:45). This suggested an elevated risk for diagnostic crossover in individuals with both AN and BN, but stabilization of the illness by the fifth year.

One factor, low self-directedness, was consistently associated with both types of crossover, according to the authors. This suggested that self-directedness might be a general characteristic that influences the course of the eating disorder. Individuals who have low self-directedness, independent of the

continued on page 8

A Dangerous Comorbidity: Eating Disorders and Substance Abuse

Comorbidity can have serious consequences when a patient with an eating disorder also has substance abuse problems, according to Dr. Cynthia Bulik, professor at the University of North Carolina, Chapel Hill. Dr. Bulik, speaking at the National Institute of Mental Health Plenary Session II, "Does Comorbidity Matter?" urged clinicians to devote more time to talking with these patients, to better understand the relationship between the eating disorder and substance abuse.

Dr. Bulik added, "Assess every patient comprehensively for an array of substance abuse problems. If you don't ask, you're not going to get an answer. Think about the fact the substance use disorder can be part of the eating disorder. Look at the role of relapse and substance abuse."

How the relationship develops

How does someone go from an eating disorder to substance abuse, or visa versa? According to Dr. Bulik, studies show that the majority of individuals either developed both an eating disorder and substance abuse disorder in the same year, or the eating disorder came first. One of the few causal factors identified among people who developed alcohol abuse was perceived parental criticism, as reported on the multidimensional perfectionism scale.

Laxative abuse: serious consequences

Dr. Bulik also described the dangers of long-term laxative abuse, adding that 38% to75% of women with bulimia nervosa abuse laxatives. These products are ineffective for weight loss, she said, because less than 10% to12% of calories are excreted since laxatives work too low in the gastrointestinal system. Dr. Bulik quipped that the symptoms of diarrhea, weakness, cramping, dehydration, and loss of normal bowel function "certainly are not the 'women's gentle laxative' that we see on TV." Instead, laxatives are problematic drugs of abuse, which cause craving constipation and rebound edema. Patients who stop using laxatives often relapse, and start using them again. Patients may feel bloated and turn to laxatives for a quick escape from it, but clinicians need to be very vigilant to laxatives as relapse cues, she said.

Dr. Bulik noted that most persons who abuse laxatives don't use these products alone; instead, laxatives are usually paired with vomiting. This is seen most commonly in the purging type of anorexia nervosa and among individuals with a history of AN and bulimia nervosa. In recent studies, laxative abuse has been associated, across the board, with worse eating disorder pathology and general psychopathology and a higher incidence of borderline personality disorder. Dr. Bulik and colleagues found that this last group had higher suicidality, feelings of emptiness, self-harm, and anger. Dr. Bulik added, "If we just focus on laxative abuse as an ineffective way to lose weight or for purging weight, when in reality patients are using this as self-harm, we are missing the mark and not really giving them the intervention they require."

Smoking: addictive and metabolic changes

Dr. Bulik reported that the prevalence of smoking among women with eating disorders is very high, and with this comes increased amphetamine, cannabis, and cocaine use. Once a patient is discharged, the urge for smoking cigarettes and caffeine increases as patients have difficulties with weight gain in more unstructured settings. The highest rates of smoking are 75% in individuals with purging BN and 60% in those with anorexia nervosa binge purge subtype.

Dr. Bulik explained that patients may not be gaining weight in more unstructured environments. In partial hospitalization programs, the ratio resting energy expenditure to free fat mass is increased with smoking. A patient may be on a break smoking and thereby is increasing her energy expenditure. Meanwhile clinicians are feeding them in a manner that should help them maintain their weight, but becomes harder and harder for patients to maintain their weight.

Emetics: a cardiotoxic factor

Dr. Bulik pointed out that many women use emetics, and that 9% of women with BN report chronic use of emetics. An emetic acts directly on the gut to lead to immediate vomiting. This vomiting can go on for 24 hours, depending on the patient's innate physiologic vulnerability, the effects of the drug and how much they took, she added. A very real problem is development of tolerance to the drug. Once tolerance develops, the patient may increase the dosage of Ipecac, for example, to get the same effect. At the same time, less of the drug is vomited out. Ipecac is highly cardiotoxic, and the clearance of the drug is less with longer-term use. Dr. Bulik advised the audience that discovering that patients use emetics is an immediate red flag. These patients need a cardiovascular examination and the clinician then must help patients get off these agents as quickly as possible, she added.

Artificial sweeteners

Dr. Bulik then turned to the peculiar overuse of artificial sweeteners seen among patients with eating disorders, particularly those who are regaining weight. It isn't usual for patients to sneak down to the cafeteria and steal packets of sweeteners, and then to use an excess amount on their food, for example, seven packets of Sweet N' Low ® on a banana. She noted that this puzzling behavior should be studied further because patients who use artificial sweeteners have an increased craving for sweetness—Splenda® is actually 600 times sweeter than sugar, she said. As a result of using these sweeteners, people might also be increasing their intake to satisfy this craving. The underlying cause is yet to be explained—is it cognitive or something neurobiological?

Starvation and the reinforcing efficacy of drugs

Animal studies have added to knowledge of the mechanisms underlying drug use in humans, she said. When rats are starved, for example, the reinforcing efficacy of drugs is increased. The effect

of food restriction is robust across all species, she said, including rodents, monkeys and humans, and across all routes of administration.

There is very little empirical guidance about how to treat people with eating disorders and substance abuse, Dr. Bulik said, adding that rigorous empirical trials are needed. She pointed out an increasing incidence of eating disorders among middle-aged women who also abuse alcohol. These women have more access to alcohol than teenage patients, and this comorbidity will become more important in time.

Finally, she added, overlooking the dangers of substance abuse in eating disorders patients may be precarious. Commonly used substances may influence weight gain and metabolism. Ongoing substance use may reflect underlying eating disordered cognitions or ongoing food deprivation, and the neurobiology of food deprivation and substance abuse may be intertwined, she added.

BOOK REVIEW

Clinical Handbook of Eating Disorders

(Edited by Timothy Brewerton. New York: Marcel Dekker, Inc.; 2004; 577 pp; hardcover, $175.00)

The *Clinical Handbook of Eating Disorders* is a welcome edition that joins such classic handbooks as those of "Garner and Garfinkel" and "Brownell and Fairburn." Dr. Brewerton, a former president of the Eating Disorder Research Society, has assembled a world-class group of contributors, who offer topics ranging from basic science to the most complex nuances of clinical practice.

The handbook is divided into four sections. The first section covers diagnosis, epidemiology and course of illness, and also includes chapters on psychometric assessment and feeding disorders of early childhood. The next section looks at risk factors, genetics, personality and both medical and psychiatric comorbidity. The third section is on psychobiology and examines neuroimaging and molecular biology, as well as neurotransmitter, neuroendocrine, and neuropeptide dysregulation. The final section on treatment is the most extensive in this section, and includes chapters on inpatient, nutritional, family, and psychopharmacological approaches. There are also specific chapters on cognitive-behavioral, interpersonal, and dialectical behavior therapies.

The final two chapters of the book are an added bonus because they go beyond the necessary and required topics for a handbook. Timothy Brewerton displays a special sensitivity when he looks at victimization and posttraumatic stress disorder in eating disorders and links these with comorbid disorders. Finally, Joel Yager provides a soaring and visionary concluding chapter on future directions in eating disorders. His speculations touch upon evolving vistas in biology and information technology as well as diagnosis, epidemiology, and psychosocial interventions.

Concise, thorough, and well referenced, this book provides, as Gerald Russell says, 'a strict objectivity in assessing relevant literature.' Its excellent integration of multiple and complex paradigms make it one of the best books in recent years for anyone interested in eating disorders.

– Russell Marx, MD
Associate Editor

Media Images of Women: Size Counts

Exposure to images of attractive thin female models can increase depression, guilt, shame, stress, and anger and body dissatisfaction in women at risk for developing eating disorders. Two University of Kentucky researchers recently tested a theory that women at risk of eating disorders who are exposed to attractive, *average-weight* models would have less expectation of reinforcement from thinness than would other women (*Pathology of Addictive Behavior* 2005;18:394).

Drs. Suzannah M. Fister and Gregory T. Smith used their theory in a study of 276 Caucasian college women (mean body mass index: 22). Before the study began, the women completed pretest questionnaires, including the Sociocultural Attitudes Towards Appearance (internalization subscale, or SATAQ) (*Int J Eat Disord* 1995; 17:81) and the Eating Disorders Inventory-2 (body dissatisfaction and drive for thinness subscales). Shortly afterward they were approached to participate in the current study, which they thought was an investigation of "personality and shopping." Before the experimental manipulation, the women were asked to indicate their clothing size, height, and weight. Then the women were randomly assigned to one of three image-viewing groups (thin, average weight, and control). In groups of 4, the women viewed a set of 10 images, spending a minute on each. While viewing, they completed the questionnaire, which was designed to encourage them to pay attention to and to compare themselves with the images. They also rated the models' attractiveness and perceived clothing size.

What the women saw

The women exposed to images of thin models and those exposed to images of average-weight models rated the two model groups similarly. However, ratings of clothing size did differ by condition: thin models were judged to have significantly smaller clothing sizes than were average-weight models

In both the control and thin model conditions, there was a strong relationship between initial risk status of the participants and subsequent expectation of thinness. In contrast, for women exposed to attractive, average-weight models, the association was much less. Even one exposure to images of women who did not correspond to the thin ideal reduced high-risk women's expectancies. The exposure to only 10 images of attractive average-weight women undermined high-risk women's propensity to believe that thinness leads to overgeneralized self-improvement.

The authors noted that popular media could actually provide a positive health learning experience by showing attractive but not overly thin images of women. If seeing just a few images of normal-weight women had such an effect upon women at risk of eating disorders, imagine what repeated exposure to normal-sized images in the media could produce. Ironically, when *Glamour*, which is one of the largest-circulation women's magazines, tried to use more average-sized models, fewer women bought the magazine.

Inpatient Care and Insurance Coverage

Inadequate reimbursement by insurance companies threatens the ability to provide optimal inpatient medical treatment for medically unstable patients with eating disorders, according to the results of a recent study at Baylor College of Medicine, Houston (*J Adolesc Health* 2005;36:221).

Jennifer L. Kalisvaart, MD and Albert C. Hergenroeder, MD recently studied the outcomes at discharge for 39 adolescent patients with medical complications of anorexia nervosa (AN) or eating disorders not otherwise specified (EDNOS) following treatment on an adolescent medical unit. The patients were admitted over three years, and were studied with a descriptive, retrospective cohort study design.

Patient characteristics

Admission criteria included a combination of estimated ideal body weight (% IBW) <85%, bradycardia (resting heart rate 50 beats per minute or less), hypothermia (35° C or lower), and orthostatic tachycardia, marked by an increase of at least 35 beats per minute after standing for 5 minutes. A final criterion was failure of outpatient treatment. At admission, 29 patients (74%) were diagnosed with anorexia nervosa, and 10 (26%) were diagnosed with EDNOS.

What the study showed

The mean age of the patients was 16.1 years, and IBW was 74.8%. The patients were hospitalized for a mean of 51 days and average daily weight gain was 0.100 kg. On discharge, 17% of the patients still had bradycardia and none had hypothermia. Discharge criteria included achieving 85% IBW.

The average hospital and professional charges added up to $105,853 per patient, and insurance companies reimbursed an average of 62% of the total charges out of the patients' medical benefits policies. No patient was discharged based solely on insurance criteria. The insurance companies uniformly denied coverage for the number of requested days. The authors reported that although the majority of expenses for inpatient care on this adolescent medical unit were reimbursed by insurance companies, reimbursement did not cover achievement of a discharge rate of 85% IBW, a weight universally associated with improved outcome. Even discharging patients once they have achieved 85% IBW may be insufficient. Many authorities believe that 85% IBW may be inadequate to assure that patients will consolidate their gains after hospitalization, gain to their truly healthy weights in the range of 100% IBW, and decrease their risks of frank relapse.

The authors also added that contrary to other reports, normalization of orthostatic pulse may not be a criterion on which to base medical stabilization. Instead, this parameter may stabilize later than body temperature and heart rate in teens recovering from malnutrition due to an eating disorder.

Friendships and Body Image Among Adolescent Girls

Girls seem particularly vulnerable to negative body image and dieting during adolescence, a time characterized by preoccupation with image and concern about social acceptance. One area that is still poorly understood is the extent to which social relationships with friends and peers is associated with adolescent girls' body image and dieting, according to a team at the Royal Melbourne Institute of Technology, Melbourne, Australia.

Peter Wilson, PhD and Bibi Gerner, MPsych recently studied a group of high school girls to determine whether poorer friendship could predict weight concerns and dietary restraint *(Int J Eat Disord* 37:313). They used questionnaires given to 131 girls who were sophomores and juniors in high school. The researchers asked specifically about perceived social support, friendship, intimacy and perceived impact of thinness on male and female friendships. Another section of the questionnaire sought information on individual beliefs and concerns about body image, and signs of body dissatisfaction and restrained eating.

Beliefs about thinness

The authors found that beliefs about the impact of thinness on male friendships predicted body image concern, body dissatisfaction, and restrained eating. Beliefs about female friendships were only predictive of restrained eating. These relationships remained even after controlling for body mass index.

There was partial support for the hypothesis that poorer friendship factors would predict the belief that being thinner improves friendships. Poor acceptance by friends was a significant predictor, regardless of actual body size. However, perceived social support and friendship intimacy were not predictive. Although heavier girls were more likely to believe that being thinner would improve their friendships (irrespective of how well their current friendships were functioning), they did not experience poorer acceptance by peers, or poorer social support or friendship intimacy. Thus, despite the stereotypes, this finding suggested that thinness is not a precondition for popularity or a necessity for having close and supportive friendships.

Because body shape is perceived as an important component of attractiveness to boys, it was not surprising that the girls would believe thinness is particularly influential in attaining successful friendships with boys. Results also underscored greater endorsement of beliefs that thinness improved popularity and acceptance and less endorsement of beliefs that thinness improved levels of friendship support and intimacy. Thus, the girls viewed thinness as an important contributor to peer status but were less likely to believe it would improve the quality of their friendships.

Although the results of this study suggest that sociocultural risk factors affect disturbed eating, and underlines the importance of perceived peer affiliation on adolescent girls' body image concerns, the extent to which deficient social relationships play a part in the development of eating disorders remains poorly understood according to the authors.

Body Fat Pattern After Weight Gain in AN

One of the hallmarks of anorexia nervosa (AN) is a distorted view of body image and size. A starved patient feels "huge" in spite of despite dramatic loss of total body fat and muscle. Furthermore, many AN patients feel that if they gain weight, they will gain it all in their waist and abdominal area. Results from a recent study indicate that they may be correct, at least immediately after they regain weight.

Researchers at Columbia University recently studied 29 women with AN and 15 healthy control women between 18 and 45 years of age to test the theory that body fat is irregularly redistributed after AN patients regain weight (*Am J Clin Nutr* 2005;81:1286). The AN patients were all receiving treatment at the New York State Psychiatric Institute and met *DSM-IV* criteria for AN, including amenorrhea. Control subjects were thin, healthy, weight-stable, regularly menstruating young women without histories of eating disorders of other psychiatric or medical problems.

All patients were admitted to the hospital for 1 to 2 weeks, during which all women were weighed daily and encouraged to eat food. Liquid nutritional supplements were added if necessary. After one to two weeks of medical and weight stabilization, self-report questionnaires and interviews assessed nutritional intake and activity, as well as body composition.

Researchers used dual-energy x-ray absorptiometry (DXA) to obtain total-body and regional fat and lean soft tissue before and after treatment and once among the control group. Whole-body magnetic resonance imagery (MRI) was also done to evaluate total body and regional adipose tissue and skeletal muscle mass. Serum assays measured cortisol, estradiol, and testosterone levels in both groups.

What the researchers found

Dr. Laurel Mayer and colleagues found distinct differences between the groups after weight gain. At low weight, the waist-to-hip ratio (WHR) of patients with AN and control subjects did not differ. However, after weight was normalized, the WHR of AN patients was significantly greater than that of the control subjects. At low weight, truncal fat as a percentage of total fat in patients was similar to that of control patients, but extremity fat was less among patients than controls.

Hormonal patterns also changed after the patients regained weight. Mean serum cortisol was elevated among the low-weight AN patients compared with controls, while mean serum estradiol levels were reduced. Despite normalization of weight, the average serum cortisol concentration of patients did not change and remained higher than that of control subjects. Serum estradiol levels increased among the AN group with weight gain, but remained below control concentrations when weight was restored. Mean testosterone levels were unchanged with weight gain.

Possible psychological effects

Dr. Mayer and colleagues do not know whether the tendency to accumulate abdominal fat during acute weight recovery has a significantly negative effect upon patients with AN. However, they noted that it is possible that those who gain the most truncal fat and visceral adipose tissue are also the most distressed about body shape and thus more prone to relapse. If this pattern of accumulating fat is only temporary, the patient may reach more normal patterns with long-term weight maintenance. Supportive therapy might help the patient tolerate the temporary body distortion until normal fat redistribution occurs. If, on the other hand, the changes are more permanent, a more targeted cognitive approach might be needed to help patients accept the change in body shape.

Risk of Overweight and Obesity Among Vegetarians

There is truth in the old adage that we are what we eat. A team led by Dr. P.K. Newby recently found that women who are semi-vegetarians, lactovegetarians, and vegans have a lower risk of overweight and obesity than do omnivorous women (*Am J Clin Nutr* 2005;81:1267).

According to the authors, surprisingly few studies have rigorously examined the relationship between a vegetarian eating pattern and obesity. Questions also remain as to whether animal products such as lean protein and dairy foods are helpful for controlling weight. In addition, recent studies have also shown a protective effect of dietary fiber and whole grains as well as dairy products and calcium.

The study group

The cross-sectional study used data from more than 55,000 healthy women participating in the Swedish Mammography Cohort. The participants were asked whether they considered themselves to be omnivores (eating all types of foods), semi-vegetarians (mostly lactovegetarians, who sometimes consume fish or eggs), lactovegetarian (consuming no meat, poultry, or fish or eggs), or vegans (consuming no meat, poultry, fish, eggs, or dairy products).

Results: Omnivores were heavier

A small percentage of women were semi-vegetarian (1.7%), lactovegetarian (0.29%), or vegan (0.15%). The omnivorous women were significantly heavier (mean: 10.9 kg heavier) than any of the vegetarian women. Mean weight, body mass index (BMI), and prevalence of overweight and obesity were highest among omnivores compared with any of the vegetarian groups. All three vegetarian groups had average BMIs lower than those of the omnivorous women. The authors noted that the vegans may be at an even lower risk of overweight or obesity than the semi- and lactovegetarians (66% risk reduction compared with 48% and 46%, respectively).

Food and nutrient intakes were significantly different across the three groups of vegetarian women. All of the vegetarian groups had higher intakes of fruit, vegetables, and fiber and lower intakes of fat and protein than women who were omnivores.

Not all carbohydrates are alike

The authors stress that it is important to differentiate between types of carbohydrate when evaluating dietary patterns, including weight loss diets. Current fad diets that promote low carbohydrate intake ignore the fact that whole and refined carbohydrate foods evoke different metabolic responses, and have different effects on appetite and energy intake. This study and others suggest that a high-carbohydrate diet may be protective against obesity if the carbohydrate originates from fiber-rich foods such as fruit, vegetables, and whole grains.

QUESTIONS & ANSWERS

Can a Head Injury Help an Eating Disorder?

Q I've recently been told about a patient with anorexia nervosa whose eating disorder seemed to *improve* after she sustained a head injury in an automobile accident. Is that possible? (D.K., Chicago)

A Remarkably, several cases of "spontaneous" improvement of patients with severe eating disorders following head trauma and even after brain surgery have been reported in the medical literature. One center reported on two patients whose eating disorders improved after right temporal lobe lesions: (1) a woman with bulimia nervosa and partial seizures arising from the occipital and right temporal regions, and (2) a woman with anorexia nervosa that resolved after a head injury resulted in right-sided inferofrontal and temporal encephalomalacia. The authors reported that not only did both patients' eating disorders resolve, but their moods and libidos also improved (Levine et al, *Epilepsy Behav* 2003; 4:781). These interesting clinical observations add to the suspicion that, in at least some patients, still-mysterious processes involving the temporal lobe may be at work in the pathogenesis of eating disorders.

–J. Y.

Nibbles by Hunter

"She told me she "needs more space"... she wants me to lose 40 pounds."

© 2005 Eating Disorders Review

CROSSOVER continued from page 1

diagnosis, may have an inability to regulate their behaviors and affect.

Crossover from AN to BN

Several factors were identified in the crossover from AN to BN, including low self-directedness and a high degree of parental criticism. Body mass index was not included in the analysis. Family factors, especially perceived criticism by parents, were particularly powerful. Families of patients with BN tend to have greater conflict and disorganization and less cohesion than AN families.

Crossover from BN to AN

Low scores on impulse-related personality traits (such as novelty-seeking) and the presence of such behaviors as alcohol abuse/dependence were important in the crossover from BN to AN. The authors hypothesize that lower-than-usual levels of impulsivity may enable the patient to maintain rigid dietary regimes long enough to lose the amount of weight necessary for a diagnosis of AN.

Some implications

If the findings from this exploratory study are confirmed, they may have important implications for treatment. For example, low self-directedness has been associated with a negative outcome. High self-directedness predicts rapid and sustained response to cognitive behavioral therapy (CBT) in BN patients and there is evidence that CBT leads to increased self-directedness (*Compr Psychiatry* 2002;43:182). Thus, self-directedness may influence not only the diagnostic stability of these eating disorders but also their course and response to treatment. Techniques designed to improve intrafamilial communication in cases of AN and addressing impulsivity in BN may also promote diagnostic stability and possibly shorten recovery times.

IN THE NEXT ISSUE

Weight Management Across the Spectrum of Eating Disorders

At the 2005 International Conference, a panel of experts provided the latest approaches to managing weight among patients with anorexia nervosa, bulimia nervosa, binge eating disorder and eating disorders not otherwise specified. New approaches are helping reduce relapse and improving success rates.

- **Obese patients with BED: Treatment Preferences**
- **Resisting Tachycardia: A Helpful Warning Sign in Anorexia Nervosa**
- **Repetitive Body Checking and Avoidance in Overweight Patients with Binge Eating Disorder**
- **Alcohol Abuse in Bulimia Nervosa**

and much more…

EATING DISORDERS REVIEW®
SUBSCRIPTION COUPON

Gürze Books
PO Box 2238, Carlsbad, CA 92018
(800) 756-7533 • Fax: (760) 434-5476
gurze@aol.com

One-year subscription (six issues and index)

	Regular:	AED or IAEDP Members:
U.S.	☐ **$65.00**	☐ **$52.00**
Canada	☐ **$75.00**	☐ **$62.00**
abroad	☐ **$83.00**	☐ **$70.00**

Two-year subscription

	Regular:	AED or IAEDP Members:
U.S.	☐ **$115.00**	☐ **$92.00**
Canada	☐ **$135.00**	☐ **$112.00**
abroad	☐ **$151.00**	☐ **$128.00**

(All payments US $ dollars)

☐ **Check enclosed** ☐ **Bill Me** ☐ **Credit Card**

We accept Mastercard, Visa or American Express.

Card No: ________ **Expr:** ________

Name ________

Organiz. ________

Address ________

City ________ State ________ ZIP ________

Phone ________

Continuing Education Quiz for Eating Disorders Review

July/August 2005 - Volume 16 - No. 4

You are eligible to receive one (1) Continuing Education (CE) credit by completing this quiz based on this issue of Eating Disorders Review (80% correct for a pass). INSTRUCTIONS: Circle the best answer to each of the following questions and return the completed test with a check for $25 (payable to PER) to PER at PO Box 2196, Keystone Heights, FL 32656.

PsychoEducational Resources, Inc. (PER) is approved by the American Psychological Association (APA) to offer continuing education credits for psychologists. PER maintains responsibility for this program. PER is approved by the National Board for Certified Counselors (NBCC) to offer continuing education credits for National Certified Counselors (#05536). PER is approved as a provider for social work continuing education (Provider # 1008) by the Association of Social Work Boards (ASWB), (1-800-225-6880) through the Approved Continuing Education (ACE) program. The following recognize the ASWB program: AK, AZ, DC, GA, IN, IA, KY, MA, MD, MO, MS, MT, NM, NC, NJ, OR, RI, SC, TX, UT, VA, VI, VT, WA, WI, and WY. PER is also an approved provider with a variety of individual state boards of social work which include: the Alabama Social Work Board, the California Board of Behavior Sciences (PCE 203), the Florida Board of Licensed Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling (BAP #351, exp. 03/07), the Illinois Social Work Board (159-000505), the Iowa Board of Social Work (#153), the Maryland State Board of Social Work, the Texas Board of Social Work (CS 1596), and the Texas State Board of Examiners of Marriage and Family Therapists. PER is a NAADAC Approved Education Provider, #374 (Exp. 10-31-05). These CE sponsorships are honored by many additional state boards of social work, marriage and family therapy, and licensed professional counseling. Some restrictions may apply. Check with your state board or call PER at 1-800-892-9249 for information regarding CE approvals. PER maintains responsibility for these programs and adheres to all sponsorship guidelines for awarding CE credits.

Your CE credits will be documented and you will be sent a letter and certificate of completion. CE credits can be used in support of your license renewal, to maintain your managed care board memberships, to obtain discounts on your professional liability insurance policy, and to document your commitment to ongoing professional development. Completing this program should: 1) increase your knowledge regarding recent research developments concerning eating disorders, and 2) enhance your clinical knowledge regarding disordered eating.

---

1. An interpersonal approach to Anorexia Nervosa emphasizes the anorexic symptoms as

a. a death wish
b. a source of life in a sea of misery
c. a rejection of others
d. a quest for autonomy and individuation and self-transcendence

2. According to attachment theory, anorexic individuals

a. are securely attached to others
b. are co-dependent with others
c. are constructively attached to others
d. are insecurely attached to others by dependency or avoidance

3. The goal of an Emotionally-Focused Therapy with anorexic individuals is

a. catharsis
b. to shift negative cycles to cycles of affiliation and trust to nurture secure attachment
c. to eliminate negative emotion by attending to latent resources and non-dominant narratives within the client's emotional story
d. to expose the latent irrationality of the negative emotion so that it is subject to clarification and rational restructuring

4. In a recent study of "crossover" between bulimia nervosa (BN) and anorexia nervosa (AN), Keel et al (2005) reported that the percentage of individuals with BN who eventually developed AN was

a. nearly 10%
b. 17%
c. 27%
d. nearly 45%

5. One factor that was consistently associated with crossover from BN to AN and from AN to BN in the Keel et al (2005) study was

a. low self-directedness
b. high achievement orientation
c. birth order
d. none of the above

(continued on other side)

6. According to Dr. Bulk, the use of laxatives by bulimic individuals is largely ineffective because by the time the laxatives take effect, nearly ____ percent of the calories have already been absorbed into the system

a. 25%
b. 50%
c. 75%
d. 90%

7. Dr. Bulk reported that approximately ____% of bulimic individuals report the chronic use of emetics to induce vomiting

a. 5%
b. 9%
c. 19%
d. 30%

8. Recent research by Fister and Smith (2005) studied women at risk for developing eating disorder. Among those women who were exposed to 10 images of attractive average-weight models, this exposure

a. had little discernable effect
b. undermined their tendency to believe that thinness leads to over generalized self-improvement
c. redouble their perceptions that the average-weight models were fat, thereby redoubling their convictions regarding the link between thinness and happiness and well-being
d. none of the above

9. In a recent study of 39 adolescent patients with medical complications related to their eating disorders, Kalisvaart and Hergenroeder (2005) found that the average hospital and professional charges added up to

a. nearly $10,000 per patient
b. almost $25,000 per patient
c. approximately $60,000 per patient
d. over $100,000 per patient

10. True or False: According to a large scale study of 55,000 healthy women (Newby et al, 2005), women who are semi-vegetarians, lacto vegetarians, and vegans have a lower risk of being overweight or obese than do omnivorous women

a. True
b. False

Name and degree as you wish them to appear on your certificate (please print):

Name: ____Degree: ________________
Address:____
____
Telephone #: ______________________________Fax #: ________________________
E-mail address: __________________License #: ______________________
I confirm that I personally have completed the above test, and I am submitting it for evaluation and certification.

Signature: ______________________________________ Date of completion: _______________

Evaluation: Overall, this issue of Eating Disorders Review: (circle appropriate response)

Provided informative updates	5	4	3	2	1	Was not informative
Expanded my knowledge	5	4	3	2	1	Did not expand my knowledge
Provided useful resources	5	4	3	2	1	Did not provide useful resources
Was appropriate for my training level	5	4	3	2	1	Was not appropriate

---

PER • P.O. Box 2196 • Keystone Heights, FL 32656-2196 • 1-800-892-9249