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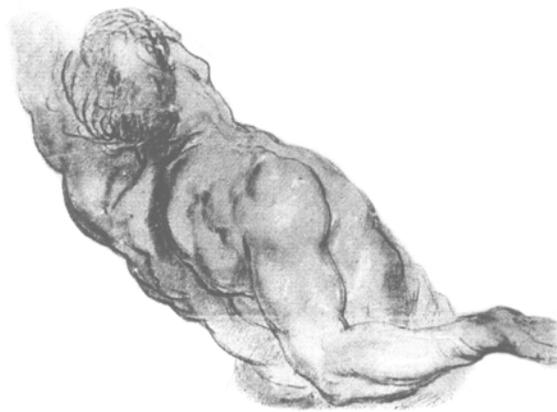


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USABP Mission Statement

The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999).

Health-threatening *Bulimia Nervosa* and a Promising New Treatment Approach

Christa D. Ventling, D.Phil.

Abstract

Patients with eating disorders such as *bulimia nervosa* (BN) are well known to be difficult to treat psychotherapeutically. A vast literature on cognitive behavioral psychotherapy (CBP), still the treatment of choice, given to in-patients for a limited amount of time testifies to the discouraging low success rates. No literature on the success rates of a body-oriented psychotherapy treatment exists as yet. This article describes highlights from the first two years of an ongoing bioenergetically oriented psychotherapy of a young woman suffering from BN with compulsive self-injury behavior, the most severe form of BN. Since eating disorders according to recent research data have certain defined neurobiological deficits, I felt it important for the patient to know about these and made psychoeducation a part of the therapeutic treatment. The combination of psychotherapy and psychoeducation proved to be of great value. Since the therapy is still going on, it is, however, too early to say whether this approach seemingly able to reverse the neurobiological deficits also is of lasting effect. Based on scientific data and the personal experience so far a 7-point treatment program for BN and similar eating disorders is proposed.

Keywords

Bulimia Nervosa - Neurobiological - Neurobiological Deficits

Introduction

We are spectators of one of the greatest cultural ironies: We produce food in excess and continuously invent tempting ways to consume it, but we are told at the same time that gaining weight is bad, ugly and unhealthy. Remaining slim is equaled to being beautiful and successful. The sad result is that for young women especially, life has become a daily battle around eating, an obsession, a life under pressure and fear often lived in secrecy and shame. In order to achieve their goal of remaining slim they either eat like a bird, picking on food only and thus keeping their weight down (leading to anorexia) or they discover how to get rid of ingested food, by self-induced vomiting (a condition called bulimia). While the shape of the anorexic woman reveals her condition to the trained eye, the bulimic woman by her looks alone cannot be distinguished from other young women. Both types of women are playing havoc with their lives without being aware of it, for they are in danger of physically breaking down anytime and requiring emergency hospitalization.

Anorexia nervosa (AN) and bulimia nervosa (BN) as these eating disorders are officially called are on the increase in all civilized countries. In Europe and the USA a conservative estimate is that about 1% of all women between the age of 15 and 35 years are anorexic (Kaye et al. 1998) and about 3% of European and 10% or more of US women are bulimic (Hettinger 2002). Sometimes anorexic persons turn into bulimics and occasionally men suffer from these disorders as well, but women are clearly over represented.

The statistical data would suggest that AN and BN are problems of modern society, but this is not the case. Anorexia and bulimia have been around in Antiquity. Both names are Greek, anorexia, composed of “an” plus “orexia” means “longing for something, reaching for something”, and bulimia is derived from “limos” meaning “excessive eating”. Both forms of disorders have been described by Hippocrates and Xenophon, the fathers of modern medicine. The meaning of the names tells us that eating/not eating is a symptom for something more profound at the basis of the disorder. Such was not even considered in the 1980ies when at least one study claimed that eating disorders among students, especially ballet school dancers etc. aged 15 to 27 were a normal part of development and did not require treatment (Abraham et al. 1983a). Today we know better. They are serious disorders in need of medical or psychotherapeutical attention or a combination of both. Let us then take a closer look .

Table 1. Eating disorders and their symptoms (according to DMS-IV and ICD-10)

Disorder	Thinking of Food = Hunger ?	Awareness of Disorder	Eating Habits	Weight Control	Body Image
Anorexia nervosa	never ?	sometimes	open, only picking food	starvation exercise	distorted view
Bulimia purging type	always	yes	secret, binge eating	self-induced vomiting laxative abuse	distorted view
Bulimia nonpurging type	always	yes	open, eating more than expected	exercise in excess, fasting	distorted view

Bulimia multi-impulsive type	always	yes	secret or open, binge eating	self-induced vomiting, laxative abuse, exercise, fasting	distorted view
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The common denominator for AN and BN patients is an aberrant pattern of eating and keeping the body weight below normal. (A normal weight is defined as a BMI² of 20; a BMI below 20 means underweight, 17.5 is considered the life-threatening cut-off point, often seen in AN patients.) Furthermore these patients have an unrealistic perception of their body shape leading to a distorted view of the body image. In general they perceive themselves as too big, too fat, too heavy and therefore ugly regardless of their weight or shape.

The third type of BN, the multi-impulsive type, exhibits impulse control problems in addition to the typical BN features and is the most severe type. The compulsiveness can take on the relative harmless form of buying unnecessary objects or of shoplifting or the much more alarming form of self-injury, like cutting the wrists with razor blades or scissors, as a means to break the intolerable tension, anger and fragmentation. Injurious behavior is seen in 25-40% of all BN cases (Leithner et al. 1998) Sometimes it is these very frightening moments of unbearable tension which will finally motivate a BN woman to seek psychotherapy, often after many years of suffering. However, only one out of three bulimic women with compulsive behavior apparently has the courage and motivation to do so (Tarr-Krüger 1989).

Onset of AN and BN in early adolescence.....

Our "eat yet remain slim"-oriented society is often made into the chief culprit for the AN and BN disorders, but is society alone to be blamed? On a superficial level it may seem so. For AN and BN emerge in early adolescence when girls become women and when the changing body shape is noticeable and menarche sets in (Halmi et al. 1979; Fairburn et al. 1997). To enter the world of sexually attractive and competitive adolescents is not necessarily something every teenager is looking forward to - much depends on the upbringing pattern, the degree of self-esteem, of identification, of assertiveness, inner values and much more, too broad a subject to discuss here. It may be so frightening that to remain a child may seemingly avoid the problem of growing up. Refusing food helps maintaining a skinny and lean body shape. Some adolescents chose this way to remain in their little-girl bodies and become anorexic. Others struggle with their developing feminine body shape due to an idealistic picture in their mind of what their body should look like, and they may go to extremes trying to obtain it (eating, then purging, abuse of laxatives, exercising in excess) without ever being satisfied. Others wish they had a different body altogether (Halmi 2002). AN and BN personality types have an identity problem. Something has gone wrong during their development into a woman.

.....is often based on childhood deficits

Their history often reveals serious childhood deficits (Battegay 1987; Kämmerer 1989; Kämmerer & Klingenspor 1989). These have to do with not being loved enough, not being seen, not being supported, not being valued, not being praised enough, etc. etc by either the father or the mother (Abraham et al. 1983a; Battegay 1987) or by getting ambivalent messages from a parent (Downing 2002). Clearly by the time they are teenagers, since they have never felt secure in mind and body, they now feel even worse and the problems are aggravated. If the marriage of the parents after all these years is on the rocks, but they stay together, the prevailing silent tension does not go unnoticed by the teenagers. Secretly they worry a great deal about the marriage of their parents, they are confused in their love for them. They rebel against their authority yet feel ambivalent towards them. Identification of the boy with the father seems less problematic than identification of the girl with the mother, as we only rarely see AN and BN in male adolescents. Not wanting to be like the parent (an unconscious process at first) can take the form of not wanting to grow up. And for girls, there is the additional problem of rivalry with other girls about looks and shapes. Tricks for staying slim are sometimes open secrets and are discussed among teenagers. While the AN woman openly and often proudly displays her shape and is sociable, the BN woman, living with a secret, feels guilty, dirty and ashamed and very lonely. She would rather hide than socialize. Because her lifestyle is her big secret and her body shape does not give it away, she often goes on for years before either breaking down physically or seeking help.

What is a good-enough psychotherapy?

AN and BN patients are ambivalent towards such topics as their body and nutrition. Thus it may be a good idea at the beginning of the therapy not to place too much emphasis on either subject, but to let it develop. It is my opinion that the developmental deficits with all their ramifications and/or childhood traumas must receive prime attention - being at the roots of the problem, with the bodies of these patients representing merely the outward symptoms. Since AN and BN patients have basically split off from their body, clearly a serious psychotherapy should also include body work, applied with utmost care and sensitivity. The problem is that we have no guidelines as yet with regard to specific techniques and bodily interventions etc. in body oriented psychotherapy for AN and BN patients.

A literature search on treatment of AN and BN reveals that the preferred treatment is cognitive behavioral psychotherapy (CBP) with emphasis on diet plans, weight control, nutritional education etc. Success rates are not encouraging, however, only 30-50% healed, with a drop-out rate of about 30%, another 30% considered incurable and about 10% ending in suicide (all figures for BN; Abraham et al. 1983b, Fairburn et al. 1993, Keel et al. 1997, Strober et al. 1997, Kaye et al. 1998). This information convinced me that treating primarily symptoms, e.g. the faulty eating patterns is unlikely to bring lasting relief.

I decided to use a different approach, whereby the topic of eating and body weight was excluded from my part, but of course addressed, if the incentive would come from the patient.

In the following I describe highlights of the first two years of an ongoing bioenergetically oriented psychotherapy of a BN patient interspersed with new research data or theoretical aspects as I see fit. Some of these I considered important enough to be discussed with the patient during sessions. Although I shall concentrate on bulimia, it is sometimes unavoidable not to include comparative aspects to anorexia due to the similarity of the disorders.

Case report: Ellen

Ellen (29 years old, not her real name) readily told me that she is a bulimic since the age of 14 and that a previous psychotherapy brought no results. After 15 years of feeling trapped in bulimia she could not stand any longer the stress and tension her lifestyle created. She needed and wanted help badly. Now her stress became my stress: I felt under considerable pressure to succeed with this therapy, since the former failed.

I declared at the beginning of the therapy that I was not going to mention food or anything related to food, weight, diet etc. unless she wished to speak about it. It was a subtle way of putting her in control. She felt visibly relieved. I explained that I was more interested in what happened in her life, especially in her childhood that led to her disorder.

She talked about her family and growing up. The facts emerged as bits and pieces during a number of sessions, not at all in a chronological order - as much was very embarrassing for Ellen to say. I learned that her father used to tease her about everything and anything, already as a little girl which made her chew her fingernails down to the bone, but especially about her looks and height later on (she is over 6 ft. tall and broad boned, taller than anyone else in the family) which reduced her to tears and made him laugh. All the while her mother would downplay this by saying "he did not mean it, it is alright". As a teenager and in the hope of pleasing her father she started to starve herself, then to binge-eat. Ellen felt ashamed for what she was doing, guilty and dirty due to the constant secret binge-eating, induced vomiting and subsequent hurried cleaning up of any traces. These feelings were so strong that Ellen even now, when she came for therapy, was convinced that people could see what she was doing by just looking at her. Attending meetings at work and having to answer to questions would cause embarrassment, make her face flush and create an intolerable tension. Just how bad this was, I learned later in the therapy.

With Ellen not trusting either parent, I figured it would be a while before she would trust me. Did her parents know about her binge eating behavior? Her father did not, her mother did, but said nothing. As a teenager when still living at home she did not binge eat and vomit as much as now yet, she said. "What about now?" I wanted to know. "Well now, yes, daily". I became very worried, feared for the worst and insisted that she must have a medical checkup - and walked right into my first confidence test. What I said scared her, she refused, but I insisted. We had our first argument. I knew the physician and I knew that he would not "treat" her, just check her physical status and leave the treatment to me. Ellen probably realized that she risked that I was not continuing to work with her if she would not start taking responsibility of her body. And so she reluctantly went for this check-up. It turned out a very positive experience, her blood values were normal and I let her know my relief. I remember that I said: "I care about you". It was also the beginning of a trusting relationship both with this physician and with me, though shaky at first.

Ellen knew that I would also work with the body whenever appropriate. In the 4th session I felt the timing right to give her a short introduction to body work by suggesting that she should roll a tennis ball under her foot and just feel what this was like. She refused point blank. Then she said that she feared that I would trick her into an embarrassing situation (like her father). I felt anger coming up ("I am not your father"), then took a deep breath and explained that I would do it in parallel with her and that she was allowed to quit this and any other bioenergetic intervention anytime, if she felt uncomfortable. With that option she dared, with her heart beating up her throat, she was so scared. Later, when speaking about what she felt, she was pleasantly surprised at what all she did feel, such as differences in temperature in her legs, in the arc of her feet, and her general feeling of elation. She smiled warmly and left the session feeling really good, she told me next time.

In the 5th session Ellen told me about her extended family and revealed eating patterns so ambivalent that I did not wonder anymore she was confused. Her mother was one of ten children, the family was poor and they raised their own vegetables and rabbits to fill all the hungry mouths. Her father also came from poor background where they tried hard to make ends meet. Ellen's two year older brother, with an inborn nutritional error of metabolism, could barely gain weight and remained small and skinny in spite of eating. Ellen, her brother and her parents often went to visit relatives; Ellen recalls visiting one particular aunt, sister of her mother and always feeling hungry there because the aunt limited the food on the table - and then another aunt who quite the contrary wanted to stuff everybody.

Ellen's father developed cancer of the throat, could not swallow anymore or breathe because of the metastases in the lungs and died a horrible death. Ellen was present when it happened. To talk about the death of her father caused her enormous pain. I was reminded of my own father's death and tears came to my eyes which Ellen noticed, as she looked up for a quick moment, then went into silence looking down on the carpet, her mind wandering to some place where I could not reach her. I stretched out a hand offering contact - she refused. I felt helpless.

It was our 10th session and it became a long session in silence. At the end, in my frustration I tried an approach I had not ever done before. I asked her since she found it so difficult to say out loud what was in her heart, whether she could put it into writing, and if she wished send it to me as an e-mail. The same evening she wrote a few lines, maybe to try me out. I answered. She wrote back, more lines this time. I replied again, just a few words. I was touched by her writing style and her depth of expression. During the next session I told her how her mail affected me emotionally and encouraged her to use this means of communication further if she wanted. For the next 4 or so weeks, she continued with e-mails between sessions and in writing she could express things she could not say otherwise. We still endured many silent moments during the sessions, but I passed on to her how her emotional expression, sometimes written between the lines, touched me. It had an effect: She let me sit closer to her, but not yet touch her.

Ellen could now write about her deep depression, her despair, her not wanting to live any longer. Unexpectedly I discovered that Ellen was a gifted writer, that she had written short stories before but had never shown them to anyone. To be finally seen and acknowledged was a big boost.

One day she wrote that she would like to tell me a secret she had never, ever, told anybody, but was afraid to do so. With my encouraging reply she did. It was about her first menstruation, which caught her unprepared, a most embarrassing moment in school. She said that the fear that everyone in her class could see stains on her clothes and know about it made her face blush in the deepest red; never had she felt so ashamed. Her mother said nothing. Ellen felt abandoned. This story broke the silence. From now on Ellen could talk and regular e-mail stopped. She could even say that she longed to be held by me (but would NEVER allow it - although later she did) because she felt dirty from the binge eating and vomiting, that she feared I would be disgusted and she said almost shyly that the time between sessions felt extremely long and lonely.

As we found more and more answers in her childhood and family relationships, she went into regression. She chose a corner to sit down on the floor, folded her body into the smallest possible package, hugged her knees, looked at her bitten fingernails and sat in silence. Her position was that of a small child, abandoned, alone, lost in time and space. As I looked at her empathetically, my mind side-tracked into her childhood.

Hunger has many different forms

Eating disorders are actually hunger disorders. The hunger which is now for food as in the case of Ellen, originally was another one. Hunger has many different forms (Battegay 1987). For a baby, there is hunger for body contact and cuddling, for attention, for playing, for making eye contact, for conversation with sounds, for love and all its expressions etc. etc. And for the small child there is hunger for love, for being seen, heard and felt, for being physically close to a parent, for being allowed to say NO, for being able to accomplish a small task, for praise etc. etc. And we continue: from the age of going to school to the end of our life we want and need love, praise, emotional support, encouragement, empathy when things go wrong etc. etc. Hunger for love is always first. Unfulfilled hunger in the long run can lead to a depression. The depression may not be conscious and can take on different forms of substitutions: drugs, alcohol and food or combinations thereof. Downing (2002) stated that eating disorders are substitutions for underlying problems originating most likely in childhood.

As Ellen sat in silence, I waited. A single tear ran down her face. When I asked her where in her mind she was, she said that she could not answer as she did not know. I extended my hand and offered it for contact, but she refused to accept it. She said her hand was dirty, therefore she could not allow me to touch her. I resorted to a teddy bear I keep in my practice and placed him into her arms. This brought a thankful warm smile and also tears into her face as she cuddled the bear. That day, she told me later, she decided to buy a bear for herself. The teddy bear incident had broken the ice and some time thereafter touching, even holding her was possible, permitted and wanted.

Then one day she came in with a dead expression on her face, said nothing, sat down in her usual corner, but pulled up a sleeve. I saw and learned for the first time that she had cut her forearm with sharp scissors. I was alarmed and feared for the worst, especially as she had mentioned more than once before that she often wished to end the suffering. She was clearly suicidal and I felt guilty about having misjudged the seriousness of it all. I let her know how worried I was and decided to use that session to educate her about depression in general and depression in bulimia with compulsive behavior in particular. Let me deviate here into what I told Ellen.

Stress leads to depression

It has long been known that stress causes people to become depressed. The stress that hunger disorder patients find themselves in is caused by their eating pattern and the aberrant behavior of weight regulation, leading in addition to anxiety and a low self-esteem. It is a vicious circle. Biochemically a depression signifies a deficit in brain serotonin, which can come about via three mechanisms (Pinel 2001):

- Serotonin synthesis (from tryptophan, an essential amino acid) is decreased. This leads to insufficient serotonin being present in the synaptic cleft (the space between two neurons) and thus an insufficient signal transmission.
- Serotonin re-uptake by the original neuron, done by specific transporter proteins present in the synaptic cleft, is too fast and again not enough serotonin is available for signal transmission.
- Serotonin degradation, a normal mechanism for removing extra serotonin in the neuron and done by monoamine oxidase (MAO) is too fast.

Various chemical substances are known to exert their specific action at just one of these sites and not the others. Thus, some inhibit specifically MAO, others specifically serotonin re-uptake. Among the latter is fluoxetine³. Norden (1996) collected data on all disorders reacting positively to fluoxetine and found that *all* eating disorders (AN, BN, overweight and obsessive compulsive disorders) do so. This is proof that not only all patients with an eating disorder suffer from a depression, but that this depression has a defined biochemical deficit and that its location is known. A number of publications on the effect of fluoxetine (or a similar compound) in curbing binge-eating behavior followed (Kaye et al. 1998, Kruger & Kennedy 2000, Mitchell et al. 2001, Bacaltchuk & Hay 2001) all with positive effects. I ended this outline by suggesting fluoxetine as being a medication worth trying.

Ellen listened with great interest and reacted with relief: "Now I finally know what is wrong with me". I sat across from her on the floor, holding her hands and she understood that I was dead serious about this. She agreed to speak to the physician I had recommended earlier and go on fluoxetine.

A miracle happened. Within two weeks on the medication Ellen told me: "it feels as if my head is holding together for the first time." Within two months on the antidepressant she was able to reduce the purging behavior to about once or twice a week on the average and she did not cut herself for almost 4 more months. She decided to stay on the drug although the recommendation was for four months. While she now

³ Fluoxetine is sold in the USA as Prozac, in Europe as Fluctine.
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readily answered my questions about effect and possible side effects (there were none) of fluoxetine, she did not mention her eating behavior and I did not ask. But I could feel that she now trusted me completely. Whether it was the fluoxetine or her trust in my abilities as a psychotherapist, I do not know but she could let go more of her inhibitions, her fear of making a fool of herself and feelings of shame diminished. This in turn allowed more body work. Grounding, breathing work on the mattress, stomping around the room, all of this became possible, as did crying and laughter.

One day Ellen started all by herself very openly to talk about the problem of discipline in eating, of “thinking about food” all the time, but not being sure whether this was equal to feeling hungry and about not knowing the feeling of satiety. Her interest in hunger and satiety feelings however stimulated me to go into a literature research. Here is what I found out:

How hormones control our hunger and satiety feelings: recent research data

Is thinking of food equal to feeling hungry? AN and BN patients both will tell us that they are constantly thinking about food, but they do not mean the same thing.

The AN patient thinks about it in terms of avoiding food altogether, how not to have to eat. The BN patient thinks about food in anticipation and fear of the next meal. If we ask them: “do you mean that you constantly feel hungry?” they are not sure. If we ask them: “do you know the feeling of satiety?” Both will answer “no”. This is something important for us therapists to remember: it tells us that the appetite control systems in the brain of our patients are not functioning properly. Our patients, unlike normal people, cannot feel hunger or satiety and they confuse thinking about food with feelings about it. This already suggests that on a biochemical level some regulatory mechanism must be out of order.

The feeling of hunger as well as the feeling of satiety occur through the concerted action of several hormones produced by different parts of the body and centrally controlled by the brain. Thus sometime before we even notice a feeling of hunger ghrelin (GHR) is synthesized in the stomach. This sends a signal to the brain, to the pituitary which now releases growth hormone (GH) and prepares the stomach for food. GHR tells us that it is time to feed our body and this saves us from starvation. Some time after we have eaten, about 20 minutes or so, the hormone cholecystinin (CKK) synthesized in the intestines tells the body that there is enough food, sends a signal to the arcuate nucleus (ARC), a specific group of neurons, in the hypothalamus which send a signal to the intestines where now several peptides belonging to the family of the so-called PYY hormones are produced. They control the appetite for sweet, salty etc. and in concerted action with insulin and leptin make us stop eating (Marx 2003). In other words CKK prevents us from overeating. Leptin is a hormone synthesized in fat cells. Together with insulin it regulates the energy balance, e.g. food input versus energy output in the long run, in other words the stability of the weight of a person (Marx 2003). All these hormones (actually small peptides) and their action are recent discoveries made during the last 10 years only (Marx 2003). In eating disorders one or possibly several of the regulatory mechanisms for appetite control are not functioning. At the moment we do not know whether the imbalance of the appetite, hunger and satiety-controlling hormones is the result of the depression or whether the unhealthy eating patterns gave rise to the hormonal imbalance and hence to the depression. While AN patients lack the feeling of hunger and consequently of satiety, BN patients claim to be ravenously hungry (and sometimes confuse this with the tension they are under), but lack the feeling for satiety. The key question here, of course, is can the hormonal dysregulation be re-established through psychotherapy? Can an altered thinking or behavior make the brain talk correctly to the body and vice-versa?

This psychoeducation session created a certain curiosity, an interest in research almost, in Ellen. She asked herself if she could induce the missing hormones in her brain if she would maintain a very disciplined eating pattern. She certainly had my encouragement to try it out, but a week later reported of not being certain about the feelings. It was to be expected that such a change would not happen over night, but it had started a process. For one, it brought up memories of a summer vacation abroad with her husband. She reported that with him she feels so safe (abroad!) that maintaining a discipline in eating was no problem and that she could feel hunger and satiety most of the time. She also realized now what her real hunger way back in her childhood was for: love, security, support, taken seriously and when on vacation with her husband she got this 24 hrs. a day. Last Christmas a curious thing happened. Ellen told me about her anticipation of eating a traditional local Christmas cookie, of which she had fond memories from her childhood. She had not allowed herself this treat for years for fear of not being able to stop eating. “But now”, she smiled, “it is different”. She later reported in mouth-watering terms about the delicious moment of eating this cookie and most important, how four of them filled her with deep satisfaction. And no, she needed no more. Ellen had no idea that she was actually confirming a hypothesis of mine. I long suspected that there exists an enjoyment factor which works in conjunction with the satiety hormone.

Hunger is a multidimensional phenomenon. When the hunger feeling sets in, we look forward to eating as an enjoyable act. It fills us with anticipatory satisfaction. We hope that the cook prepares a delicious meal as we have

known before. All of us have recollections of good-food or bad-food situations. We may shudder with disgust remembering a particularly bad tasting dish or almost salivate in memory of a particularly delicious dessert. Enjoying the food we eat is based on such discriminating memories. With a cold and blocked sinuses and the need to breathe through the mouth, food tastes rather dull. The enjoyment factor I propose depends on the proper functioning of the taste buds (the gustatory sense) on our tongue which allow us to distinguish between sweet, sour, bitter and salty and on our sense of smell (the olfactory sense) which lets us perceive all those ingredients which give the food its unique flavor, such as herbs and spices and last but not least on our memory which registers all of this. Some patients with hunger disorders cannot recall such good memories with the appropriate emotion. Eating for them was never truly enjoyable; eating in company with people enjoying themselves is a nightmare, and this not just because of their fear of gaining weight.

Ellen had told me several times how she suffered through business lunches and family dinners. Now for the first time she tells about a pleasurable eating experience and how "normal" she felt. If such a proposed enjoyment factor exists - I even venture to claim that it is an endorphin - then it would mean that it can be restored through psychotherapy. Ellen was very excited, I was very excited, it was a giant leap towards healing.

At this time of writing Ellen has been in therapy for 2 years of which 1 ½ years on fluoxetine. Ellen considers fluoxetine a life-saver, she compares it to insulin for the diabetics, but with a difference. The depression being no problem anymore, she feels that her self-perception has sharpened, that her self-image is no longer a big shapeless blob but being adjusted to reality, to what she sees in the mirror and most of the time she likes what she sees. She goes to a fitness center and dares expose herself there. She has gained in self-confidence, dares to speak up at work and even when blushing, it does not throw her into an unbearable tension as in previous years. She cooks for friends occasionally and enjoys it, that is new. She continues to write. She also discovered painting as a meditative act to calm down. Self-injury is a thing of the past, although at times she can feel the tension mounting, yet it is never so strong that to break it would require to injure herself. Occasional binge eating episodes happen, which she considers "the exception to the rule". The therapy is continuing.

Preliminary conclusions: treating the depression first

Many scientific studies have pointed out that the depression in eating disorders must get priority. Whether we do this by psychotherapy alone or in combination with an antidepressant medication or some other means is a decision to be taken together with the patient. In any case she should be informed about what is known and available in terms of research results and which alternatives exist apart from antidepressant medication.

Since the beneficial effects of fluoxetine in eating disorders became known, a number of studies dealing with other similar specific serotonin reuptake inhibitors (SSRIs; see Berkow, Beers and Fletcher 1999) on anorexia and bulimia followed. Sertraline, paroxetine and fluoxetine - better known under the names of Zoloft, Paxil and Prozac in the USA were the most important ones used. In studies with either these three antidepressants tested in parallel, or fluoxetine compared to MAO inhibitors, or to tricyclic antidepressants (TCA) - the latter two act on different sites in the neuron than fluoxetine - fluoxetine was always best in curbing binge-eating behavior and reducing the drop-out rate (Kaye et al. 1998, Kruger & Kennedy 2000, Mitchell et al. 2001, Bacaltchuk & Hay 2001).

An alternative and interesting route was chosen by Lam et al. (1994) who, having recognized the depression in bulimic patients, used light therapy (a well-known standard treatment for winter depression) and compared it with that of an antidepressant in 17 bulimic patients without psychotherapy. All patients profited. This shows that treating the depression is apparently key. In another study sertraline helped 5 underweight cases of BN purging type to gain weight and to reduce their purging behavior (Frank et al. 2001). In another study where a group of AN and BN patients on SSRI medication was compared with a second group receiving CBP or with a third one receiving both SSRI medication plus CBP, the combination treatment was best (Mitchell et al. 2001).

But the results with antidepressants are not always clear-cut and convincing. Five publications exist about clinical trials with BN (and AN) patients where the effect of antidepressants alone or in combination with psychotherapy, mostly CBP was studied, which ended with controversial results (Mitchell et al. 1990, Fichter et al. 1991, Agras et al. 1992, L. Leitenberg et al. 1994, Walsh et al. 1997, Agras 1997). The improvement in bulimic symptoms with CBP alone was greater than with medication and combining the two was not significantly better than CBP alone, except for one single case. In summary over the past 30 years, fewer than 20 controlled clinical trials with in-patients were carried out evaluating the effectiveness of various types of psychotherapy (but never body-oriented psychotherapy!) in BN and AN and the evidence remains questionable (Kaplan 2002). Most studies used CBP with a set number of therapy sessions and a very structured daily activities plan. The majority favor an SSRI as antidepressant medication with relatively good results, at least for bulimic patients. Badly needed data on the stability of the result are still missing as are data on out-patients.

Towards a promising body-oriented psychotherapy for bulimic patients

Let me emphasize that eating disorders although also called mental disorders are not genetic disorders. The genes are alright. It is their regulatory mechanisms which are faulty or inhibited and in need of restoring. The question is just how can this be done ?

It is assumed that long-established patterns of thinking and behavior in our brain can be altered through new insights and adapting a new behavior pattern. Learning by conditioning is well-known to achieve this, but the effect is not necessarily and always a lasting one. With mental disorders the problems are much more deeply "engraved", yet the treatment of choice for BN and also AN so far has been and still is nutritional rehabilitation with medical attention, as individuals or in group therapy receiving CBP. The less than 50% success rates (Kaye et al. 1998, Halmi 2002) suggest however, that a purely cognitive approach for treatment of these disorders, with emphasis on strict eating schedules and a neglect of the body feelings is seemingly not sufficient for the patients.

The new neurobiological findings on the malfunctioning of hormones regulating hunger and appetite, and those on depression in eating disorders and the different ways to deal with it, when integrated into our basic knowledge on these disorders should entice us to rethink our psychotherapeutic approaches. Hormonal expressions can often be felt - such as the elated feeling after a grounding exercise is due to an output of an endorphin. By educating a patient about the modern theory on hunger and satiety and stimulating her interest and curiosity in this subject it may start her to want to listen more attentively to the signals of her body. This again challenges us therapists to work on the perceptive abilities of the patient. I have described exercises to increase the perceptive abilities of pregnant women as a means of preparing them for "reading" the baby (Ventling 2001a, 2001b). These exercises for the visual, auditory, gustatory, olfactory and tactile sense are equally well suited for patients with eating disorders; I have done those for the visual and auditory sense with Ellen, with success. She said she "noticed" things differently thereafter; the proof was that she noticed pictures in my office for the first time which in fact have always been hanging there!

A last practical word about BN patients: these women maintain a relatively normal weight and are therefore undistinguishable from the rest of the population by appearance, they also prefer to keep their secret and often may not reveal anything in therapy for a long time, least of all problems of compulsive behavior. Table 2 therefore lists warning signs for the therapist to watch out for:

Table 2: Warning signs

<ul style="list-style-type: none"> • Excessive weight loss; fear of weight gain, preoccupation with food • Obsession with clothing size, scales, and mirrors • Refusal to eat with others; ritualistic eating • Excessive exercise • Moodiness; social withdrawal • Frequent vomiting or use of laxatives • Absent or irregular menstruation • Excessive facial and body hair • Hair loss or straw-like hair • Swollen salivary glands • Broken blood vessels in the eyes

Final remarks: To Eat or Not To Eat

BN (and AN) patients view the body as an enemy, an ugly addition, a cumbersome responsibility, that has to be fed but is neither liked nor loved, just tolerated. Downing (2002) emphasizes that it is important to work with their body as soon as possible, to bring life back. We must, however, remember that these patients are extremely distrusting, therefore building up a trusting therapeutic relationship has priority over body work. It requires us therapists to be patient, empathic, careful and perceptive.

Bulimic patients feel ashamed about what they are doing (AN patients do not). Thus the sensitive therapist will adjust to the individual, although there are no established rules to follow. Bulimic patients must be allowed to decide when and how they want to mention food, eating patterns etc. in the sessions, when to let us therapist into their secret. Probing into their eating patterns will make them clam up, an understandably defensive reaction.

We also need to judge the degree of the depression the patients are in and make it transparent to them. Suicidal thoughts might lurk in the background. It may sometimes be useful to use an antidepressant for a certain length of time. Of course this must remain the patient's decision and requires a prescription from her physician. It can get the patient out of her depression quickly and thus provides a head start for the therapy.

When we find out what their real hunger is all about, patients may regress. We need to remain alert for any suicidal tendencies and act accordingly. To replace the void (which was filled with too much or too little real food) with pleasure, gratification etc. from resources and assets is the next goal. Discovering one's creativity greatly raises the self-esteem, it brings joyfulness into life and thus, hopefully, the beginning of a new freedom.

To sum up, I would recommend to work along the following 7 points when treating hunger disorders like bulimia and anorexia:

Table 3: Seven Treatment Points

- **Do not discuss food, diets, eating patterns or weight etc.**
- **Build up a trusting relationship and educate the patient about her disorder.**
- **Name the depression and explain it. If patient agrees provide antidepressant.**
- **Work on the body, make it come alive.**
- **Focus on the real hunger and its origin.**
- **Work on resources (creativity, interests, talents, social engagement etc.)**
- **Occasionally check on hunger and satiety feelings, returning to normal.**

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Biography

Christa D. Ventling received a M.Sc. at the University of Lausanne (Switzerland), followed by a D.Phil. at the University of Oxford. She has held research and teaching positions at the University of Iowa City and at The Johns Hopkins and Maryland University in Baltimore MD. She has published over 50 articles. She studied psychology at the University of Basel, Switzerland, graduating with a Masters and honors. She was certified in 1995 as a bioenergetic therapist. She is a supervisor and an active member of the Swiss Society of Bioenergetic Analysis and Therapy (SGBAT) where she heads the section of science and research. She is the winner of the First Prize for Outstanding Research in Body Psychotherapy, awarded at the USABP Conference in Baltimore MD, June 2002. She is the editor of "Childhood Psychotherapy: A Bioenergetic Approach" and of "Body Psychotherapy in Progressive and Chronic Disorders" (both published at Karger, Basel, 2001 and 2002). She has two grown children and three grandsons and works in a private practice in Basel, Switzerland.

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