



Fast Facts: Eating Disorders

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Declaration of Independence

This book is as balanced and as practical as we can make it.
Ideas for improvement are always welcome: feedback@fastfacts.com



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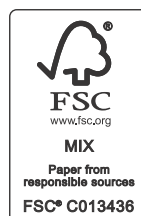
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Perspectives	5
Introduction	7
Classification	9
Epidemiology	12
Etiology and pathogenesis	18
Diagnosis	31
General management principles	51
Treatment of anorexia	60
Treatment of bulimia	74
Course and prognosis	84
Other eating disorders	89
Research areas	94
Case studies	96
Useful resources	105
Index	106

Perspectives

Hans Steiner writes: This first poem, written by one of my patients, is a powerful glimpse of what the acute phase of these illnesses looks like from within, after one has stripped away the numbing effects of malnutrition. What comes through is tremendous disappointment and loneliness which needs combating before healing and forward-moving development can be restored. It is not clear who exactly the poet is referring to: parent, doctor, teacher, sister, aunt. But the message is clear: positive and powerful female role models in girls' lives are tremendously important and an essential part of recovery. The second perspective tells us that patients can, with support and effective treatment, find their point of 'balance'.

Persephone's Mother Pays a Visit

You dread this part: entering the room
Where the child you slowly do not recognize
Waits, all bone-shiver and whisper
Of robes in the flickering dim.

She's losing it, she tells you.
Shedding when she runs her fingers through it.
Brittle as grass-husks under snow—
The girl has become nothing but a mouth,
Closed to their pleas to open,
Take and eat.

Witness to her waning pulse,
You greet her with a red-rimmed gaze,
Those flowers she has grown to hate.
It's a matter of principle.

They're alive and she's not,
So she withers them with a glance,
And turns your hopes for antidotes to guilt
In what she doesn't say.

You nurtured the earth
While she starved to death— no, *in* death already
This maiden of nothing, feasting on empty platters—

You made the field that led her to her fall,
The food that trapped her there. You gave her hell
A start but not an end; sickness without cure.

The scene replays itself: You, unable to stop her
As she reaches for the seeds of that ripe fruit.
How they glisten, even in memory,
Butcher-block red like the landscape of your heart.

Now, in the frailing light, as you walk home
Alone in the knowledge that you had a part in this,
That you were no mother to her,
Only a goddess who failed.

Isabella Fukutomi

“I have been an eating disorder patient for the last 21 years. For many of these years my anorexia/bulimia was the most important part of my life. In and out of the hospital, I became increasingly isolated from my family and friends. My doctors and treatment team became my social network. The transition back to normal life was slow and erratic, but I am fortunate to have had the patient and flexible medical and psychological care I needed.

I now have a family and have learned healthier, more productive ways to create the order and structure once provided by my disease. I still struggle with associated issues, but with my children as my priority, I have managed to find a mostly successful balance.”

A patient

Introduction

The classic eating disorders anorexia nervosa and bulimia nervosa represent relatively common and significant disturbances that are now being seen with increasing frequency by healthcare professionals. Within the carefully coordinated and comprehensive multidisciplinary intervention that is required for every patient with an eating disorder, the primary care team has an important role in initial screening and in the subsequent monitoring of the patient's physical state. There is evidence that treatment can be successful; however, it is unclear if significant risks and vulnerabilities for recurrence ever completely resolve.

Eating disorders are classic 'psychosomatic' syndromes in the sense that psychological and somatic functioning are inextricably intertwined. In *Fast Facts: Eating Disorders*, we look at the association between pathological thoughts and emotions concerning appearance, eating and food. We also examine the deviant eating behavior that can lead to alterations in body composition and functioning.

Eating disorders are often conceptualized as developmental disorders. However, few prospective studies have examined normative and pathological phenomena in populations at risk. Only a few studies have employed longitudinal designs, and these are discussed where appropriate throughout the book.

This book summarizes the available evidence base that underpins the current diagnosis and treatment for eating disorders, which we have broadly divided into anorexia, bulimia and related disorders. We discuss in some detail the role of the primary care physician in identifying the disorder, working with the treatment team and providing essential therapeutic services.

Definition of anorexia nervosa

Anorexia nervosa is characterized by the refusal to maintain a bodyweight equal to or above a minimally normal weight for the individual's age and height. Bodyweight is at least 15% below the norm. The weight loss is self-induced by several means:

- fasting
- use of laxatives or diuretics
- self-induced vomiting
- excessive exercise.

Individuals with anorexia exhibit an overwhelming fear of putting on weight and a distorted view of the size and shape of their body.

Postmenarcheal females experience amenorrhea, i.e. the absence of at least three consecutive menstrual cycles, or if the menstrual cycle occurs it does so only as a result of hormone administration.

There are two subtypes of anorexia:

- restricting type, in which the individual does not regularly engage in binge-eating or purging behavior
- binge-eating/purging type, in which the individual regularly engages in binge-eating or purging behavior.

Binge-eating is characterized by eating large amounts of food in a discrete amount of time and feeling a sense of a lack of control. Purging behavior includes self-induced vomiting or the misuse of laxatives, diuretics or enemas.

The specific diagnostic criteria for anorexia from the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) are discussed in more detail in Chapter 4 – Diagnosis.

Definition of bulimia nervosa

Bulimia nervosa is characterized by recurrent episodes of significant binge-eating – eating large amounts of food in a discrete amount of time and feeling a sense of a lack of control – followed by inappropriate

Studies of treatment options for bulimia are more advanced than those for anorexia. The focus of the majority of these studies is on young adult populations. For patients suffering from bulimia, the most common modes of treatment involve psychological therapy, medication or a combination of both. Evidence shows that treatment can be successful, but it is still unclear whether significant risks and vulnerabilities for recurrence ever completely resolve in severe cases.

Stepped care approach

The treatment for bulimia involves a stepped care approach, starting with primary care and/or self-help programs; this is followed, as necessary, by hospital outpatient or day treatment, then inpatient treatment in a general psychiatry unit or, preferably, specialist unit-based therapies.

Recent studies on the treatment of bulimia have demonstrated that, for adults, cognitive interventions and antidepressants, especially selective serotonin-reuptake inhibitors (SSRIs), are effective. These findings do not necessarily apply to adolescents. For the younger patients, family therapy may be indicated; ultimately, data indicate that intensive treatment modalities play an important role in any attempt at recovery.

The primary goals of treatment for bulimia are:

- to help a patient stop bingeing and purging
- to help a patient learn, regain and maintain healthy eating patterns
- to address other psychological issues related to the primary diagnosis of bulimia.

Non-pharmacological treatment

The most commonly used treatments for patients with bulimia are psychological and patient-led interventions. Non-pharmacological methods include:

- cognitive-behavior therapy (CBT)
- behavioral techniques
- relaxation training
- stimulus control
- family and marital therapy
- group therapy
- support groups/stepped programs
- self-help approaches.

Cognitive-behavior therapy comprises four distinct phases for patients with bulimia. Initially, a clinician makes an assessment of the patient's psychological, emotional and behavioral functioning by means of a clinical interview. The patient is also asked to self-monitor nutritional intake, and bingeing and purging behaviors. The patient is then educated about healthy regular eating patterns and is encouraged to resume or engage in nutritious eating. This is an attempt to normalize the sporadic and out-of-control dietary intake. CBT also seeks to restructure the patient's cognitive distortions about food, thinness, achievement and assertiveness. Finally, by continually discussing signs of relapse and focusing on preventative strategies, an emphasis is placed on the prevention of relapse. Therapy is slowly tapered when the patient shows consolidated signs of progress.

Behavioral techniques. The technique of exposure plus response prevention is often used, and is based on a model of anxiety and phobic avoidance that is involved in the binge-purge cycle. Patients are made to eat foods that they fear either gradually or through a binge and are then prevented from purging. Repeated exposure to the foods without compensatory purging behaviors aims to decrease the patient's anxiety over time. Concomitantly, the patient also becomes less fearful of normal eating.

Relaxation training. A prime example of relaxation training is progressive muscle relaxation. Patients with bulimia benefit from learning alternative means of dealing with negative emotions such as anxiety. Patients follow a routine of tightening and relaxing muscles in

their entire body while playing a pre-planned tape of smooth calming music with narrated instructions. Relaxation training becomes increasingly useful as patients become more comfortable with the techniques and are able to maximize the benefits of the exercise.

Stimulus control. With this technique, antecedent and consequential behaviors associated with bingeing and purging are examined and restructured to prevent binges and purges.

Family and marital therapy. Patients whose family and marital dynamics contribute to, or exacerbate, bulimic symptoms may benefit from family or marital therapy. A study of 49 adolescents with eating disorders and their families found that mothers' critical comments explained 28–34% of the variance in outcome for the patients, and that it was the best predictor of outcome. Two studies of the family environments of patients with bulimia showed that punishment contributed to overall outcome difficulties and was indicative of poor family functioning.

There have been promising results in studies of adolescents with bulimia who still live with their parents. For example, a pilot study found that treatment of female patients (aged 14–17 years) with brief family therapy resulted in significant decreases in bulimic behavior at 1 year. This type of therapy has also produced good results in older patients with marital discord or ongoing conflicts with parents. However, it is generally less effective than in patients with anorexia.

Group therapy. Patients who demonstrate particularly poor social skills and who appear particularly susceptible to group or societal pressures toward thinness may benefit from group therapy targeted at bulimia recovery. This method may also help patients to deal more effectively with the feelings of shame commonly surrounding the disorder, as well as provide additional peer-based feedback and support.

Support groups/stepped programs. Some patients have found groups and programs such as Overeaters Anonymous (see page 105) to be