Eating and its Disorders

Edited by John Fox and Ken Goss
EATING AND ITS DISORDERS
Wiley Series in

CLINICAL PSYCHOLOGY

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Eating disorders have often attracted considerable public and media interest, with many magazines commonly discussing celebrities’ difficulties with their eating or their body sizes. In some ways, this fascination with eating and its disorders comes from the fact that Western society is riddled with contradictions when it comes to eating and ideal body shape. Women (and increasingly men too) are constantly bombarded with images of ‘thin models’, which are linked to messages of success and wealth, whilst we are also living in a culture that values eating and the importance of eating in demonstrating care and connectedness to others. At first glance, it may seem that eating disorders are a new phenomenon, but there have been reports of eating problems stemming back into history. In a fascinating book on Catherine of Siena (Bell, 1987), the author argues that her search of asceticism, in a sense of being closer to God, was pursued via a ‘holy anorexia’. Whilst the first bona fide accounts of ‘girls starving themselves’ is discussed by Brumberg (2001), where he highlights that the first reported cases stem back to the nineteenth century. At this time there were numerous reports of ‘fasting girls’, such as Mollie Fancher, otherwise known as the ‘Brooklyn Enigma’, who was very well known for her claim of not eating, or eating very little for extended periods of time. There was also the famous case of the ‘Welsh fasting girl’ (Sarah Jacob) who claimed not to have eaten any food at all after the age of 12. Sadly, Sarah died shortly after being admitted into hospital after the effects of pronounced starvation (thereby ‘proving’ that she could not survive without food!).

Despite this history, we are still very much in the infancy of understanding and treating eating disorders. This is a worrying state of affairs as Fairburn and Harrison (2003) point out that eating disorders are still a significant source of physical and psychosocial morbidity, and they carry the highest mortality rate of any of the psychiatric disorders (e.g. Herzog et al., 2000). These high levels of morbidity and mortality are particularly pronounced when it is considered that the prevalence of anorexia is 0.3%, 1% for bulimia nervosa (Hoek, 2006), and for EDNOS recent research has suggested that there is a prevalence rate of 2.4% (Machado et al., 2007). These rates suggest that there is a high level of eating distress within society and a large proportion of cases often slipping beneath the radar of mental health services (Hoek, 2006).

When we both sat down to plan this book, it struck us early on that there have been many books on the topic of eating disorders, so we were left thinking what could a new volume bring to the field. Our motivation for compiling this edition was to consider the issues that we face in our everyday clinical practice. We wanted to edit a book that the jobbing clinician could pull off the shelf to help them address the issues and dilemmas that their clients will present on a regular basis and to help those planning and delivering services. These issues include: managing the process of assessment; client engagement with services; developing better models to help us and our clients understand eating disorders, and working with specific client groups with eating disorders (e.g. men or severe and enduring clients). It also provided us
with an opportunity to explore a range of perspectives on the challenges of working with people with an eating disorder. These included service organization and therapeutic approaches. It was on the back of these decisions that we decided to divide the book into four sections: (i) clinical assessment of eating disorders, (ii) psychological processes in eating disorders, (iii) psychological therapies, and (iv) specific populations and service-related issues.

The first section looks at the issues involved in assessing people with eating disorders, with a focus on risk and common co-morbid mental health difficulties (Andrews), psychological assessment (Goss et al.), medical assessment (Glover and Sharma), assessment of occupation and social performance (Morris), motivation to engage in treatment (Kitson), ethical issues and dilemmas (Giordano), and sufferers’ and carers’ perspectives on living with an eating disorder (Tierney). Recent developments in the field have enhanced our understanding of the emotional and cognitive processes that may be aetiological or maintenance factors in eating disorders. We explore these developments within the second section of this volume. The authors in this section outline and discuss the role of trauma within eating disorders (Holman), shame and pride (Allan and Goss), and basic emotions perspective (Fox et al.). Finally, Lopez et al. explore the use of cognitive remediation therapy to target potential neuropsychological abnormalities in anorexia nervosa.

Over our journey in designing this book we reflected upon the benefits and potential limitations of current therapies for eating disorders clients. We are at the stage where NICE recommends treatments of choice for some eating disorder clients (e.g. CBT for bulimia nervosa). However, these are not as effective as we, and indeed our patients would like them to be, and for many clients there are no recommended treatments of choice. It was our intention to revisit, arguably, the most influential therapeutic schools and to consider new approaches that have developed from these. We start this section with an introduction to metacognitive approaches (Cooper), and Tatham et al.’s recommendation that existing NICE guideline treatment (CBT) needs to get off on a flying start so that both clients and clinicians adhere to the treatment model. Winston revisits a more traditional psychodynamic approach to eating disorders. The limitations of individual therapy, particularly working with severe and enduring eating disorders or younger clients, are identified within the NICE guidelines. Simic and Eisler consider a family therapy approach in working with people with eating disorders to address some of these limitations, whilst Newell outlines the cognitive analytic therapy approach that has its roots in both psychodynamic and cognitive approaches. In the second half of this section we introduce three new approaches that have developed from recent advances in our understanding of the aetiology and maintenance of eating disorders. Goss and Allan outline compassion-focused therapy for eating disorders which specifically targets shame, self-criticism and pride. Fox et al. discuss ways of working with emotions from a number of different theoretical perspectives.

In the fourth section of this book our aim was to recognize the diversity of our clients and services and the challenges that this can present in assessment and treatment. Changes in the ways treatment may be funded has led to a re-evaluation of the traditional split between inpatient vs. outpatient care, particularly in the United Kingdom. We are aware that most of the therapies outlined in this book were designed to be delivered within specialist outpatient services (in line with NICE guidelines), although they can be often applied by clinicians working in generic settings. However, there remains the need for more intensive treatments and these are explored by Fox...
et al. (inpatient treatments) and Willinge et al. (day patient treatments). These authors discuss how these modalities may enhance the care of eating disorder clients as well as their potential pitfalls. It is often thought that our client group are young women, but sadly there are men, children and older women who also struggle with eating disorders. It is our sense that these groups represent real challenges to us as clinicians as our adult young female-based models frequently break down. It is often striking that there are a number of our clients who do not improve in treatment and, as a consequence, develop more complex, chronic presentations. It felt important for this book to address the differing needs of these client groups. Sampson et al. and Geller et al. provide timely guidance on working with the most challenging of our clients, such as those with a personality disorder or clients with a severe and enduring eating disorder. De Beer and Wren discuss the client population that we are seeing more often in clinical practice, namely men with an eating disorder. Finally, Quine explores the specific challenges of assessing children and adolescents with an eating disorder.

In sum, it has been a privilege and a pleasure to work with all of our contributors and it is our hope that this book represents a thought-provoking and informative edition for both the academic and clinician in their work in trying to understand and work with people with eating disorders.

John R.E. Fox
Ken P. Goss
July 2012

References

We would like to thank Adrian Wells for inviting and supporting us in the compiling of this book. We would also like to thank Karen Shield for her patience and encouragement; there were times when she must have thought we would never finish!

It has been a pleasure to read the contributions from all of the authors. We thank them for their hard work, we know how difficult it is to fit writing around the ‘day job’ but their chapters offer an important contribution in enhancing our understanding and treatment of people with an eating disorder.

The encouragement and support of our employing organizations (for John, University of Manchester and colleagues at Priory Hospital Cheadle Royal, and for Ken, Coventry and Warwickshire Partnership NHS Trust) allowed us the time to develop this work. The inspiration for this book came from our patients. Their generosity in sharing their stories and allowing us to join them on their journey to understand and overcome their eating disorder has allowed us to develop our ideas and share them with the reader.

Finally we would like to thank our families for their patience, support and encouragement whilst we worked on the book. So, Shannon, Lewis, Adam and Tasha – you can have your Dads back, Kirsti and Gill – you are stuck with them . . . again!
Section 1

CLINICAL ASSESSMENT
Chapter 1

INTRODUCTION TO CLINICAL ASSESSMENT FOR EATING DISORDERS

Ken Goss and John R.E. Fox

The first section of this volume will outline multidisciplinary strategies for assessing people with an eating disorder (ED), including differential diagnosis between eating disorders, and assessing for psychiatric and medical co-morbidity. As a preface to this section, we will outline the most frequently used eating disorder diagnoses and how these may relate to the course of illness and prognosis. We also explore some of the difficulties with the diagnostic categorization of people with an ED.

EATING DISORDER DIAGNOSES

Eating disorders often attract considerable public and media interest, with many magazines commonly discussing celebrities’ difficulties with their eating or their body sizes. Fairburn and Harrison (2003) pointed out that EDs are a significant source of physical morbidity, psychosocial impairment, and they carry the highest mortality rate of any of the psychiatric disorders (e.g. Herzog et al., 2000).

Diagnostic classificatory systems may be an anathema to many readers of this volume. However, a basic familiarity with them, and an understanding of their utility and limitations, is important for clinicians undertaking eating disorder assessment and treatment; not least since treatment pathways (and indeed the commissioning of services) are frequently based upon diagnosis.

One of the most commonly used classificatory systems for mental health diagnosis (DSM-IV; APA, 2004) groups EDs into three main types: anorexia nervosa (AN), bulimia nervosa (BN) and atypical eating disorders or eating disorders not otherwise specified (EDNOS).

The term ‘anorexia nervosa’ is of Greek origin, which translates to a ‘lack of desire to eat’, and the first reported cases stem back to the nineteenth century. The word *bulimia* derives from the Greek *βουλίμια* (boulimia; ravenous hunger), a compound
of βους (bous), ox and λίμος (limos), hunger, and is now understood as meaning an ‘ox-like hunger’. Unlike AN, the history of BN is considerably shorter, with Gerald Russell publishing the first account of BN in 1979 (Russell, 1979). Like anorexia, recent interest in the popular media has become considerable, with famous cases disclosing their own struggles with the condition, including Diana, Princess of Wales, Geri Halliwell and John Prescott. Eating Disorders Not Otherwise Specified (EDNOS) is defined within DSM-IV applying to individuals with clinically severe EDs, but that do not conform to the diagnostic criteria for either AN or BN. (The current DSM-IV and proposed disorder diagnostic categories are outlined in Appendix 1.1 at the end of this chapter.)

The common theme across these diagnoses are extreme concerns about shape and weight (described by Russell (1970) as a ‘morbid fear of fatness’), a marked tendency to evaluate one’s own self-worth by body shape and weight, and an extreme preoccupation to be ‘thin’.

Additional diagnostic categories have also been proposed. These include Binge Eating Disorder (BED) (APA, 1994) where there is no compensatory behaviour for bingeing; Multi-Impulsive Bulimia (MI-BN) (Lacey and Mourelli, 1986) where eating disorder symptoms present alongside, and are interchangeable with a number of self-destructive behaviours; and Machismo Nervosa (Whitehead, 1994) where the preoccupation is not with thinness but with gaining muscle bulk.

A number of authors have argued that current classificatory systems are unsatisfactory. For example, difficulties in identifying fear of weight gain in non-European samples and lack of amenorrhoea in very low weight women (Cachelin and Maher, 1998) have brought two of the key diagnostic criteria for AN into question. Similarly frequency and duration of binges (one of the core criteria for diagnosing BN and BED) may have limited clinical utility in predicting outcome or distress and so may need to be re-evaluated with regard to their role in diagnosis (Franko et al., 2004).

Eating disorders diagnoses are likely to be relatively fluid over time. It is reported that 25–33% of those with BN have a history of AN (Braun, Sunday and Halami, 1994), whilst 54% of women with AN are likely to develop BN over a 15.5-year period (Bulik et al., 1997). Despite the limitations of the current classificatory systems it would appear that the overarching category of ‘eating disorder’ does remain relatively stable over time, regardless of the initial, more specific, diagnosis (Milos et al., 2005).

THE DISTRIBUTION AND COURSE OF EATING DISORDERS

People with EDs often do not disclose their symptoms to others and, as a consequence, it is difficult to ascertain their exact prevalence. This secretive nature of EDs is often due to the ego-syntonic nature of thinness within AN (Serpell et al., 1999) and the shame associated with BN (Hayaki, Friedman and Brownell, 2002). However, despite these difficulties there is evidence that the occurrence of EDs has increased over recent years (Willi, Giacometti and Limacher, 1990; Turnbull et al., 1996).

Polivy and Herman (2002) estimated that the incidence of EDs range from 3 to 10% of females aged 15–29 years, with the incidence of AN and BN ranging from 0.3 to 0.9% and 1 to 1.5%, respectively, among Western European and American young women (Hoek and van Hoeken, 2003; Hudson et al., 2007). The increase in incidence rates may be, in part, due to better diagnostic practices, better detection and increased help-seeking behaviours, especially in AN (van Hoeken and Lucas, 1998). As de Beer...
points out later in this volume (Chapter 27), relatively little is known about the prevalence and incidence of EDs in men, although it is generally thought to be much lower than that in women.

In terms of EDNOS, recent research has suggested that there is a prevalence rate of 2.4% (Machado et al., 2007). Estimates suggest that between 20% and 60% of those seeking treatment will be diagnosed as EDNOS (Anderson, Bowers and Watson, 2001; Turner and Bryant-Waugh, 2004). Up to 50% of these clients go on to develop AN or BN over a four-year period (Herzog, Hopkins and Burns, 1993). This can present challenges to treatment services that have developed AN or BN specific care pathways. NICE (2004) implicitly recognizes this, when it suggests that clients with EDNOS should be offered treatment for the presentation that most closely matches an AN or BN diagnosis. It is important to note that the levels of psychosocial distress and the impact on psychosocial functioning associated with EDNOS appear to be as severe as that found in clients with AN or BN (Herzog and Delinsky, 2001). For a more detailed discussion of the challenges that EDNOS presents see Norring and Palmer (2005).

The course and outcome of EDs is extremely variable and appears to involve the complex interplay of a number of factors that dictate the nature of the course of the ED. Steinhausen (2002) argued that the age of onset, duration of illness, severity of weight loss and development of bingeing and vomiting appear to lead to a poor prognosis in AN. It also appears that for 10–20% of cases, AN becomes unremitting and intractable (Sullivan et al., 1998), with 50% of the cases developing into BN (Bulik et al., 1997).

For BN, the course is slightly different. Individuals with a history of AN often develop BN (Fichter and Quadflieg, 2007). Whilst for those without a history of AN, BN often starts later in life than AN. Here, BN frequently starts via dietary restriction which then descends into a vicious cycle of bingeing and vomiting with no associated weight loss (Fairburn, Cooper and Cooper, 2000). Prognosis for untreated BN is poor, as up to 50% of individuals meeting criteria for BN will continue to meet diagnostic criteria for an ED (normally EDNOS) 5–10 years after initial onset (Collings and King, 1994; Keel et al., 1999). Similarly, atypical eating disorders have also been shown to have a poor prognosis, and they often develop into AN or BN (Herzog et al., 1993).

Agras et al. (2009) in a four-year prospective study of 385 participants meeting DSM-IV criteria for AN, BN, BED and EDNOS at three sites, found that remission rates for clients with EDNOS and BED were similar and had the shortest times to remission, with BN having the longest time to remission followed by AN. At four-year follow-up 78% of the EDNOS group were remitted compared with 82% of the BED group, 47% of the BN group, and 57% of the AN group. Retrospective review of past ED diagnoses for the EDNOS group found that 78% of the EDNOS group had a past full ED diagnosis. Over the duration of the study 27% of this group developed either AN or BN, 14% continued as EDNOS, and 59% recovered without developing another ED diagnosis. Only 18% finished the study with no other ED diagnosis.

Mortality rates directly attributable to eating disorder diagnosis vary between diagnostic groups, and also appear to have been improving over time. Anorexia nervosa has been seen as having the highest mortality rate of all the psychiatric disorders, with 5–8% dying from conditions directly relating to their AN (Herzog et al., 2000; Steinhausen, Seidel and Metzke, 2000). In a more recent literature review of 24 randomized controlled studies, Keel and Brown (2010) found crude mortality rates of 0–8%, and a cumulative mortality rate of 2.8% for AN, 0–2% and 0.4%
for BN, 0–3% and 0.5% for BED, with no deaths reported in the limited number of EDNOS clients without BED.

Keel and Brown (2010) also noted that there are relatively few reliable indicators of eating disorder outcome. In AN the longer the duration of illness prior to treatment or the need for inpatient admission predict relatively poor outcome; whilst relapse predictors include the client’s desire for a lower body weight and treatment in general rather than specialist eating disorder services. Psychiatric co-morbidity and general psychiatric symptom severity, Avoidant Personality Disorder, and a family history of alcohol abuse appear to predict a poorer outcome in BN. Relapse predictors in BN are poor motivation to engage in treatment and inpatient admission.

A number of predictors of poor outcome have been reported in BED; however none have been replicated across studies. The main prognostic indicators in EDNOS have been low BMI, previous diagnosis of AN, and lack of close friends. Keel and Brown (2010) conclude that prognostic indicators for AN appear to be closely related to duration and severity of illness, in BN they are related to severity of co-morbid syndromes, and in BED and BN appear to be more related to greater interpersonal problems.

**SUMMARY**

Although there are debates about specific eating disorder diagnosis, the diagnosis of ‘eating disorder’ does appear to reflect the difficulties of a substantial minority of people in relation to issues of size, shape, weight, eating and ‘eating-disordered’ behaviours (such as purging). There appear to be significant similarities between diagnostic groups, and often people will cross over between diagnoses over time, either on their way to another eating-disordered presentation, or toward recovery. The good news is that mortality related to an eating-disordered diagnosis does appear to be falling. This is likely to be the result of better detection, assessment and treatment.

**CLINICAL ASSESSMENT OF EATING DISORDERS**

In the first section of this volume we have collected the perspectives of a number of authors outlining the components of a comprehensive assessment for a person with an ED. NICE (2005) recommends that clinical assessment of EDs should be multidisciplinary, and cover psychosocial and physiological assessment.

Chapter 3 by Goss et al. outlines the functions of psychological assessment in EDs, how the client’s stance influences the assessment process, the use of clinical interview and self-report questionnaires and integrating psychological assessment with other assessments. Andrews (Chapter 2) notes that psychiatric co-morbidity is common and clinical risk relatively high in eating-disordered populations. She outlines how the mental state examination can be used during the assessment process and how this can help to identify these factors. In Chapter 4, Glover and Sharma focus on the assessment and management of physiological complications in the ED. They also address how these physiological complications can be managed, in ‘routine’ and ‘high risk’ eating disorder populations, including those with severely low weight, a diagnosis of diabetes, and in pregnant women.
Many clients with an eating disorder function with very little impact on their everyday lives. However, as Morris’s chapter (Chapter 5) explores, difficulties in daily living can affect a significant minority of eating-disordered clients. She argues that a comprehensive assessment should also include the social and occupational aspects of the person’s life. And identifies ways in which difficulties in these can be assessed and treated to improve the person’s quality of life.

Perhaps the most challenging aspect of working with people with an ED is ambivalence or reluctance of many clients to engage in appropriate treatment. In Chapter 6, Kitson provides a helpful way of making sense of motivation to change, and how it may be enhanced when working with people with an ED.

The final two chapters of this section explore both the ethical and legal dilemmas faced by clinicians and the perspectives of the sufferer and the carer. Clinicians are often faced with a client who has high risk of medical or psychiatric complications of their ED, but remains unmotivated to address them. Giordano provides a very helpful introduction to these issues, and guides us through the complexities of the Mental Health Act, whilst exploring the ethical challenges that are likely to confront clinicians working in the area on a regular basis. Likewise, Tierney addresses the challenges of working with this client group from the perspective of the client and the carer. This is a very useful chapter for the clinician as it offers the all important insight into the world of the sufferer, whilst offering suggestions for overcoming these challenges.

References


