Eating disorders: diagnosis, treatment and recovery

Greta NOORDENBOS
Leiden University, Clinical Psychology Section, Leiden, The Netherlands

Although the first characteristics of anorexia nervosa (AN) were described by Morton as early as 1694, the diagnostic criteria for eating disorders (EDs) are still subject of debate. In the earliest diagnostic criteria for AN, bulimic behaviour such as binging, vomiting and using laxatives was seen as a possible consequence of AN rather than a separate disorder. In 1989, however special diagnostic criteria for bulimia nervosa (BN) were developed. In the DSM-IV-TR criteria were also introduced for binge eating disorder (BED), that is, having recurrent binges not compensated by purging behaviour and often resulting in excess weight and obesity.

Many patients with severe eating and weight problems, however, do not fulfill all criteria for AN, BN or BED and are diagnosed with Eating Disorder Not Otherwise Specified (EDNOS). Most prevalent are patients with EDNOS and BED, while the prevalence of BN and AN is the lowest. In the forthcoming DSM-5 the criteria for AN, BN and BED have been changed in such a way that fewer patients are classified as EDNOS. Although the DSM criteria for EDs are mutually exclusive many EDs patients cross over from one diagnosis to another. For that reason a transdiagnostic approach of EDs has been developed.

EDs show a very skewed gender distribution: around 90% of patients are women and 10% men. Most EDs are found in young women aged 15-25 years. For men, however, the body ideal is not being slim but having strong muscles. The question is whether muscle dysmophia can be seen as seen as a male variant of AN.

Because EDs have severe consequences early diagnosis and effective treatment are very important. A problem, however, is that in the first stage EDs patients deny having eating problems, or feel too ashamed to seek help. Their disturbed eating behaviour is not (yet) experienced as a problem but as a solution for underlying problems such as low self esteem, negative body image and lack of emotion regulation and social coping strategies. In the first period of their ED patients are not motivated for treatment, because they are afraid of losing their control over food, gaining weight, and becoming fat. Because of patients’ and doctors’ delays EDs are underrecognized and undertreated.

Sooner or later ED patients are confronted with severe physical consequences (such as emaciation, tiredness, low body temperature, amenorrhoea, abdominal pain, sore throat, osteoporosis, fertility problems), psychological consequences (such as obsessive and compulsive thoughts about food and weight, lack of concentration, negative emotions, depression, suicidal thoughts), and social consequences (such as distrust of others, isolation, and being unable to continue their education or job). Confronted with these effects they often become motivated for treatment. Motivational interviewing can be very helpful at this stage.

ED patients are often first diagnosed and treated by a GP or psychologist. Severe EDs patients are admitted to a hospital or a clinic for EDs. Most treatments start by reducing the ED symptoms, such as underweight and undernourishment in AN, binges in BN and BED, and purging behaviour in BN. Several strategies are used, such as psycho-education about food and weight and registration of food intake and emotions in a diary in order to increase patients’ insight into their disturbed eating behaviour. For BN cue-exposure is used in order to prevent binging and purging. Although antidepressants can help to reduce binges and depression, medication is not the core treatment for EDs. Effective treatments for EDs are cognitive behavioural treatment, psychodynamic therapy, interpersonal therapy, body oriented therapy and emotion-focused treatment. For young ED patients family therapy is very important. Recently mindfulness, acceptance and commitment therapy (ACT), and compassion therapy have proved to be useful strategies in the treatment of EDs.

Metastudies on effect, outcome and follow-up studies show that in general 45-50% of ED patients recover, 30% improve and 20% stay chronically ill; 5% die. Because of a lack of consensus about the criteria for recovery these percentages vary greatly between different studies, which makes a comparison between outcome studies debatable. For full recovery and prevention of relapse after treatment it is important that not only the disturbed eating behaviour is normalized and the physical consequences are reduced, but also the underlying problems are tackled. Important criteria for recovery from ED are healthy eating behaviour and weight, a positive body attitude, more self-esteem, and better emotion regulation and social coping strategies.

Dr. Greta Noordenbos is senior researcher at the Department of Clinical Psychology, Leiden University, the Netherlands. She finished her Ph.D. thesis about Cultural factors in the development of ED in 1987. She did research at prevention of ED, risk factors and risk groups, chronic ED, criteria for recovery and the process of recovery. In 1994 she founded the Dutch Commission for Prevention of ED and she participates in SIG group Prevention of the of AED. She has written several books about EDs, some together with Prof. dr. W. Vandereycken from the Leuven University in Belgium. Greta Noordenbos was co-editor of the Dutch Handbook Eating Disorders and was member of the Task group of the Dutch Guidelines for ED. In 2012 a new book about Guidelines for Recovery from Eating Disorders will be published.

Address for correspondence: Dr. Greta Noordenbos, Leiden University, Clinical Psychology Section, Wassenaarseweg 52, 2333 AK Leiden, The Netherlands. e-mail: Noordenbos@FSW.Leidenuniv.nl