Eating Disorders: An Expert Interview With Andrea D. Vazzana, PhD

Posted 03/06/2009

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Editor's Note:

Recognition of eating disorders is rapidly increasing, as is prevalence, thanks in part to media emphasis on body shape and high-fashion silhouettes. Because of the pervasive nature of these disorders and their association with severe complications and even death, it is imperative that clinicians be well versed in their recognition and management.

The mainstay of treatment of eating disorders is psychotherapy, usually cognitive-behavioral therapy (CBT) in adults. When health is threatened acutely, hospitalization and other urgent interventions are needed. To learn more about classification, diagnosis, and management of eating disorders, as well as directions for future research, Medscape interviewed Andrea D. Vazzana, PhD, Clinical Assistant Professor of Child and Adolescent Psychiatry at New York University in New York, NY.

Medscape: How are eating disorders classified? Are there subtypes? If so, how do these subtypes differ?

Dr. Vazzana: Currently, there are 2 recognized eating disorders: anorexia nervosa and bulimia nervosa. Anorexia is characterized by a refusal to maintain a minimally healthy body weight, most often by severely restricting what one eats. In comparison, bulimia is characterized by a pattern of binge eating followed by drastic attempts to avoid weight gain by engaging in self-induced vomiting, fasting, exercising, etc. With both disorders, the individual's primary means of self-evaluation is through shape and weight.

A third eating disorder, binge-eating disorder, has been proposed by the psychiatric community and likely will be included in the next edition of their diagnostic manual. Binge-eating disorder is characterized by the binge eating seen in bulimia but without the subsequent attempts at weight loss.

Medscape: How prevalent are eating disorders? Is the prevalence increasing?

Dr. Vazzana: The prevalence of eating disorders varies depending on the type of disorder. Of the eating disorders, anorexia is the least common, affecting 1% or less of adolescents and young adult females in the United States. Anywhere from 1% to 3% of female adolescents and young adults have bulimia. Binge-eating disorder is the most common, with recent estimates indicating that it occurs in approximately 3.5% of the

female population. Eating disorders are less common in males, but estimates of prevalence rates vary widely, in part because the stigma of having a "female disorder" makes males less likely to present for help. Rates have ranged from 1 in 1000 to 1 in 400.

Although rates of anorexia have remained relatively stable over time, the incidence of bulimia has increased significantly over the past 30-40 years. As the pressure to be thin has become more pervasive, eating disorders are occurring at earlier ages and among a more diverse ethnic population.

Medscape: What are the pertinent demographics and risk factors?

Dr. Vazzana: Despite these trends, the people who are most at risk for developing eating disorders continue to be white females in their late adolescence and early adulthood. Aside from these demographic factors, there are several additional risk factors for developing an eating disorder -- most notably that the intense hunger that results from strict dieting often triggers a cycle of disordered eating. Personality traits, such as perfectionism and impulsivity, and a history of physical or sexual trauma have also been identified as risk factors for developing these disorders. Ballerinas, models, jockeys, and others whose jobs require them to stay in peak physical form are at particular risk of developing eating disorders. Having a family member with an eating disorder also increases a person's risk of developing an eating disorder.

Medscape: How are eating disorders best detected and diagnosed, and to what extent do they overlap with other psychiatric conditions?

Dr. Vazzana: The onset of eating disorders is often linked with periods of life transitions or a stressful life event. Some signs and symptoms of eating disorders may be detected by those close to the individual. Most obvious in those with anorexia is their emaciated appearance. Odd eating habits (such as food rituals or combining seemingly incompatible foods to make them less palatable) might also be detected. As a result of their poor nutrition, people with eating disorders are often tired, irritable, socially withdrawn, and/or depressed. In combination with unhealthy eating habits, difficulty concentrating and frequent physical complaints (such as feeling cold or light-headed, having stomach aches, irregular periods, and difficulty sleeping) could also be warning signs of an eating disorder.

Eating disorders wreak havoc on the body, causing chemical imbalances, changes in bone density, and cardiac abnormalities, among other complications. Because of the dangerous physical complications associated with eating disorders, it is essential that a medical doctor evaluate anyone potentially suffering from an eating disorder.

A mental health professional (such as a psychiatrist or psychologist) should conduct a comprehensive clinical evaluation to determine whether the symptoms identified rise to the level of an eating disorder and what the best form of treatment would be. Because eating disorders commonly coexist with depression, substance abuse, and anxiety

(including obsessive-compulsive disorder and posttraumatic stress disorder), symptoms of these disorders should also be assessed.

Medscape: What about the morbidity, mortality, and complications associated with eating disorders?

Dr. Vazzana: Anorexia is the most lethal of all psychiatric illnesses. Studies have documented that as many as 25% of individuals with anorexia die as a result, including approximately 5% who die from suicide. Complications of anorexia and bulimia include hormonal changes, heart disease, infertility, osteoporosis, neurologic problems (including seizures and structural brain changes), anemia, and organ failure. Because people with binge-eating disorder don't compensate for their caloric intake, they are frequently obese. As such, they typically experience the complications associated with obesity, including diabetes, high blood pressure and cholesterol, certain cancers, and heart disease.

Medscape: How are eating disorders best managed and treated?

Dr. Vazzana: As with most disorders, the management and treatment of individuals with eating disorders is largely determined by the severity of the disorder at the time that the individual presents for help. While many patients can be treated on an outpatient basis, there are various levels of care that provide increasing support and structure for those with eating disorders. Partial-hospitalization programs, including day-treatment hospitals, allow patients to continue to reside at home while receiving up to 8 hours a day of mealtime support in the form of individual, family, and group therapies.

When patients have had severe or rapid weight loss, have been unable to benefit from outpatient treatment, and/or have significant psychiatric comorbidity and/or medical complications, inpatient hospitalization may be warranted. Finally, residential treatment would likely be beneficial for chronically ill individuals who have been unable to maintain medical or psychological stability.

Psychotherapy is the most effective treatment. CBT is typically the treatment of choice for adults with eating disorders. CBT targets dysfunctional thoughts (such as, "If I eat that bagel, I'll become fat.") and behaviors (for example, engaging in food rituals such as chewing food a set number of times before swallowing) that maintain the maladaptive eating patterns.

An alternative therapy shown to be effective is interpersonal therapy, which targets social problems underlying the eating disorder. A relatively new treatment for anorexia is family-based treatment, also known as the Maudsley Method (named for the Maudsley Hospital in London, England, where it was developed). It has been demonstrated to be an effective -- and arguably more developmentally appropriate -- treatment for the younger population. In family-based treatment, therapists coach parents on strategies to increase their child's food intake in spite of the child's resistance.

Medscape: Does pharmacotherapy play any role in the management of eating disorders?

Dr. Vazzana: When medications are used in patients with eating disorders, it is very often for the purpose of treating symptoms of comorbid disorders. Unsurprisingly, antidepressants and antianxiety medications are often used to alleviate such symptoms.

Medscape: What do you recommend in terms of future research?

Dr. Vazzana: As the saying goes, "An ounce of prevention is worth a pound of cure." Prevention research could be invaluable for developing and testing early interventions in groups of individuals most at risk. In the best of worlds, we would prevent eating disorders altogether. Likewise, research that focuses on the early identification of eating disorders could prevent the symptoms from becoming more deeply entrenched. On the other end of the spectrum, even after individuals have recovered from eating disorders, they are at risk of relapsing. Finding ways to strengthen current treatments so that the effects can be maintained for longer periods of time is critical to patients' long-term outcome.

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