Use a 'Multidisciplinary Stance'

Eating Disorders *from page 1*

help parents become part of a unified team in assisting their child to change her behavior," she explained.

"The important point to make to both patients and families is that, unless you change your behavior, you won't be able in the long run to correct your eating disordered thoughts and feelings," Dr. Guarda said. "Treatment is a process of conversion—from seeing dieting as the answer to recognizing it as the problem."

Discussions with patients include making patients realize that it is normal to have ambivalent feelings toward change, to relapse on the road to recovery, and to be initially dissatisfied with the changes to their bodies. Body dissatisfaction typically lags behind behavioral change by several months, Dr. Guarda said.

Despite the reluctance of some therapists to weigh patients for fear of encouraging focus on weight, it is critical to weigh patients at weekly office visits, because it is very difficult to know how things are going without doing so. "We are very explicit with patients that we require [weigh-ins] in order to treat them," she said. "You don't treat hypertension without checking a patient's blood pressure; why would we treat anorexia nervosa without checking weight?"

Many patients with eating disorders have problems with preparing meals and eating in social settings, which can be isolating and result in occupational and educational limitations. Social activities in which patients do participate may be maladaptive, such as exercising excessively. Eating disorders can "freeze" a person's developmental progress, resulting in impaired formation of identity and intimate relationships, and difficulty in separating from parents, according to Dr. Guarda.

"It's very important to educate parents about grocery shopping," because eating disorder patients "often want to be intimately involved in planning family meals, the grocery shopping list, and anything that has to do with food," said Sandra Kirckhoff, a nurse on the inpatient unit in the eating disorders program. Adolescent patients can request some nondiet foods, but they should not be in charge of doing the shopping or making menus or lists.

Families should try to eat balanced meals together at a table, with no one eating diet food, such as having only a light salad for dinner, or excessively discussing how foods are prepared. After-meal activities can help to prevent purging, strenuous exercise, or guilt from feeling full.

At various points in a patient's treatment, clinicians may have to assess the family's mealtime behavior and parenting skills and assist them in setting firm but supportive limits on disordered behavior and in carrying out the roles assigned to them by the treatment team. This may involve having the family practice designing menus, going to the grocery store, and eating at a restaurant together. Family members must show a united front in setting limits on the patient's behavior and in following through with consequences, Ms. Bodenstein said.

"When lines get blurred, roles become unclear, and progress stalls or regresses; it can be helpful to use a behavior contract … to reset the treatment frame and to redelineate and make explicit what everybody's role is," said Dr. Graham Redgrave, assistant director of the eating disorder program at Johns Hopkins.

During hospitalization, clinicians at Johns Hopkins consistently try to "take the emotion out of the meals" and do not allow any arguments over whether something should be eaten or not, Ms. Kirckhoff said.

The nursing staff supervises meals and encourages patients to eat all of their food. Each patient is expected to eat like a "normal weight, nondieter," to consume a wide food repertoire, and to stop all exercise if on weight gain. Team sports and weight training are introduced when patients reach their target weight. The staff also teaches patients to determine appropriate portions for weight maintenance by eyeballing portions, not measuring them.

When patients transition to partial hospitalization and earn time off the unit, they are asked to keep a record of any meal they eat outside the hospital, bingeing/purging behaviors, urges, and exercising.

Patients initially go on outings to restaurants in the partial hospital setting with staff so that they can practice and prepare for real-life social eating.

Because many patients have lost or not developed skills that are appropriate for their age, Fiona Scott, an occupational therapist with the eating disorders program, works with patients on money management, coping strategies, work/study skills, and body image.

Daily and weekly schedules are important for planning social activities, meals, and filling in free time to stave off boredom, which is a trigger for eating disorder behavior, Ms. Scott said.

Clothes shopping "is probably one of the most important things that a patient has to do, especially after they've gotten up to normal weight," Ms. Scott said. She instructs patients to get rid of all of their old clothes, especially ones that were associated with the illness. Sick clothes can include overly large sweatpants or overly small child sizes. New clothes should be appropriate for their age and size, and reasonably tailored, neither baggy nor excessively tight fitting. ■

Sparse Data on Eating Disorders Prompt Call for Research

BY JEFF EVANS
Senior Writer

BETHESDA, MD. — The release this year of American Psychiatric Association guidelines on treating eating disorders and two analyses of the available evidence to support such treatments have highlighted the dearth of effective, evidence-based interventions for the disorders.

The lack of such data and the funding to support eating disorders research show that much remains to be accomplished before the disorders get the recognition they deserve from the medical community and insurers, said speakers and attendees at the annual conference of the National Eating Disorders Association. At least 5 million Americans have the disorders, and anorexia nervosa has the highest premature mortality of any mental illness.

The National Institute of Mental Health is funding 10 extramural studies on eating disorders at outside locations (seven of which are in New York), but none of the institutes within the National Institutes of Health are conducting any intramural studies on the disorders. In comparison, the NIMH and other NIH institutes are funding 12 intramural studies on schizophrenia and 14 on bipolar disorder, in addition to many more extramural studies, said Dr. Pauline S. Powers of the department of psychiatry at the University of South Florida, Tampa. The total NIMH/NIH funding for schizophrenia, which affects 3 million Americans, is estimated to be $291 million, while about $30 million is spent on eating disorders research, Dr. Powers said.

Efforts aimed at spreading the word about the high prevalence, morbidity, and mortality of eating disorders to legislators may be the best bet for greater funding of eating disorders, which in turn may attract greater interest from researchers to submit research grant proposals, said Dr. Thomas R. Insel, director of the NIMH.

While the lack of research funding has made it difficult to discern which treatments are best for particular eating disorders, the APA's new guidelines will still be helpful for clinicians who "are not real familiar with the kinds of things that you see as complications in patients with eating disorders," said Dr. Powers, who was a member of the APA work group on eating disorders that wrote the guidelines.

For providers to make the best judgment of the level of care and specific type of treatment that a patient needs, the APA guidelines stress the assessment of physical complications and laboratory tests that may be relevant in patients with anorexia nervosa or bulimia nervosa (Am. J. Psychiatry 2006;163[suppl.]:1-54). For different organ systems, the guidelines list symptoms and signs to look for and particular laboratory tests that may help to diagnose the problem.

"Almost everyone seeing patients with eating disorders should at least know the symptoms and then be able to choose how they're going to work with those particular problems—either by themselves, or [by] consult with a primary care doctor or a specialist," Dr. Powers advised.

The APA guidelines stress the assessment of physical complications and lab tests that may be relevant in patients with anorexia nervosa or bulimia nervosa.

Bulimia nervosa patients may have many of the same symptoms as anorexia nervosa patients because they have a past history of anorexia.

According to the guidelines, basic laboratory tests for bulimia and anorexia patients should include urinalysis for ketones and blood tests for electrolytes, urea nitrogen, creatinine, thyroid-stimulating hormone, a complete blood count, liver enzymes, and erythrocyte sedimentation rate.

Other tests may be necessary in certain circumstances, such as dual-energy x-ray absorptiometry in anorexic patients who haven't had a menstrual period for more than 6 months, Dr. Powers said. At her center, clinicians also routinely order an electrocardiogram, a 24-hour urine creatinine clearance test, and a test for level of complement 3, which is an immune system protein that often drops to low levels early in anorexic patients.

It also may be easier to make a case for insurance coverage with reviewers if you have baseline values for laboratory tests, she noted.

The guidelines recommend placing patients at different levels of care (outpatient, intensive outpatient, partial hospitalization, residential treatment center, inpatient hospitalization) according to categories that are used to assess the severity of their illness, even though there is little evidence to substantiate such placements.

The independent, nonprofit health services research agency ECRI (formerly the Emergency Care Research Institute) conducted a meta-analysis of 48 unique randomized clinical trials on bulimia nervosa.

The report found weak to moderate evidence supporting the effectiveness of medications in reducing bingeing and purging behaviors, as well as anxiety and depression. Except for moderate evidence suggesting some benefit of cognitive-behavioral therapy (CBT) on purging, little data were available to support its effectiveness on bingeing and anxiety or depression.

Weak evidence suggests that CBT may be more effective than medications for purging behaviors, but no other distinction between the two interventions could be made.

Virtually no evidence exists to suggest that CBT is better than other forms of psychotherapy. There was no evidence on whether the interventions improved quality of life.

Fluoxetine is already Food and Drug Administration–approved at 60 mg per day for the treatment of bulimia nervosa, based on 6- to 18-week trials showing that it reduced binge eating, purging, and associated psychological features, even though the results were "pretty weak because of the high dropout rates," said Dr. Russell Marx, medical director of the eating disorders program at the University Medical Center at Princeton (N.J.).

Dialectical behavior therapy has shown preliminary evidence of being effective for bulimia.

In binge eating disorder, short-term trials of selective serotonin reuptake inhibitors have reduced the severity of illness as well as eating, psychiatric, and weight symptoms, compared with placebo. ■