

Guest Editorial

Eating Disorders

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The past 3 decades have seen dramatic changes in our approach to eating disorders. These changes include marked improvements in the recognition and understanding of the disorders and in the reduction of the morbidity and mortality due to anorexia nervosa (AN) and bulimia nervosa (BN). These gains, including those in the level of knowledge and appreciation by the public, have been transmitted to the benefit of patients; however, there remain significant difficulties in treating people with eating disorders. Critical research may address gaps in knowledge and lead to more efficacious treatments.

To highlight how care in this area has changed, Professors Walsh (1,13) and Kaplan (2) focus in this issue on specific aspects of treatment. Walsh provides a thorough review of the pharmacologic approaches to AN, BN, and the newly emerging binge eating disorder (BED). Use of medication for AN has been disappointing, but there are always new medications appearing, and the recent case reports of the benefits of olanzapine are worth pursuing. However, to date, medications have added little to overall management. More promising are the relapse-prevention approaches that use medications such as selective serotonin reuptake inhibitors (SSRIs) to prevent weight loss and recurrence of anorexic psychopathology after weight restoration.

Much more work has been done on BN—for reasons well-documented—and this literature shows value in the SSRIs, especially when combined with psychotherapy. They may be particularly useful in relapse prevention (3). Here again, novel medications are being tried (for example, in the recent study of the value of ondansetron [4]). The evidence for treating BED is less well developed, but again, there is an emerging literature on the benefits of antidepressant medication, as well as on novel approaches such as the use

of anticonvulsant (topiramate) and weight-loss (sibutramine) agents in obese patients with BED.

Kaplan (2) focuses his review on controlled treatment trials for AN and concludes that this area is limited by the following: few studies (though most of these have come out in the last decade and more are under way), small sample sizes, the life-threatening nature of the disorder, and high dropout rates. He also examines denial and treatment resistance as an important dimension for consideration. While the controlled treatment studies are few, there are enough data to point to promising areas for future clinical research. At the same time, treatment approaches are dramatically different.

In the 1960s, it was common to have treatment for AN based on a long-term psychoanalytic model, which was ineffective, or on combinations of potentially harmful medications. Today, there is general acceptance of the value of nutritional restoration or stabilization before people can meaningfully benefit from psychotherapy. The types of psychotherapy that are useful vary. Cognitive analytic therapy has been shown to benefit in AN (5). Work from the Maudsley Hospital has documented the value of family therapy for the young restricting patient with AN (6). Older patients with AN and BN benefit from cognitive-behavioural therapy, but this has been much more carefully described for BN. The latter group has also been shown to benefit from interpersonal therapy (7). As noted, the antidepressant drugs, including the SSRIs, have also been useful for BN sufferers, although in controlled studies they are not as useful as the psychological treatments (1). As a result of these advances in understanding and in care, AN mortality may have been reduced, and more patients are completely well at follow-up (8). In contrast, BN has a much lower mortality and a more variable course (9).

Clinical science has had a real bearing on these improvements. The randomized controlled trial, first applied to

evaluating the efficacy of antibiotics in tuberculosis and pneumococcal pneumonia, quickly led to comparative studies of psychotropic agents in the early 1950s. Progress in psychotherapy research was greatly enhanced more recently (in the late 1980s) when developed for studies on depression. This research has since been adapted to treatments for BN. Controlled trials for AN are rare and are much more difficult to conduct—but are imperative for the field to advance.

Understanding the ego-syntonic nature of the primary symptoms in AN is significant in this regard. Recent work on motivational enhancement, adapted from the addictions field, may provide significant benefits but requires careful evaluation (5). It is also important to develop lines of research on treating comorbid states. Whether it is drug dependency or depression, the lack of demonstrable treatments—and facilities prepared to undertake combined treatments—is a serious impediment to enabling the more chronically ill to develop lives with meaning and dignity. Further, trials aimed at preventing complications are also warranted. Studies of relapse prevention—in both AN and BN—are currently under way and are most welcome.

Regardless of clinical trial benefits, there will be a significant group of people suffering from these disorders who will continue to display the complications of chronic illness. Eating disorders disrupt the individual at many levels. Recognizing these complications in both the psychosocial and physiological domains and developing interventions to minimize them will require significant treatment and research efforts in the coming years. For example, recent epidemiologic work has described the high frequency of comorbidity for affective disorders, anxiety disorders, and alcoholism (10,11). This may account for some proportion of the psychosocial impairment. Understanding the nature of these associated conditions and decreasing their impact will have an important effect on patients with eating disorders. A second example relates to improved understanding of the osteoporosis that is frequently a complication of AN. Two characteristic features of AN—low body weight and amenorrhea—serve as important risk factors for developing osteoporosis. In recent years, with the increased frequency of eating disorders and their not infrequent chronicity, attention has been given to the problem of bone demineralization. Several alarming reports have documented the presence of severe osteoporosis and pathologic fractures in these patients (12). There remains, however, a relative lack

of understanding about the mechanisms responsible for the demineralization of bone. Several factors may contribute, including low body weight, repeated vomiting and purging, low estrogen levels and amenorrhea, high levels of cortisol and growth hormone, as well as alterations in somatomedin. The approach to treating osteoporosis in eating disorders has not been worked out well.

For patients who have been continuously ill for 10 or more years, coercive hospital treatment with overly ambitious goals is rarely helpful and may precipitate depression and suicide. A more realistic approach to managing this type of patient involves brief, time-limited admissions to hospital to help work on continuing weight loss or metabolic complications. This should be associated with supportive psychotherapy, either individually or in a group. In the future, much more thought must be given to the ongoing care of this particular patient group, with respect to both brief hospital stays and ongoing management, so that these patients can lead lives of dignity with minimal sequelae and intrusion by the illness.

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