An Overview of Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorders: Implications for Rehabilitation Professionals


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Headnote
Abstract - This article addresses anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorders (BED) through the discussion of demographic information, symptomatology, DSM IV criteria for diagnosis, etiology, current treatment modalities, and the potential prognosis of each of these disorders. Additional information about an eating disorder that exclusively affects men is also provided. Intervention strategies for each eating disorder, as well as the relapse phenomenon affecting recovery from eating disorders, are discussed. Specific suggestions are provided for rehabilitation counselors as well as suggestions for future research.

Dieting has been a very popular topic and activity for some time. So it should come as no surprise that in a country where many people are dieting, that eating disorders have become more prevalent among all age groups and constitute a persuasive threat to a person's psychological and physical well being (Berg, 2001). In fact, reports of dieting, body image concerns, attempts to lose weight, and an overall fear of fatness has been reported in children as young as 7 years old, and in adults as old as 51 years of age (O'Dea, 2002). Because of these concerns, the retailers of weight loss programs, diet books, and media advertisements for other diet products have been steadily cashing in on our society's quest to "fit in". The typical physiques of athletes and the typical petite sizes of models (which happens to be the image of an individual who has been diagnosed with the eating disorder anorexia nervosa) have had a great deal of influence on how individuals view and value their own body image (Costin, 1999).

This article will address Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder, who is affected by eating disorders, how individuals develop them, related medical problems, and the DSMIV checklist requirements for diagnosis. In a special section entitled Eating Disorders and Men, information will be provided regarding how eating
Disorders affect men, which is of particular interest since eating disorders are typically associated with women. Treatment options and their importance, the etiology of the disorders including particular emphasis on ego deficiencies, cognitive disturbances, and mood disorders often associated with each of the eating disorders will be discussed. The likely prognosis for eating disorders, relapse potential, and the significance of a thorough multi-faceted rehabilitation intervention will be discussed.

Anorexia Nervosa

The clinical term Anorexia Nervosa (AN), which is defined as a lack of desire to eat due to a mental condition, more accurately reflects the true essence of an eating disorder than the often abbreviated term "anorexia" that more literally means the person has a strong desire to control his or her appetite. The word anorexia (an [lack of] crexis (appetite)) is of Greek origin meaning a lack of an appetite. "It [anorexia] was originally used to describe the loss of appetite caused by some other ailment such as headaches, depression, or cancer, where the person actually doesn't feel hungry" (Costin, 1999, p.6). Individuals who are troubled with this disorder often restrict their food intake. However, these individuals may yearn to eat, may actually dream about eating, and may spend a considerable amount of time thinking about eating. Some individuals may actually lose control and eat enormous amounts of food. In fact, the focus of appetite control is the core characteristic of this disorder, not the loss of appetite as is generally regarded (Costin, 1999).

The frequency of AN is around 0.25-1% among middle school and high-school aged girls. Yet, the rate increases to around 25-35% among college-aged women (Costin, 1999). Almost half of the people diagnosed with AN lose weight by restricting their food intake in a pattern called restricting-type anorexia nervosa. Others lose weight by literally forcing themselves to get rid of the food they ingest by vomiting after eating or by taking diuretics or laxatives. They may also go on eating binges in a pattern called the binge-eating/purging-type AN (APA, 2000, 1994).

The clinical picture reveals that individuals participate in anorexic-type behaviors due to a deep fear of becoming obese, of giving in to their mounting desire to eat, and more generally of losing control over the size and shape of their bodies (King, Polivy, & Herman, 1991). Overall, they are preoccupied with almost every aspect of food, which is suspected to be the consequence of food deprivation versus being the cause of the deprivation. Moreover, people with AN tend to have a distorted view of their body shape (i.e., dysmorphia) (Keys, et al., 1950).

The most notable physical symptoms of AN are emaciation, constipation, dry skin, brittle nails, metabolic changes, edema of the hands and feet, cardiac and renal problems, and estrogen deficiencies; all of which are largely associated with the side effects of starvation (O'Dea, 2002). Additional symptoms can include amenorrhea in females (the cessation of the menstrual cycle), low blood pressure and body temperature, reduced bone mineral density, and a slow heart rate (which could lead to death) (Froelich, et al., 2001).

According to the DSM IV checklist, in order to be clinically diagnosed with AN, individuals must refuse to maintain at least a minimal body weight for their height, age, and gender, or exhibit an intense fear of gaining weight, even though they are underweight. They also must have an overall distorted body perception, deny the seriousness of their current low weight and, if female and postmenarcheal, have amenorrhea (APA, 2000, 1994). Since self-induced starvation is a direct opposition to ordinary typical bodily impulses, it can hardly ever be maintained over a certain period of time. As a result 30-50% of individuals that are initially diagnosed with AN end up altering their actions to fit that of a diagnosis of bulimia nervosa (Costin, 1999).

Bulimia Nervosa

The term bulimia is derived from Latin and means "hunger of an ox" (Costin, 1999, p. 9) and nervosa refers to a mental condition. People with "Bulimia" are often referred to as "failed anorexies" [that] they have repeatedly tried to control their weight by restricting [their food] intake and have been unable to do so (Costin, 1999, p. 9). Nonetheless, it is the force and rate of recurrence of the binges and purges that separates people with bulimia nervosa (BN) from people with AN. Although most people with BN experience the same symptoms and thought patterns as people with AN, the general consensus is that people with BN live in a world that is completely divided by compulsiveness, starvation, and binging. These individuals end up binging on food, then out of extreme anxiety purge through self-induced vomiting, laxative or diuretic abuse, or by using other compensatory behaviors to make up for their binges such as fasting, excessively exercising, or using a sauna (Costin, 1999). In fact, some people with BN become so rigid in their actions that they binge and purge up to 50,000 calories per day without even thinking about it, thus having little or no ability to be productive in relationships, on the job, or in school.

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Like AN, BN occurs mostly in females. The prevalence of BN varies among age groups. For instance, 1-3% of middle-school and high-school aged girls, 1-4% of college aged women, and 1-2% of individuals in an average community exhibit some sort of symptom related to BN, which often persists for several years with only sporadic remission (Costin, 1999). Unlike AN, the weight of people with BN usually stays within the normal range, although it may oscillate markedly within that range. However, some individuals with BN may eventually become so gravely underweight they meet the requirements for an AN diagnosis (APA, 2000,1994). Individuals who engage in compensatory behaviors such as self-induced vomiting and taking laxatives or diuretics are diagnosed with the purging-type BN. Individuals who engage in the compensatory behaviors of fasting, excessive sauna or exercising, are diagnosed with nonpurging-type BN (APA, 2000, 1994). According to the DSM IV checklist, individuals must have had recurring episodes of bingeing and/or demonstrated inappropriate compensatory behaviors in order to prevent weight gain, have had symptoms that persist twice a week for five months in a row, or must deny their current weight or shape to be diagnosed with BN (APA, 2000,1994).

**Binge Eating Disorder**

The term binge eating disorder (BED) was not used prior to 1992 - at which time it was officially introduced at an international eating disorders conference (Costin, 1999). Individuals with this type of eating disorder were formerly referred to as food addicts or emotional eaters. There are two identified types of BED. The first is described as deprivation-sensitive binge eating and the second is known as addictive or dissociative binge eating. In the first case, the deprivation-sensitive type appears to occur as a result of frequent restrictive eating or dieting activity. In the second case, the addictive or dissociative type occurs from the practice of self-soothing with food, which is in contrast to the restricted eating pattern of AN (Costin, 1999).

A much more unique aspect, of the BED is that it appeals to affect a more diverse population when compared to AN and BN. For instance, African Americans and men seem to be equally at risk for developing this particular eating disorder (Costin, 1999). For the most part, individuals who are affected by BED usually begin to binge when they are in their late teens or their young adulthood years.

DeAngelis (2002) stated that 8% of those who are severely overweight and 2% of the entire population suffer from BED. It is also suspected that binges occur after the individual experiences feelings of immense tension (Crowther et al., 2001). In other words, these individuals struggle with adverse patterns of eating in order to soothe themselves rather than following psychosomatic cues to eat when prompted to do so (Costin, 1999). The person is usually moody, feels detached, and feels powerless in controlling the amounts of food they are eating. Thus, during the binge individuals actually feel that they are unable to stop eating, which is a unique symptom to this eating disorder. Individuals may also show the symptom of eating when they are not hungry and are likely to eat alone to avoid embarrassment (Crowther et al., 2001). Even though the binge relieves their previous feelings of immense tension, it is typically followed by feelings of shame, self-blame, guilt, depression, and fear of weight gain that may result from their actions (Hayaki et al., 2002).

BED is not officially recognized as an eating disorder in the DSM IV, but it is included under the category titled, "Eating Disorder Not Otherwise Specified" (EDNOS) since it is considered to be an atypical eating disorder (APA, 2000, 1994). However, the DSM IV does include information for projected diagnoses as well as specific research criteria that includes, but is not limited to, an episode in which the person eats an immense amount of food at specific times for which they have no control over. In addition, the binge episodes must be associated with three or more of the following: overeating, feeling depressed after overeating, eating alone due to embarrassment of the amount consumed, or eating hastily. Lastly, the binge eating has to take place, on average, no less than two days a week for six months at a time (Costin, 1999). Yet again, even though the BED is not officially recognized as an eating disorder in the DSM IV, it can and often is diagnosed by a physician via a physical examination, a thorough review of the person's medical history, assessment of the person's mental health, and an overall assessment of the person's attitudes about food and body shape (Gelliebter, 2002).

**Eating Disorders and Men**

"According to surveys on body image, people in our society are much more dissatisfied with their bodies now than they were a generation ago. Women are still more dissatisfied than men, but today's men are more dissatisfied with their bodies now than the men of a generation past" (Gardner, Cooke, & Marano, 1997, p. 42). Unfortunately, for the most part, men with eating disorders have been and still are overlooked. This may be in part due to men.

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traditionally being judged for what they do not how they look, whereas the opposite is true for women. However, what some people consider "general guy behavior" may actually be a more serious condition. A "hearty" eater could be privately bingeing and purging or struggling with a BED just as an avid exerciser or health "nut" may be 
driven by the same urge for thinness that typifies women with AN (Anderson, Conn, & Holbrook, 2000).

Men account for approximately 5-10% of all eating disorder cases. The reasons for this gender difference is not yet completely clear (Smolak & Murken, 2001). One possible explanation is that men are not under as much pressure from society as women are to have a particular physique. Another may be that as a rule, men choose to exercise to lose weight whereas women usually diet to lose weight. This is a critical observation because dieting often causes an onset for eating disorders, which largely affects women (Robb & Dadson, 2002). Yet another reason just may be that men go undiagnosed because they are least suspected of having a "female problem" and they are less likely to admit having an eating disorder (Olivardia et al., 1995).

Men seem to develop eating disorders in relation to the strict requirements set forth in some types of sports and in certain types of jobs. The highest rates of eating disorders in men have been found in body builders, distance runners, swimmers, and jockeys (some of which will spend hours in a sauna before a race trying to shed as many pounds as possible or take laxatives or diuretics to reduce their weight) (King & Mezey, 1987). Likewise, male wrestlers may restrict their food intake to "make weight" for their matches (Thompson & Sherman, 1993). Men may also go on binges after their matches to gain strength or to "feast" before the next restriction period. Ultimately, a rigorous cycle of losing and gaining weight ends up shifting their metabolic activity and endangering their health (Mickalide, 1990; Steenetal., 1988). Overall, body image appears to be the primary predictor of eating disorders in men, the same as it is in women (Kearney-Cooke & Steichen-Ash, 1990).

Moreover, a new kind of eating disorder has been discovered called reverse anorexia nervosa or muscle/body dysmoiphia that has been linked almost exclusively to men (Olivardia et al., 1995). The significant difference in this disorder from AN and BN is that instead of thinking they cannot become thin enough, these men think they cannot become big enough, thus compelling themselves to become larger and larger by any means necessary (Anderson, Conn, & Holbrook, 2000).

Individuals who have muscle/body dysmoiphia are somewhat comparable to those who develop traditional eating disorders. For example, individuals usually display shame about their body image and may have a history of depression, compulsive behaviors, anxiety, or self-destructive behaviors. About one-third of them also exhibit interrelated dysfunctional behaviors such as bingeing (Olivardia et al., 1995). All in all, men today seem to be struggling with the same issues and concerns as women (e.g., self-esteem, body image, sexuality) (Anderson, Cohn, & Holbrook, 2000).

Etiology

Most theorists now point to a multidimensional risk perspective, which is a theory that pinpoints many risk factors that when combined may cause a disorder. Thus, the more risk factors that exist, the greater the risk of developing the disorder (Lask, 2000). Significant among these are society's emphasis on thinness combined with a bias against obesity, especially for women, and includes the differences in acceptance among various cultures and social classes. In addition, if a person comes from a household with enmeshed family patterns (e.g., members are too involved in one another's affairs and are overly concerned with one another's overall welfare) they may be more susceptible to developing an eating disorder (Minuchin, Rosman, & Baker, 1978). According to Bruch (1982, 1962), (a pioneer in the study and treatment of eating disorders), ego deficiencies and cognitive disturbances are clearly parts of the multidimensional risk perspective. This includes individuals who have a poor sense of autonomy and self-control that may be the result of ineffective parenting. For example, when a parent fails to attend to a child's internal needs on a consistent basis as the child is developing, the child may develop a sense of helplessness. In some instances, the child may develop ineffective coping strategies and attempt to overcome uncomfortable feelings by controlling what food is eaten, when it is eaten, as well as body size and shape (Bruch, 1962, 1962).

Individuals diagnosed with eating disorders, predominantly those with BN, report experiencing symptoms of depression that include feelings of sadness, apathy, low self-worth, unwarranted humiliation, cynicism, and impaired judgment on a frequent basis (Le Grange & Locke, 2002; Serpell & Treasure, 2002). This discovery has caused some theorists to suggest that mood disorders (i.e., depression) may set the stage for eating disorders (Zaider et al., 2002; Hsu et al., 1992).

Four types of evidence help to support the mood disorder connection. First, when compared to the general

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population, many individuals who have an eating disorder qualify for a clinical diagnosis of major depressive disorder (Brewerton et al., 1995). Secondly, close relatives of people with an eating disorder also have a higher rate of being diagnosed with a mood disorder (APA, 2000). Thirdly, similar to the serotonin irregularities found in depressed individuals, many people with eating disorders (particularly BN) also have low serotonin levels. And finally, some of the same antidepressant drugs used to treat depression also help individuals with eating disorders.

Lastly, certain biological factors have also been related to causes of eating disorders such as genetic tendencies, adverse hypothalamus, and biochemical activities. Many biological theorists postulate that some people may inherit a genetic tendency toward developing an eating disorder. In fact, some research has shown that if at least one relative has an eating disorder other relatives are up to six times as likely to develop one (Strober et al., 2001). Biological theorists also question the potential role of serotonin since many individuals who have been diagnosed with an eating disorder also have low serotonin levels (Carrasco et al., 2000). Other biological theorists point to the hypothalamus as a possible cause since it helps to regulate a variety of involuntary bodily functions including eating and hunger (Leibowitz & Hoebel, 1996). A chemical and natural appetite suppressant known as glucagon-like peptide-1 (GLP-1) is suspected to be the primary chemical in the brain that initiates activation of different centers of the hypothalamus in responding to food (Turton et al., 1996).

Another link to the potential causes of eating disorders is the body's weight set point. The weight set point is the level of weight that an individual is predisposed to retain, which consists of the lateral and ventromedial hypothalamus and the chemical GLP-1. Therefore, when individuals diet and lose weight below their weight set point, their brain attempts to bring back the weight in some way. Therefore, some biological theorists believe that hypothalamic activity may produce a preoccupation with food as well as a desire to binge (Keesey & Corbett, 1983).

Treatments

Presently, treatment for eating disorders has two primary goals. One is to rectify abnormal eating patterns as quickly as possible. The other is to deal with the psychological and specific situations that have led to the disorder (Sherman & Thompson, 1990). The following information is based on what researchers believe are the best treatments currently available for each specific eating disorder.

Anorexia Nervosa

The immediate goal of treatment for individuals with AN is to help them return to their normal weight, recuperate from malnourishment, and ultimately eat in a normal manner again. Therapists must then help the individual make psychological and perhaps familial changes, in order to preserve the gains. Treatment is usually provided in an outpatient setting (Cowers et al., 2000; Pyle, 1999). Proper weight and normal eating patterns are restored via a forced eating tube or through intravenous feedings in clients who absolutely refuse to eat (Treasure, Todd, & Szmukler, 1999). For clients who are not refusing to eat, a mixture of supportive nursing care and a high-calorie diet (in which the patient's calories are gradually increased) is initiated (Roffo, 1991; Treasure et al, 1995).

Overall, lasting changes are achieved in many ways. One aspect of successful treatment is to help clients develop more autonomy by acknowledging their need for independence and teaching proper ways to implement appropriate self-control through enhancing self-awareness, which in turn helps them to better manage their feelings (Dare & Crowther, 1995; Robin et al., 1995). Successful treatment also requires individuals with AN to correct their disturbed cognitions about themselves by changing their overall attitudes about weight and eating (Gardner & Magana, 2002; Christie, 2000). Yet another goal is to help individuals change their familial interactions. As a modus operandi, therapists meet with the entire family, point out any disruptive patterns such as poor communication and attitudes about body shape, food, and eating, and then assist all members of the family in learning to make the appropriate changes (Lock & Le Grange, 2001). In particular, the individual with the eating disorder may need to recognize and then appropriately detach from enmeshed family patterns (Dare, & Eisler, 1997).

Bulimia Nervosa

Treatments such as (a) individual insight therapy, (b) cognitive behavioral therapy, (c) antidepressant medication, and (d) group therapy are often administered in combination for BN in eating disorder clinics. Such programs share the immediate goal of assisting clients in eliminating binge-purge patterns and in developing more effective eating patterns (Davis et al., 1997).

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Individual Insight Therapy.

The individual insight therapy encompasses two specific methods: (1) interpersonal psychotherapy and (2) psychodynamic therapy. The first method, interpersonal psychotherapy, focuses on helping clients improve their overall interpersonal functioning in order to rebuild and maintain a higher level of self-esteem and a more normal personal and professional social life. This is accomplished through a series of unique dynamic exercises. This approach has a promising but less impressive track record than the cognitive method and is often used when clients are not responding to the cognitive treatment modality (Mitchell et al., 2002; Wegner & Wegner, 2001).

The second method of individual insight therapy is the approach of psychodynamic therapy. This technique includes the use of gentle interpretations and free association that are designed to help clients discover and work through their feelings of powerlessness, their need for control, and their lack of trust (Dare & Crowther, 1995; Lerner, 1988). For the most part, psychodynamic therapy has been used for BN clients (Bloom et al., 1994; Fichter, 1990). However, only a few research studies have actually tested the helpfulness of this approach in treating BN although the results from those few studies are optimistic and supportive of this therapeutic approach (Valbak, 2001; Yager, 1985).

Cognitive Behavioral Therapy.

Cognitive therapy has been noted as one of the most effective methods and is often used first. In this type of therapy, therapists attempt to help the client notice and then change maladaptive attitudes toward weight, body shape, and food (Mitchell et al., 2002; Wilson et al., 2002). Typically, cognitive therapists administer exercises that seek to teach clients to challenge the negative thoughts that usually pave the way to a binge. Overall, 65% of clients stop bingeing and purging with the help of cognitive therapy (Mitchell et al., 2002).

Behavioral therapy is generally used to enhance cognitive therapy treatments (Mizes & Bonifazi, 2002; Tacon & Caldera, 2001). In one aspect of behavioral therapy, clients are advised to record daily eating behaviors, the flux of their feelings, and changes in sensations of hunger and fullness into a diary in an effort to encourage them to objectively observe their eating patterns and better recognize the emotions that trigger binge desires (Latner & Wilson, 2002). In another approach of behavioral therapy, clinicians use a technique known as exposure and response prevention in which the client is exposed to situations that normally elevate their level of anxiety and then the client is prevented from performing the routine compulsive behaviors in an effort to extinguish the undesired behavior (Spiegler & Guevremont, 2003; Rosen & Leitenberg, 1982). Each of these approaches has demonstrated success in the treatment of eating disorders.

Another effective approach in cognitive behavioral therapy is the use of self-care manuals. Clinicians advise clients to utilize contemporary information that can be found in self-care manuals. These guidebooks offer varying suggestions regarding diverse education and treatment strategies for clients to refer to when other treatments are ineffective (Palmer et al., 2002; Garvin et al., 2001).

Antidepressant Medications.

Research has shown that only around 25-40% of clients actually experience a reduction in bingeing and vomiting when taking antidepressant medications. Antidepressant medications (e.g., Prozac, Fluoxetine) are sometimes used in the treatment of BN and seem to work best in combination with other therapies (Mitchell, 2001; Walsh et al., 1997).

Group Therapy.

Group therapy provides clients with an opportunity to disclose their concerns, thoughts, and experiences with one another (Riess, 2002; Pyle, 1999). According to various studies, group therapy is helpful in at least 75% of BN cases, especially when it is used in combination with individual insight therapy (Mckisack & Waller, 1997). It is also highly favored among clients because they have opportunities to receive support and empathy from one another - and of even greater importance is that they are able to learn that the eating disorder is not unique to them (Manley & Needham, 1995). Clinicians may also recommend for clients to participate in self-help groups that provide a more comforting environment for them to share their experiences and their innermost thoughts and fears with others who can empathize. Groups of this type usually meet at local community centers, hospitals, churches, or in eating disorder clinics.
Relapse

Recovery is not always permanent and relapse can become a problem for any person even if they respond successfully to treatment (Keel et al., 1999). However, many clients are unaware that relapse is a normal part of the recovery process and instead view the relapse as an absolute failure vs. a backslide (Miller & Rollnick, 2002). For example, Prochaska and DiClemente's (as cited by Miller & Rollnick, 1991) legendary six stages of change clearly include relapse as a part of the recovery process.

Because the approach is client-centered, the six stages of change are highly regarded as successful interventions by rehabilitation counselors and clients as well as being well documented in numerous research studies. Moreover, individuals who experience relapse tend to have a better chance of success when they resume the stages of change since they often learn new ways to deal with old behaviors thus acquiring enhanced skills for recovery (Miller & Rollnick, 2002).

In the case of AN, nearly 20% of individuals continue to have difficulty for many years (APA, 2000). Research has documented that relapse occurs in at least one-third of recovered patients and is typically prompted by new stresses, such as pregnancy, marriage, or a major relocation of some sort (Penning et al., 2002; Lay et al., 2002; Schilberg & Norring, 1992). Therefore, it should not come as a surprise that many recovered individuals continue to convey concerns about their appearance and weight several years later. Some even continue to keep a tight rein on their diets, experience anxiety when they eat around others, or continue to hold distorted ideas about eating, food, and weight (Fichter & Pirke, 1995). For the most part, females have a better recovery rate than males, as do teenagers in comparison to older adults (APA, 2000).

Analogous to the case of AN, BN relapse is often prompted by the same instances as well as new life stressors such as divorce, death, layoffs, or relationship changes (Abraham & Llewellyn-Jones, 1984). Research has shown that approximately one-third of individuals who had once recovered from BN relapsed within two years of treatment, typically within six months time (Olmsted, Kaplan, & Rockert, 1994). However, relapse is more likely to occur in individuals who have histories of substance abuse or who have difficulty trusting others (Keel et al., 2000, 1999; Olmsted, Kaplan, & Rockert, 1994). On a positive note, around one-third of previous clients develop healthier behaviors at work, home, and in social situations, while an additional one-third are more efficient in at least two of these areas (Hsu & Holder, 1986).

In the case of BED, trying to lose weight before resolving the underlying psychological, relational, or emotional issues will almost always result in relapse after treatment (Costin, 1999). Unfortunately, this occurs because many dieters, physicians, and health care professionals tend to make the mistake of not referring clients to a trained professional to help these individuals address and deal with the underlying issues that precipitate the behavioral responses of psychological eating (Costin, 1999). Overall, durable recovery can only begin when these underlying issues have been exposed and adequately addressed.

Prognosis

The outlook for individuals with AN has been significantly improved by the use of combined treatments, yet the road to recovery may still be difficult. Although, the course of this disorder differs from person to person, researchers have been able to detect particular trends (O'Dea, 2002). In the case of AN, once treatment begins weight can be re-established swiftly. In fact, one study showed that around 83% of patients consistently demonstrated improvement years after their initial recovery. Roughly 33% were fully improved while 50% improved somewhat (Treasure and Szmukler, 1995). An additional positive observation is that a majority of females with AN begin to have regular menstrual cycles once they regain their weight (Iketani et al., 1995). Death rates also appear to decline (Treasure and Szmukler, 1995). However, deaths that do occur can be attributed to medical complications resulting from starvation, infection, gastrointestinal problems, electrolyte imbalance, or suicide attempts (Treasure & Szmukler, 1995). Nonetheless, if caught early, most clients can fully recover from this eating disorder and many of the associated medical conditions are reversible (Costin, 1999).

In the case of BN, if left untreated this disorder can last for years improving only occasionally for a short periods of time (APA, 2000). Fortunately, treatment generates immediate, vital improvement in around 40% of clients. With treatment, individuals are able to reduce or totally stop bingeing and purging, eat appropriately, and sustain a normal weight. Another 40% show an average response to treatment while as many as 20% showed little improvement (Keel & Mitchell, 1997; Bitten, 1993). Overall, ten years after treatment, 89% of individuals with bulimia experience either complete or partial recovery (Keel et al., 1999). However, those who experience only a
partial recovery still struggle with binging or purging from time to time.

Information varies greatly as to the likely prognosis for individuals with BED. For example, on a less positive note, one review stated that the usual course of BED is chronic due to the rarity in which individuals actually stop binge eating. However, this review also acknowledges that this information pertains more to the past characteristics of individuals who have had BED rather than the likely future outcomes based on current treatment approaches (Pitcher, Quadflieg, & Gnuztman, 1997). According to reports based on an outcome study conducted over a six-year period, results showed that approximately 57.4% of individuals achieved a good outcome, 65.3% achieved an intermediate outcome, 5.9% had a poor outcome, and 1.4% became so disordered in their eating behaviors that they died. Shorter timeframes of this study did not achieve the same type of positive results indicating that treatment timeframe affects outcomes for people with BED (Pitcher, Quadflieg, & Gnuztman, 1997).

Rehabilitation Concerns

For many years, some would have disagreed that an eating disorder was a serious one, let alone a mental condition as the DSMIV stipulates. Furthermore, since weight is a controversial issue within itself many of the professionals (e.g., doctors, nurses, dieticians, psychologist, and rehabilitation counselors) involved in the treatment process hold differing viewpoints on how and when to assist the client. According to standardized treatment approaches, the physician's initial assessment of tests, observations, and questions should set the foundation for the next professionals' current intervention and future prevention therapy. In the case of nurses and dieticians, they fulfill all supportive nursing care duties by handling the weight restoration part of the process. On a gradual basis, nurses increase a clients' diet over the course of numerous weeks to more than 2,500 calories per day. Along the way, nurses and dieticians educate clients about the program, monitor their progress, give encouragement, and help them recognize their weight gain is under control. Although the process is demanding, studies have proven that clients gain the necessary weight within 8-12 weeks when in nursing-care programs (Treasure et al, 1995).

When working with individuals who have eating disorders, rehabilitation counselors may want to consider using a method of communication espoused by Miller and Rollnick's motivational interviewing techniques. This approach is "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25). The motivational interviewing approach helps clients progressively bring out and effectively deal with the problems that initiated the eating disorder in the beginning so they can permanently return to a healthy way of living. The underlying spirit of motivational interviewing relies not only on being able to understand, but also to be able to experience the human nature that pro vides rise to a genuine way of helping people (Miller, & Rollnick, 2002).

In addition, the counselor always remembers and shows the client that they are the primary source in finding answers and solutions. So while the counselor's own beliefs in the client's ability to change become a self-fulfilling prophecy, counselors will keep in mind that the clients' personal beliefs in the prospect of change is crucial and motivating, thus the client is responsible for choosing and carrying out the changes.

Professionals must work toward helping clients deal with the ego deficiencies and cognitive disturbances underlying the eating disorder so they can improve their feelings of autonomy, self-control, and helplessness (Bruch, 1982,1962). Professionals also must find ways to assist clients in learning how to deal with the lows and highs of a mood disorder so they can turn feelings of sadness into happiness, apathy into interest, low self-worth into high self-esteem, unwarranted humiliation into pride and confidence, cynicism into optimism, and disturbed judgment into mindfulness (Le Grange & Locke, 2002; Serpell & Treasure, 2002). If antidepressant drugs are prescribed, psychologists and rehabilitation counselors must determine if side effects are affecting the individual's social, physical, and vocational interactions and seek appropriate accommodations.

Conclusion

The focus of this article was to discuss current issues regarding AN, BN, and BED including the origins, the people who are often affected, and the prognosis and treatment modalities that are deemed most effective at this time. Weight continues to be a controversial issue within itself and within the many professions and the professionals who work with and provide treatment to individuals with eating disorders. For many years, disagreement has persisted as to whether eating disorders are serious conditions or simply matters of a lack of self-control. As our knowledge base and understanding of these issues have progressed, we have come to realize that eating disorders are serious mental conditions requiring specific treatment modalities.

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Future research conducted on eating disorders needs to place a special emphasis on the extent to which eating disorders plague male youth and elders since concerns about weight and physical appearance have been noted in people as young as 7 years of age and as late as 51 years of age. There also appears to be a significant need for more longitudinal studies for all three types of eating disorders as well as addressing the phenomenon of reverse anorexia nervosa/muscle dystrophy. Furthermore, only a minimal amount of research has addressed cultural differences in eating disorders. Additional emphasis needs to be placed on comparing the prevalence and prognosis of eating disorders in the U.S. to other countries. And finally, consideration needs to be given to moving the BED diagnosis from the Eating Disorders Not Otherwise Specified section of the DSM IV to be included in the main sections of the DSM IV where AN and BN are discussed as well as to provide more specific information regarding the symptoms and diagnosis of BED.

[Reference]

References


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