Services for eating disorders: how comprehensive is comprehensive?

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The theme of my commentary will be "how comprehensive is comprehensive?". I will add a number of points that are not mentioned by K. Halmi that I think are important to developing a comprehensive service, and highlight a number of areas that are mentioned. These include: a) the emergence of new concepts in the nomenclature of eating disorders; b) the need to separate children and younger adolescents from adults and

older adolescents in treatment facilities; c) the role of prior trauma and its link to psychiatric comorbidity; d) the importance of the Maudsley family based treatment approach for the treatment of children and adolescents, and e) the role of complementary treatments.

Approximately one-half of patients treated in eating disorder clinics do not meet full criteria for either anorexia nervosa, bulimia nervosa or binge eating disorder, and are best diagnosed with eating disorder not otherwise specified according to DSM-IV. There has been some work aimed at more specifically delineating this large subgroup. One myth that exists is that patients with eating disorder not otherwise specified are less severely ill than patients with full syndromes, but this is not necessarily true. Consider someone who vomits several times a day but does not binge eat, in contrast to someone who binges and purges twice a week. The term "purging disorder" has been coined to describe such individuals who purge but don't binge, and they have been found to be just as impaired and to have similar medical morbidity, psychiatric comorbidity and course of illness as patients with bulimia nervosa (1,2). Brewerton et al reported that the lifetime prevalence of any purging to lose weight was 12.6% in a large representative sample of women in the United States (3). This group had significantly higher lifetime histories of major depression, substance abuse, post-traumatic stress disorder (PTSD) and victimization experiences, as well as higher body mass index and number of comorbid psychiatric disorders.

One of the issues that Halmi does not address is how to manage the treatment of eating disorder patients of different ages. Most experts in the field recommend age-appropriate services and consider it optimal to separate children and younger adolescents from adults and older adolescents during treatment in inpatient, residential, partial hospital and day treatment facilities (4). It is important to protect children and adolescents from being exposed to older patients, who may inadvertently "teach" children new maladaptive behaviors, and who often have very serious "adult" issues to process, such as working through traumatic life experiences.

It is now well established that eating disorder patients with bulimic symptomatology have significantly higher rates of criminal victimization experiences and resulting PTSD or partial PTSD, which in turn mediates higher rates of comorbidity (5-7). Such patients can be quite challenging and are overrepresented in inpatient settings. This necessitates that comprehensive eating disorder services are well prepared to assess and treat severely traumatized individuals and all trauma-related disorders (5).

Halmi notes that "the most robust evidence-based trials for anorexia nervosa are those of family therapy with adolescents", and this very important finding deserves further elaboration. The first major study that reported the efficacy of family therapy for anorexia nervosa indicated its usefulness in weight recovered patients upon discharge from the Maudsley hospital (8). After one year of treatment, family therapy was found to be more effective than individual therapy in patients whose illness was not chronic and had begun prior to age 19 years. In addition, a more provisional finding was the greater value of individual supportive therapy in older, more chronic patients. These results were confirmed at 5-year follow-up (9). Since then other studies have successfully applied the Maudsley model of family based treatment in underweight children and adolescents with anorexia nervosa (10).

Some comprehensive programs have incorporated specific complementary and spiritually oriented treatments into their armamentarium, such as massage therapy, yoga, meditation and 12-step groups. In one study of patients with anorexia nervosa, massage therapy significantly reduced measures of body dissatisfaction as well as plasma cortisol levels (11). In bulimia nervosa, those who received massage reported less depression and anxiety and had significantly improved scores on several subscales of the Eating Disorders Inventory (12). Other complementary treatments, such as yoga, can be an effective method for increasing self-awareness, personal reflection and body satisfaction, as well as reducing anxiety (13,14). Principles of mindfulness meditation are an integral part of dialectical behavior therapy, an empirically validated treatment for bulimia nervosa, binge eating disorder and borderline personality disorder (15-17). Some models have incorporated 12-step programs, such as Overeaters Anonymous, which has been shown to be helpful in eating disorder patients (18). Mounting evidence suggests that spirituality is an important but underestimated factor in the long-term process of full recovery from an eating disorder (19-23), and comprehensive treatment programs would do well to honor these findings.

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