

26.5.10 Eating disorders

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<https://arms.evidence.nhs.uk/resources/hub/1031525/attachment> 26.5.10 Eating disorders

Christopher G. Fairburn ESSENTIALS The eating disorders are a group of conditions, central to which is a disturbance of eating behaviour. The main diagnoses are anorexia nervosa and bulimia nervosa, in both of which there is an extreme concern with weight and shape. In anorexia nervosa, persistent dietary restriction leads to weight loss, which may be severe. In bulimia nervosa, the dietary restriction is interrupted by repeated episodes of binge eating (typically followed by self-induced vomiting) and weight is usually unremarkable. Both disorders may be accompanied by medical complications that present to physicians. Anorexia nervosa has the potential to be life-threatening because of the consequences of starvation. Patients may require medical attention for the correction of electrolyte disturbance and sometimes admission to a medical unit for refeeding. The main treatment of eating disorders is psychological. The prognosis of bulimia nervosa is generally good but is less positive for anorexia nervosa. Introduction The eating disorders are conditions in which a persistent disturbance of eating is the most prominent feature. There are two main eating disorders, anorexia nervosa and bulimia nervosa, and a third separate condition termed binge eating disorder. In addition, there is a residual category (termed here 'other eating disorders' or OEDs) reserved for eating disorders of clinical severity that do not meet the diagnostic criteria for anorexia nervosa, bulimia nervosa, or binge eating disorder. Box

26.5.10.1 lists their principal diagnostic criteria. Aetiology The aetiology of the eating disorders is poorly understood. While many risk factors have been identified (Box 26.5.10.2), it is not clear how they operate and interact. The most prominent risk factors for anorexia nervosa and bulimia nervosa are being young and female, and living in a 'Western' culture in which slimness is prized and dieting is common. The personality traits of perfectionism and low self-esteem appear to increase the risk of both disorders, as does a family history of depression or an eating disorder. In common with many psychiatric disorders, adverse childhood experiences are also associated with an increase in risk. A family history of substance misuse or obesity specifically increases the risk of binge eating, as does an early menarche and a history of impulsivity. Family-genetic studies indicate an important genetic contribution and there appears to be cross-transmission between the eating disorders, suggesting shared familial liability. Molecular genetic studies have yielded inconsistent findings, probably in part because of small sample sizes and problems defining the phenotype.

Box 26.5.10.1 Classification and diagnosis of the eating disorders

Classification of eating disorders

- Anorexia nervosa
- Bulimia nervosa
- Binge eating disorder
- Other eating disorders (OEDs)

1 Principal diagnostic criteria

Anorexia nervosa

1. Overevaluation of shape and weight (i.e. judging self-worth largely, or exclusively, in terms of shape and weight)
2. Active maintenance of an unduly low body weight (e.g. body mass index <17.5)

Bulimia nervosa

1. Overevaluation of shape and weight (i.e. judging self-worth largely, or exclusively, in terms of shape and weight)
2. Recurrent binge eating (e.g. episodes of uncontrolled overeating at least once a week)
3. Extreme weight-control behaviour (e.g. strict dietary restriction, frequent self-induced vomiting, or laxative misuse)

4. Diagnostic criteria for anorexia nervosa are not met

Binge eating disorder

Recurrent binge eating in the absence of the extreme weight-control behaviour seen in bulimia nervosa

Other eating disorders

Eating disorders of clinical severity that do not meet the diagnostic criteria for anorexia nervosa, bulimia nervosa, or binge eating disorder

1 The fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders refers to these states as 'Other specified feeding or eating disorder'.

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Once established, a variety of processes maintain an eating disorder. These include persistent dieting, usually driven by the overevaluation of shape and weight; repeated checking of body shape, which tends to magnify concerns about appearance; and reliance on aspects of the eating disorder (especially binge eating) to cope with adverse moods.

Epidemiology

In the general population among women aged 16–35 years, the point prevalence of bulimia nervosa is between 1 to 2% and that of the OEDs as high as 5%. Anorexia nervosa is much less common. In clinical settings, the diagnostic distribution differs according to age. Among adolescents, anorexia nervosa is the main presentation, whereas among adults the OEDs and bulimia nervosa are more common (Fig. 26.5.10.1). Nine out of ten adults with anorexia nervosa, bulimia nervosa, or an OED are female and most are in their twenties. The demographic distribution of binge eating disorder is different in that most patients are middle-aged and about a third are male. It is widely thought that eating disorders have become more prevalent over recent decades, but other explanations are plausible, including greater help-seeking, better detection, and changes in diagnostic practice.

Clinical features

Anorexia nervosa and bulimia nervosa, and most OEDs, share a distinctive 'core psychopathology', the overevaluation of shape and weight. Whereas most people evaluate themselves on their perceived performance in a variety of domains of life (the quality of their relationships; their work, and so on), people with eating disorders judge their self-worth largely, or even exclusively, in terms of their shape and weight and their ability to control them. This psychopathology is peculiar to the

eating disorders and is rare in the general population. Most features of these disorders are secondary to this psychopathology and its consequences. For example, it results in a pursuit of weight loss and an intense fear of weight gain and fatness, and it leads many patients to scrutinize their bodies focusing on parts that they dislike. This may contribute to them overestimating their size. Anorexia nervosa In anorexia nervosa, the pursuit of weight loss leads patients to engage in a severe and selective restriction of food intake with foods viewed as fattening being avoided. There is no true 'anorexia' (in the sense of a loss of appetite). In the early stages undereating may be a goal in its own right, the patient valuing the sense of self-control that it imparts. Some also engage in a driven type of exercising which contributes to their weight loss. Self-induced vomiting and other extreme forms of weight control (such as the misuse of laxatives or diuretics) are practised by a subgroup. Depressive and anxiety symptoms, irritability, lability of mood, impaired concentration, loss of sexual appetite, and obsessional features are frequently present. Importantly these features get worse as weight is lost and improve with weight regain. Interest in the outside world also diminishes as patients become underweight with the result that most become socially withdrawn and isolated. The patient does not see their pursuit of weight loss as a problem and therefore has little desire to change. Bulimia nervosa The eating habits of people with bulimia nervosa resemble those seen in anorexia nervosa. The main distinguishing feature is that the attempts to restrict food intake are punctuated by repeated episodes

Box 26.5.10.2
Principal risk factors for anorexia nervosa and bulimia nervosa

- General factors
- Female
- Adolescence and early adulthood
- Living in a Western society
- Individual-specific factors
- Family history
- Eating disorder of any type
- Depression
- Substance abuse, especially alcoholism (bulimia nervosa)
- Obesity (bulimia nervosa)
- Premorbid experiences
- Obstetric complications
- Adverse parenting (especially low contact, high expectations, parental discord)
- Sexual abuse
- Family dieting
- Critical comments about eating, shape, or weight from family or others
- Occupational or recreational pressure to be slim
- Premorbid characteristics
- Low self-esteem
- Perfectionism (anorexia nervosa and to a lesser extent bulimia nervosa)
- Neuroticism
- Anxiety and anxiety disorders
- Obesity (bulimia nervosa)
- Early menarche (bulimia nervosa)
- Type 1 diabetes (bulimia nervosa)

Fig. 26.5.10.1 Typical distribution of the eating disorder diagnoses among specialist adult outpatients. AN, anorexia nervosa; BN, bulimia nervosa; BED, binge eating disorder; OEDs, other eating disorders.

26.5.10 Eating disorders 6511 of binge eating. The frequency of these episodes ranges from once a week (the diagnostic threshold) to several times a day, and the amount eaten per episode is typically between 1000 and 2000 kcals. In most cases, compensatory self-induced vomiting or the taking of laxatives or diuretics follows binge eating, but there is a subgroup of patients who do not 'purge' in this way. The weight of most patients is unremarkable as the effects of the undereating and overeating cancel each other out. Depressive and anxiety symptoms are prominent accompaniments and a subgroup is prone to substance misuse or self-injury or both. Other eating disorders The other eating disorders are very similar to anorexia nervosa and bulimia nervosa. There is the same overevaluation of shape and weight, and the same tendency to engage in persistent and extreme dieting and other forms of weight-control behaviour. Most of the OEDs are mixed states in which the features of anorexia nervosa and bulimia nervosa are combined in such a way that it is not possible to make either diagnosis. Body weight may be low if the dietary restriction is marked. Many people with an OED have a history of anorexia nervosa or bulimia nervosa, or both, reflecting the diagnostic migration that is common among the eating disorders. The OEDs are as impairing as bulimia nervosa. Binge eating disorder Binge eating disorder differs

from the three other eating disorder diagnoses. There is no tendency to engage in extreme weight-control behaviour and generally no overevaluation of shape and weight. Instead, the binge eating occurs against a background of a general tendency to overeat, much as in many cases of obesity. Indeed, many people with binge eating disorder are overweight or have obesity. The course of binge eating disorder is generally phasic rather than persistent with extended periods, often lasting many months free from the disorder.

Differential diagnosis There is a long differential diagnosis of medical conditions that can cause weight loss. The main psychiatric differential diagnosis is weight loss due to severe depression. However, the diagnosis of an eating disorder is best made on positive grounds using the history and mental state examination to detect the characteristic behavioural and attitudinal features, not by simply ruling out possible physical causes.

Treatment

Detection and diagnosis Many people with an eating disorder do not seek treatment. Those with anorexia nervosa may not be aware that they have a problem or they may attempt to hide it. Those with bulimia nervosa often keep their problem secret. When people do present for treatment they may do so only tentatively. Patients with anorexia nervosa typically attend for help at the insistence of concerned others. Those suffering from bulimia nervosa or an OED may attend of their own accord, although often with physical complaints associated with the disorder such as menstrual problems, infertility, or gastrointestinal disturbance. Under these circumstances, making the correct diagnosis can be difficult. The attitude and skill of the clinician during the initial appointments is important as patients are easily put off from re-attending.

Place of treatment Most patients are treated as outpatients. A few may require admission to a specialized eating disorders unit. Some may require admission to a medical unit.

Management of medical complications Physical symptoms, signs, and abnormal laboratory investigations are often found in patients with anorexia nervosa (see Box 26.5.10.3). These are secondary to the disturbed eating habits and the compromised nutritional state (especially low body weight) and most are reversed by restoration of healthy eating habits and sound nutrition. Treatment should focus on the eating disorder itself. It is, for example, inappropriate to treat starvation-induced hypothyroidism with thyroxine, and care is needed when correcting chronic electrolyte disturbance. Life-threatening complications must be addressed and the patient's nutritional state optimized. Patients with a BMI less than 13 or who have lost weight at a rate of more than 1 kg per week are at risk of death. They may require intensive nutritional support as a medical inpatient, with monitoring of electrolytes and an electrocardiogram. In such cases, collaborative management with a psychiatrist skilled in the management of severe eating disorders is essential. Behaviour intended to prevent weight gain may be very challenging to manage on a medical ward and additional specialist nursing may be required. While oral refeeding is preferred, nasogastric tube feeding may be needed. Patients with a BMI of less than 13 are at risk of refeeding syndrome in which there is a potentially fatal shift in fluids and electrolytes in response to unduly rapid refeeding. The Mental Health Act can be used to treat life-endangering starvation as this is regarded as a manifestation of a mental illness. One other chronic medical problem deserves particular mention. This is the decrease in bone mineral density seen in longstanding anorexia nervosa, which is associated with a substantially increased fracture risk. Unlike the other medical complications, it may not be fully reversed by the restoration of a healthy weight, adequate diet, and the resumption of spontaneous menstruation. There is no proven treatment for it. Few physical abnormalities occur in bulimia nervosa unless purging is frequent, in which case there is risk of electrolyte disturbance. There are no medical complications of binge eating disorder other than those secondary to comorbid obesity.

Management of the eating disorder The main treatments are psychological and are delivered on an out-patient basis. Various drugs influence the binge eating of patients with binge eating disorder,

but they are not widely used given the effectiveness of psychological interventions.

SECTION 26 Psychiatric and drug-related disorders 6512 Drug treatment There are no pharmacological treatments for anorexia nervosa. In bulimia nervosa antidepressant medication may produce a decrease in the frequency of binge eating, but it is not clear if this benefit persists. Psychological treatment There is strong evidence supporting a specific form of cognitive behaviour therapy (CBT) for bulimia nervosa, which is endorsed by many national clinical guidelines. Recently this treatment has been superseded by an 'enhanced' version (CBT-E) that can be used to treat any form of eating disorder. It is a personalized treatment that addresses the specific processes maintaining the individual patient's eating disorder (Box 26.5.10.4). Among nonunderweight patients, two-thirds make a full response to CBT-E, whatever their eating disorder diagnosis. Treatment in those who are underweight (BMI <17.5) is more difficult and not always successful. Psychological treatment with CBT-E may need to be lengthy. The response rate has yet to be firmly established, but it appears to be approximately 40%. In adolescent patients, a specific form of family therapy is the favoured treatment with a response rate in the region of 50%. Binge eating disorder responds well to a variety of psychological interventions including following a cognitive behavioural self-help programme with a limited amount of support. Prevention The research on prevention has mostly focused on programmes designed to reduce concerns about body shape. The group targeted has been adolescent girls and young women. While these programmes can reduce shape concerns, it has not yet been demonstrated that this has any effect on the likelihood of developing an eating disorder. Whether this is the right strategy is a moot point as body image concerns are only one among many risk factors for developing an eating disorder, and the magnitude and universality of its contribution is not clear. Outcome Established eating disorders tend to persist without treatment. Treatment-seeking is often delayed and presentations may be initially to medical services for physical complications of the disorders.

- Electrolyte disturbance (varied in form; present in those who vomit frequently or misuse large quantities of laxatives or diuretics): vomiting—metabolic alkalosis and hypokalaemia; laxative misuse—metabolic acidosis, hypokalaemia
- Other abnormalities
 - Enlarged cerebral ventricles and decreased cortical substance
 - Osteopaenia and osteoporosis, especially of the spine (with heightened fracture risk)

Box 26.5.10.3 Principal medical complications of anorexia nervosa and bulimia nervosa

Physical symptoms

- Heightened sensitivity to the cold
- Gastrointestinal symptoms—bloating, constipation, fullness after eating
- Dizziness, palpitations, syncope
- Amenorrhoea (in females not taking an oral contraceptive); low sexual appetite; infertility
- Poor sleep with early morning waking

Physical signs

- Emaciation
- Stunted growth and failure of breast development (if prepubertal onset)
- Dry skin; hair loss; fine downy hair (lanugo) on the back, forearms, and side of the face
- Skin abrasions and callous formation on dorsal surface of the hand (in those who use their fingers to induce vomiting; Russell's sign)
- Swelling of parotid and submandibular glands (especially in bulimia nervosa)
- Erosion of inner surface of front teeth (perimyolysis) in those who vomit frequently
- Cold hands and feet; acrocyanosis; hypothermia
- Bradycardia; hypotension; cardiac arrhythmias (especially in those with electrolyte abnormalities)
- Dependent oedema (complicating the evaluation of body weight)
- Weak proximal muscles (elicited as difficulty rising from a squatting position)

Abnormalities on investigation

Endocrine

- Low gonadotropin-releasing hormone (GnRH), luteinizing hormone (LH), follicle-stimulating hormone (FSH), oestrogen, and testosterone
- Low T3, T4 in low normal range, normal thyroid-stimulating hormone, TSH ('low T3 syndrome')
- Mild elevation of plasma cortisol
- Elevated growth hormone with increased IGF-1
- Hypoglycaemia (uncommon)

Cardiovascular

- Electrocardiogram abnormalities (especially in those with electrolyte disturbance)
- Reduced left

ventricular mass Gastrointestinal • Delayed gastric emptying; delayed small bowel transit time • Acute gastric dilatation (rare, secondary to binge eating or excessive refeeding) • Decreased colonic motility (secondary to chronic laxative misuse) Haematological • Moderate normocytic normochromic anaemia • Mild leucopenia with relative lymphocytosis • Thrombocytopenia (uncommon) Other metabolic abnormalities • Hypercholesterolemia • Hypophosphatemia (exaggerated during refeeding) • Dehydration

Revision #1

Created 2026-01-22 16:43:58 UTC by Omar Ayman

Updated 2026-01-22 16:43:58 UTC by Omar Ayman