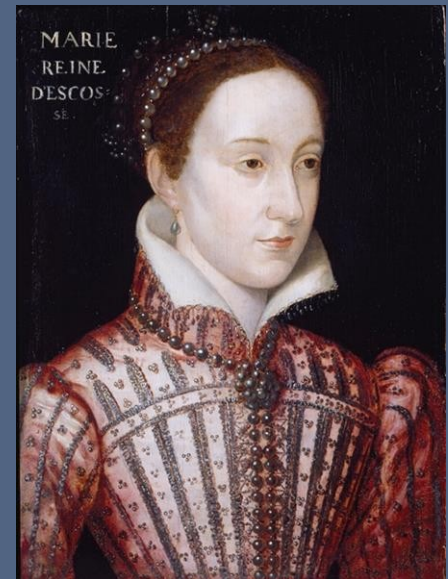


Eating Disorders

Abnormal & Clinical Psychology

Historical Context

- Cases of starvation have been reported in classical and medieval times (e.g. St Catherine de Siena).
- Mary, Queen of Scots
- 'Anorexia nervosa' – Sir Williams Gull
- 'Fames canina' – disorder characterized by large food intake followed by vomiting (bulimia nervosa).



Prevalence

- Eating disorders are common in the general population, more common in women than men, and more common in Western countries than in Asian countries (Qian et al., 2015).
- Among specific types of eating disorders, the highest prevalence was found for BED, followed by BN, and AN (Qian et al., 2015).

The extent of eating-related problems

- 25-30% of females claim to be currently dieting or attempting to lose weight (McVey et al., 2004)
- 13.4% of girls and 7.1% of boys engage in disordered eating patterns (including fasting, dieting, overeating or binge eating) (Neumark-Sztainer & Hannan, 2000)
- Adolescents in the US indicated that 21.8% of girls and 11.2 % of boys self-reported engaging in disordered eating behaviours within the last 30 days (Loth et al., 2014)

The three main eating disorders are:

- Anorexia nervosa
- Bulimia nervosa
- Binge-eating disorder

Anorexia nervosa

Important features of anorexia nervosa include:

- A refusal to maintain a minimal body weight
- A pathological fear of gaining weight
- A distorted body image in which sufferers continue to insist they are overweight

Main DSM-5 diagnostic criteria for AN

- A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- B. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Types of AN

- Restricted type anorexia nervosa

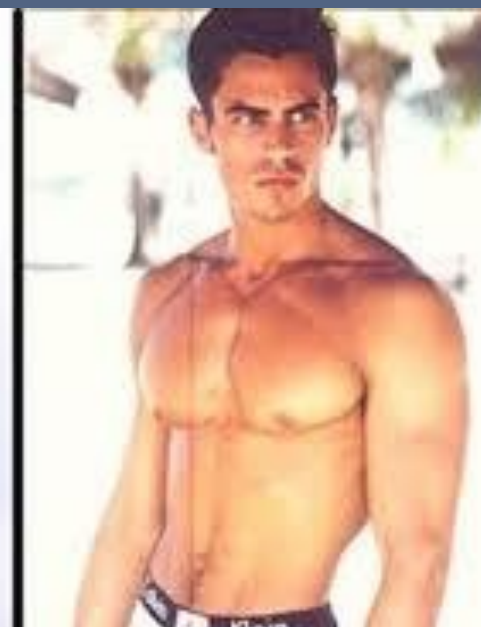
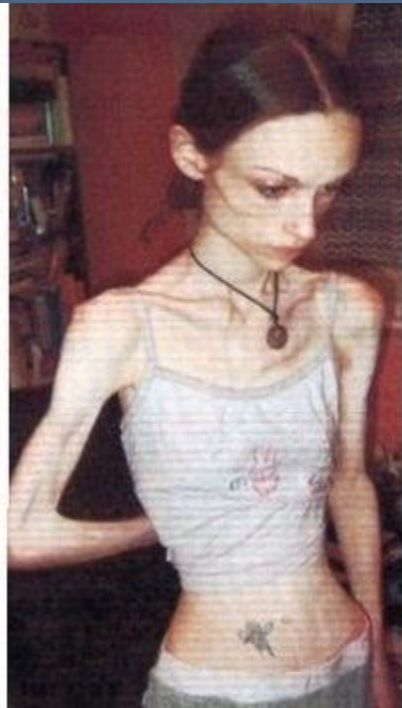
A type of anorexia nervosa in which self-starvation is not associated with concurrent purging (e.g. self-inducing vomiting or use of laxatives)

- Binge eating/purging type anorexia nervosa

A type of eating disorder in which the sufferer regularly engages in purging activities to help control weight gain

Physiological effects of AN

- Tiredness, cardiac arrhythmias, low blood pressure and slow heartbeats
- Dry skin and brittle hair
- Kidney & gastrointestinal problems
- The development of lanugo (a soft, downy hair) on the body
- The absence of menstrual cycles (*amenorrhea*)
- Hypothermia, often resulting in feeling cold even in hot environments



Prevalence rates of anorexia nervosa

- Lifetime prevalence rates for females is 0.5%
- Prevalence rates may differ across cultures and across time
- Anorexia nervosa is highly comorbid with other psychiatric disorders (e.g. major depression, OCD, Obsessive-Compulsive Personality Disorder)
- It has the highest mortality rate of all mental disorders and relapse happens frequently (Zipfel et al., 2014).

Prevalence of AN

Table 3.2

Application of National Collaborating Centre for Mental Health prevalence indicators

AN prevalence	6,819
BN prevalence	360,764
BED prevalence	357,261
Total ED prevalence	724,845

Source: BEAT (2015). *The costs of eating disorders: Social, health and economic impacts*. Retrieved from <https://www.b-eat.co.uk/latest/602>

Bulimia nervosa

- Characterized by a fear of gaining weight and a distorted body image
- Main feature is periods of binge eating followed by periods of fasting or purging
- Typical onset is in late adolescence or early adulthood
- Around 90% of those suffering bulimia are female

DSM-5 diagnostic criteria for bulimia nervosa

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - 1. Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most individuals would eat in a similar period of time under similar circumstances.
 - 2. A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- B. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur excessively during episodes of anorexia nervosa.

Prevalence rates for bulimia nervosa

- Life prevalence rate is 1-3% among females
- The prevalence rates in males is 0.1-0.3%
- The incidence of bulimia in women in Western cultures appears to be increasing (Keel & Klump, 2003)
- Highly comorbid with psychiatric disorders (e.g. major depression, personality disorders, and substance abuse and dependency)
- Manifestation of broader 'multi-impulsive' syndrome

Binge-eating disorder (BED)

- Characterized by recurrent episodes of binge eating, but without associated fasting and purging
- Sufferers tend to be overweight, with a long history of failed dieting and weight-loss attempts
- Typically develops during late adolescence or early adulthood

Main DSM-5 diagnostic criteria for BED

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - 1. Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
 - 2. A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
- B. The binge-eating episodes are associated with three (or more) of the following:
 - 1. Eating much more rapidly than normal.
 - 2. Eating until feeling uncomfortably full.
 - 3. 3. Eating large amounts of food when not feeling physically hungry.
 - 4. Eating alone because of feeling embarrassed by how much one is eating.
 - 5. Feeling disgusted with oneself, depressed, or very guilty afterwards.

The prevalence of binge-eating disorder

- Lifetime prevalence in the general population is 3%
- Can be as high as 30% in individuals seeking weight loss treatment (Dingemans et al., 2002)
- Majority of sufferers are female, but the incidence in females is only 1.5 times higher than in men (Stice et al., 2000)
- Triggered by stress, dieting, negative body image and boredom
- Diagnostic overlap with bulimia

Cultural and demographic differences in eating disorders

- Bulimia nervosa rarely found in individuals who have NOT been exposed to Western ideals (Keel & Klump, 2003)
- African American women are less likely to have eating disorders than American white women (Lovejoy, 2001)
- In the USA, rates of eating disorders in Asian immigrants are increasing (Chamorro & Flores-Ortiz, 2000)
- Anorexia nervosa has been reported in individuals who have NOT been exposed to western ideals (Keel & Klump, 2003)

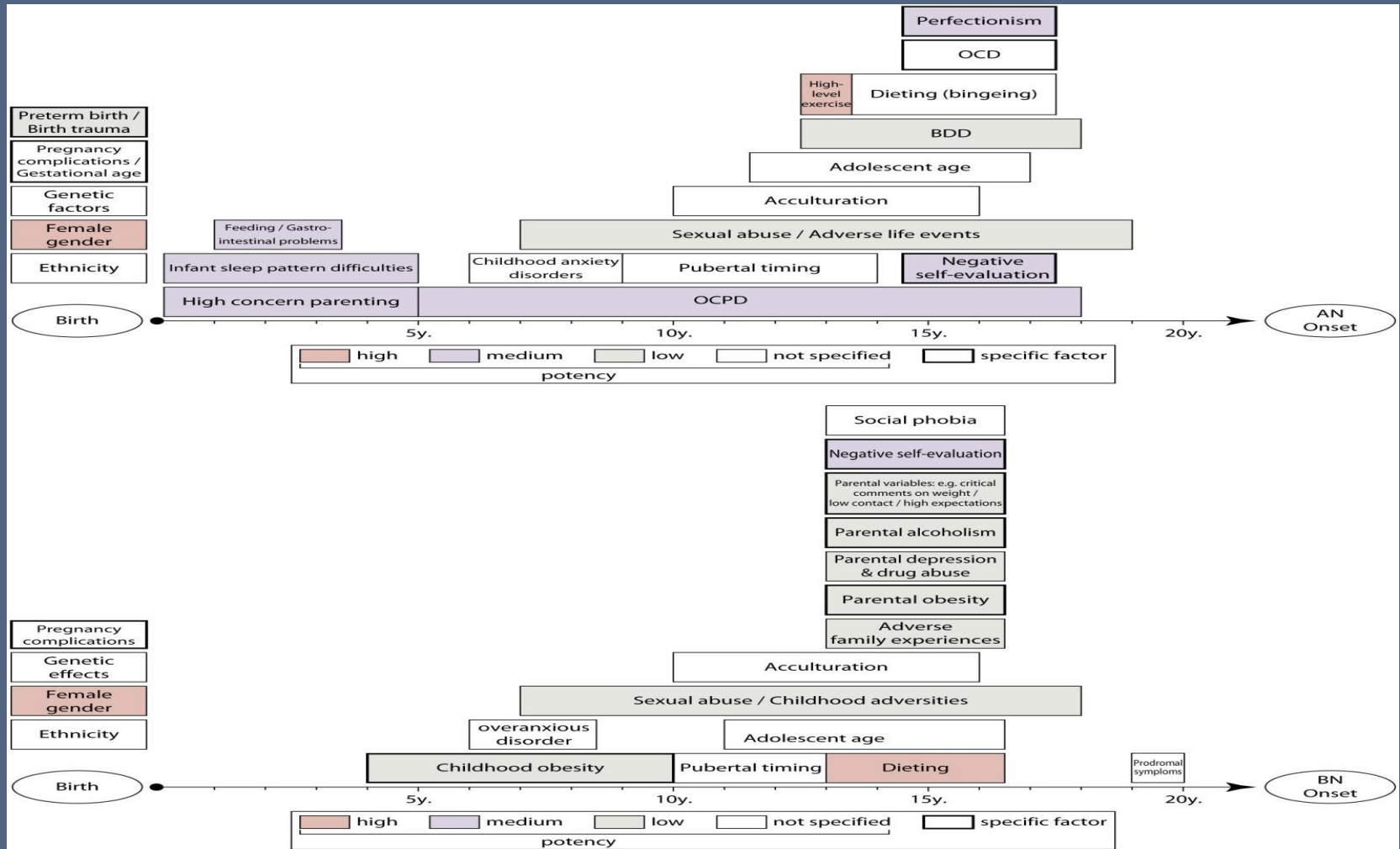
Cultural and demographic differences in eating disorders

- Females are ten times more likely to develop eating disorders than males
- Female thinness may be an important social value
- Eating disorders are higher in groups of males whose body weight and shape are of more significance to them (e.g. athletes, ballet dancers)

The aetiology of eating disorders

- Biological factors
- Sociocultural influences
 - Media influences, body dissatisfaction & dieting
 - Peer influences
 - Familial factors
- Experiential factors
- Psychological & dispositional factors
- Transdiagnostic models of eating disorders

Risk Factors



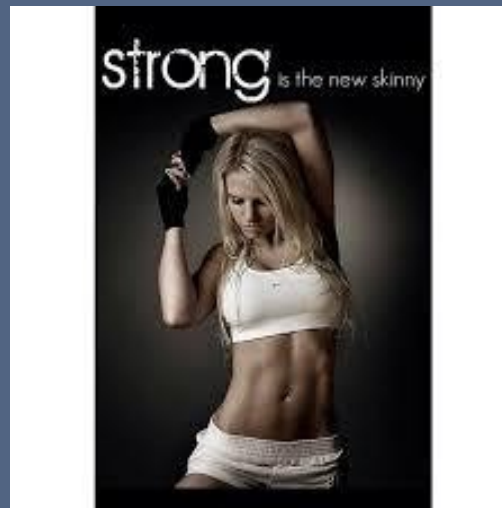
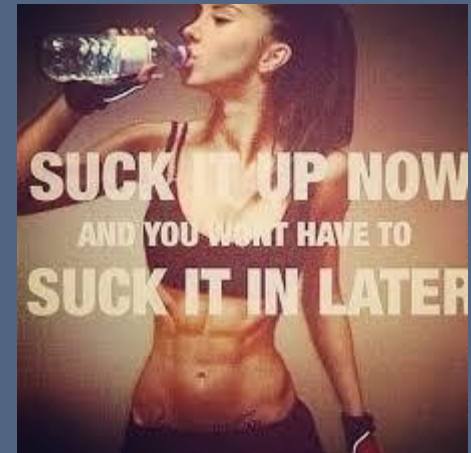
Biological factors

- Genetic component
 - Heritability component may be >50% (Klump et al., 2001)
 - Significant co-impact of unique environmental factors
 - Different genetic contribution for AN/BN
- Role of the *lateral hypothalamus*
- Reinforcement by endogenous opioids
- Serotonin metabolites
- Neuroendocrine dysfunction

Socio-cultural influences

- Media influences (Groesz, Levine, & Murnen, 2002).
- Body dissatisfaction and dieting behaviour (Maltby et al. 2005; Schupak-Neuberg, Shaw, & Stein, 1994).
- Peer influences (gender identity)
- Familial factors ('gender transmission' – Hodes, Timimi, & Robinson, 1997).

Media influences



Media influences

‘Thinspiration’:

<https://theproanalifestyleforever.wordpress.com/>

<http://anamia-thinspo.blogspot.co.uk/p/ana-tips.html>

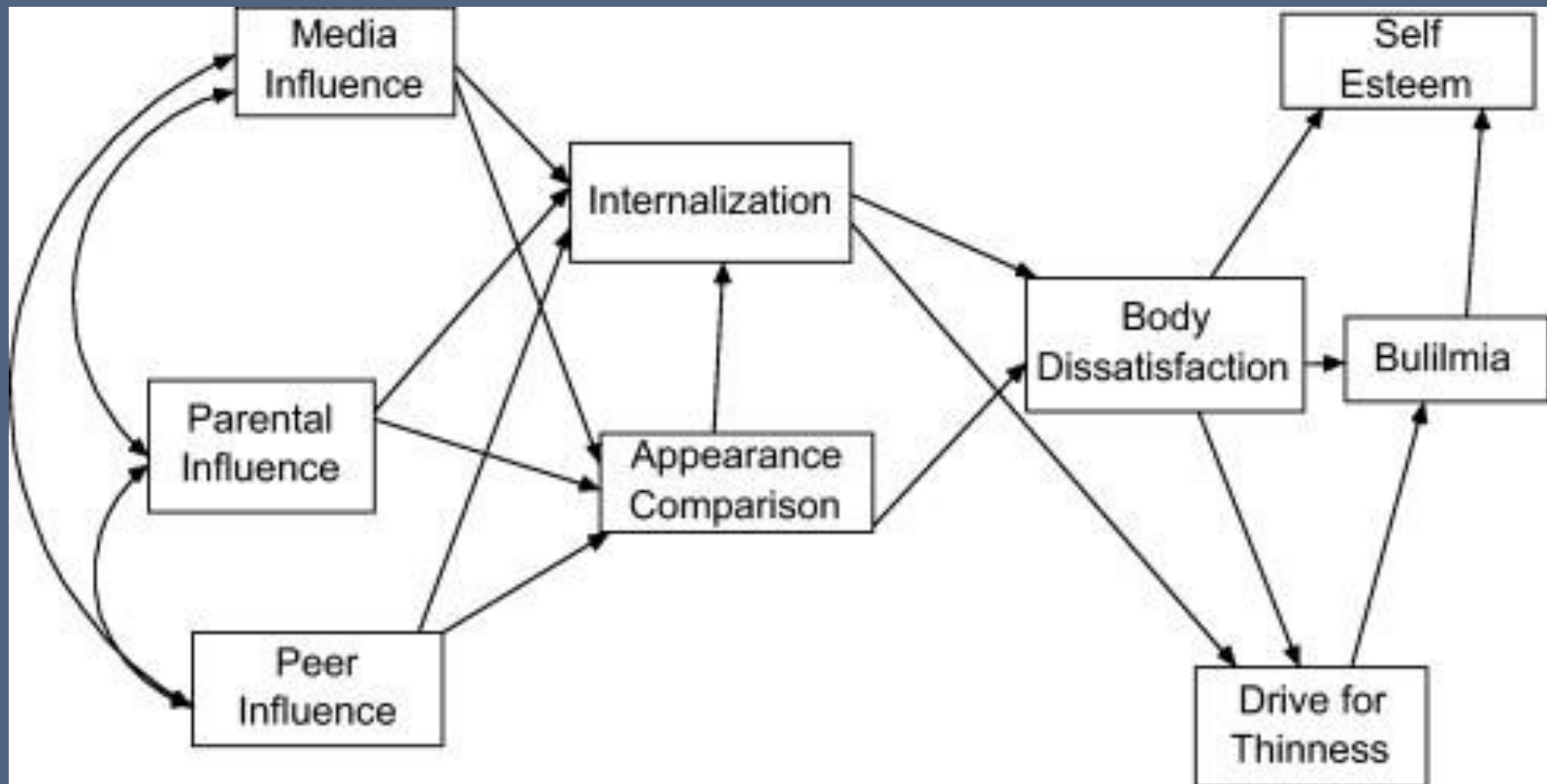
Media influences, body dissatisfaction & dieting

- Increases in ED associated with changes in media representations of the ideal female body shape
- Young women adopt ideal body shape goals that are achievable for only 5% of the population (Irving, 2001)
- Body shape dissatisfaction associated with watching TV shows that present idealized female images (Tiggerman & Pickering, 1996)
- Contribution of shifting low-cal food trends
- *Value judgment* of obesity versus thinness

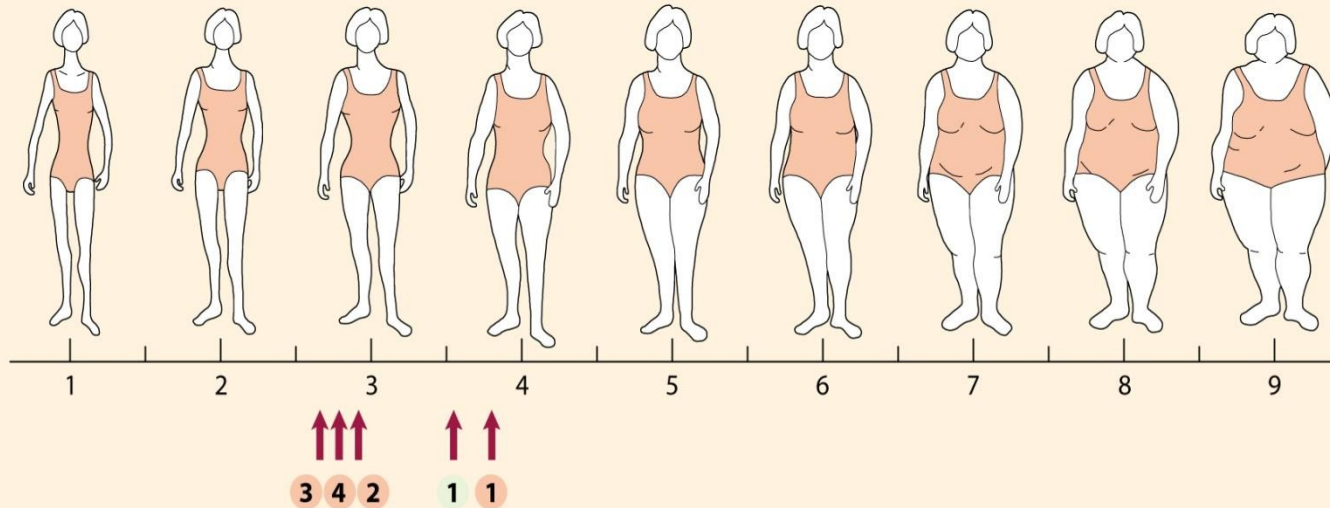
The role of body shape dissatisfaction

- Defined as “the gap between one’s actual and ideal weight and shape”
- Most theories of eating disorders implicate body dissatisfaction
- Body dissatisfaction is likely to trigger dieting
- Body dissatisfaction is not a sufficient condition for eating disorders – many women with high body dissatisfaction do not develop eating disorders
- Vulnerability factor

The tripartite model



Female overestimation of body shape & size



For female participants

Mean rating

- | | | |
|---|--|------|
| 1 | Which body type closely matches your own? | 3.85 |
| 2 | Which body type would you most like to have? | 2.99 |
| 3 | Which body type would most women like to have? | 2.69 |
| 4 | Which body type do you believe men like best? | 2.85 |

For male participants

Mean rating

- | | | |
|---|--|------|
| 1 | Which body type do you find most attractive? | 3.52 |
|---|--|------|

Peer influences

- Adolescent girls tend to learn their attitudes to slimness and dieting from their peers (Levine et al., 1994).
- Adoption of unhealthy weight control behaviours (e.g. self-induced vomiting, etc.) influenced by dieting behaviour of friends (Story & Perry, 2005)

Use of websites to swap bulimic experiences

- after you eat would you go to the bathroom? I am relatively new at it but have had some luck but just not as much coming up as I thought. How soon after and how long would you do it for?
- ok im so sure someone would have to have an answer for me... ok so i'm really good at making myself sick.. but 4 the last 2 days i cant get anything up.. its nasty tho bc i definatly get dry heaves and i gag for about 10 minutes at a time... and the last time i tried it i was choking.. i could still breath but i was gasping.. i freaked myself out.. and i know to chew really well and all that, so i know thats the problem.. u think its because my esophagus is irritated or something like that?? please give me a bit of advice.. thanks

Familial factors

- Eating disorders have a tendency to run in families
- Eating disorders may best be understood by considering family dynamics (Minuchin et al., 1975)
- The sufferer may be embedded in a dysfunctional family structure that actively promotes the development of eating disorders

Eating disorders & family systems theory

- Families with eating disorders may show at least one of the following characteristics (Minuchin et al., 1975):
 - Enmeshment
 - Overprotection
 - Rigidity
 - Lack of conflict resolution

The role of mothers

- Mothers of individuals with eating disorders are also likely to have dysfunctional eating patterns (Hodes et al., 1997)
- Mothers of those suffering eating disorders also tend to excessively criticize their daughters' appearance and attractiveness (Hill & Franklin, 1998)

Experiential factors

- Anorexia and bulimia sufferers report more negative life experiences than healthy controls (Rastam & Gillberg, 1991; Welch et al., 1997)
- Higher incidence of childhood sexual abuse is found in those with bulimia and anorexia (Brown et al., 1997; Steiger et al., 2000) but not in binge-eating disorder sufferers
- Eating disorder comes to be a coping mechanism

Psychological & dispositional factors

- Perfectionism
- Shyness
- Neuroticism
- Low self-esteem
- High introspective awareness
- Negative or depressed affect
- Dependence & non-assertiveness

Transdiagnostic models of eating disorders

- Common processes or maintaining factors common across all eating disorders
- Transdiagnostic cognitive-behavioural model (Fairburn, 2008)
 - ❖ Dysfunctional sense of self evaluation is central
 - ❖ Self worth is defined by control over eating, weight and shape
 - ❖ Leads to dietary restraint
 - ❖ Low self esteem, perfectionism and mood intolerance

The treatment of eating disorders

- Pharmacological treatments
- Family therapy
- Cognitive Behaviour Therapy (CBT)

Difficulties in treating eating disorders

- Sufferers often deny their disorder or illness
- Individuals with severe eating disorders often require medical treatment prior to psychological interventions
- Eating disorders are regularly comorbid with other psychiatric disorders requiring complex treatment

Self-help & alternative delivery systems

- Self-help groups
- Alternative delivery systems
 - Treatment & support via telephone, email and internet
 - Computer software CD-ROMs
- Prevention programmes

Prevention programmes

- School-based prevention programmes emphasise:
 - The role played by the media in promoting extreme body ideals
 - The need to develop positive body image
 - The need for a healthy, balanced diet
 - The development of skills associated with expressing feelings and combating depression
- Body Project (Stice et al. 2012)
- Healthy Weight (Stice et al 2003)

Pharmacological treatments

- Antidepressants are the most common form of drug treatment
- Some evidence that this can reduce bulimia symptoms (e.g. Bellini & Merli, 2004)
- However, pharmacological treatments with anorexia have tended to be less successful (Pederson et al., 2003)
- Antidepressant treatments associated with greater relapse and drop-out than psychological interventions
- Best outcomes when drug treatments are combined with CBT programmes

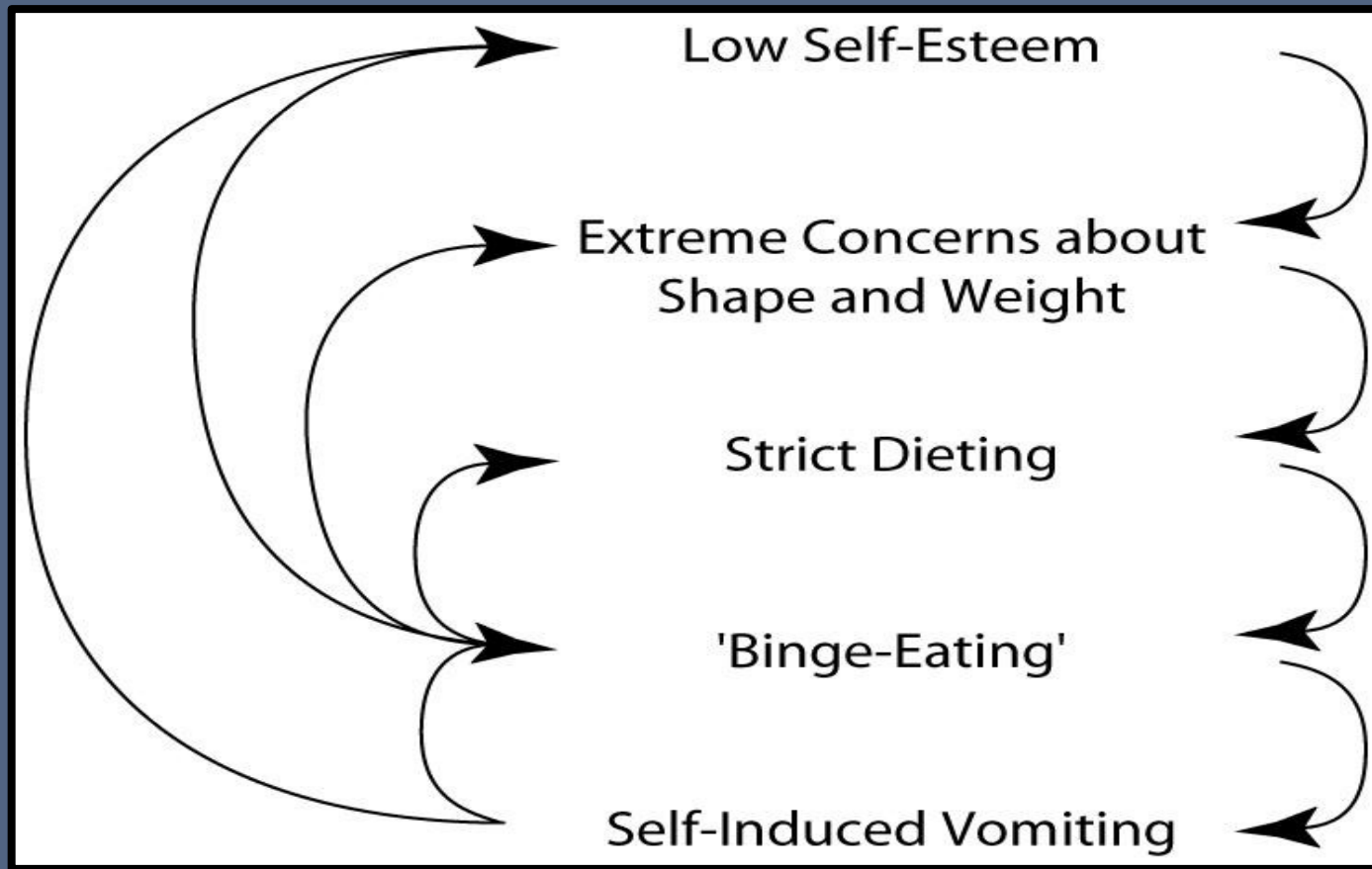
Family therapy

- One of the most common interventions used with eating disorders
- Based on the view that eating disorders hide important conflicts within the family
- Stems mainly from theories of Minuchin
 - Family systems theory
 - Recently developed Maudsley approach
 - Staged approach to recovery

Cognitive Behaviour Therapy (CBT)

- The treatment of choice for bulimia is considered to be CBT (Wilson & Shafran, 2005)
- Based on the cognitive model developed by Fairburn et al. (1999)
- Individuals with bulimia develop negative evaluation and idealized beliefs about thinness, and distorted views of their own body shape
- These are all challenged during CBT
- Enhanced form of CBT can also be used
 - Especially helpful for those who are significantly underweight

Fairburn's (1997) cognitive model of bulimia



Stages of CBT for bulimia

- CBT for bulimia will cover:
 - Meal planning and stimulus control
 - Cognitive restructuring to address dysfunctional beliefs about shape and weight
 - Developing relapse prevention methods