Complex Cases and Comorbidity in Eating Disorders

Assessment and Management

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Preface

Eating disorders are almost always “complex cases”, as the great majority of such patients have other significant clinical problems. Most meet the diagnostic criteria for another mental disorder and are often recipients of a diagnosis of some personality disorder. Marked interpersonal difficulties and severe psychosocial impairment are common. Moreover, physical complications are almost always present, and, in a subgroup of patients, a general medical condition coexists and interacts with the eating disorder psychopathology.

Clinicians often use the term “comorbidity” to describe the clinical problems that coexist with eating disorders. The term has become commonly used, and somewhat “fashionable” in psychiatric circles, to indicate not only those cases in which a patient is diagnosed with a psychiatric disorder and a medical one (e.g. major depression and type 2 diabetes), but also those cases in which the patient receives a diagnosis of two or more psychiatric disorders (e.g. major depression and panic disorder).

However, comorbidity is a complex issue, both conceptually and clinically. From a conceptual point of view, the definition of comorbidity refers to a situation in which “a distinct clinical entity develops during a disease” (e.g. when a patient with diabetes mellitus develops Parkinson’s disease). In this case, there are two distinct clinical entities, and a lifetime concept is applied. Instead, from a clinical point of view the definition of comorbidity refers to a situation in which “two or more distinct clinical entities coexist”. In this case, the prevalence of comorbidity depends on the definition of the disorders in question (i.e. the classification system and its diagnostic rules). In the field of mental health, in which specific biomarkers are thus far lacking, it is questionable whether psychiatric illnesses are in fact “distinct” clinical entities, or simply the result of the diagnostic criteria currently being applied to their symptoms. Indeed, reliance to the letter on the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system being used today, the DSM-5, may encourage the application of several psychiatric diagnoses in the same patient.

Problems related to the definition of comorbidity may have important clinical consequences that affect treatment. For example, the features of depression are

common in patients with eating disorders, but may be evidence of either a coexistent clinical depression ("true comorbidity") or the direct consequence of eating disorders ("spurious comorbidity"). In the first case, clinical depression should be treated directly, while in the second case, treating the eating disorder should lead to remission in the depressive features.

Furthermore, uncritical management of comorbidities may have the paradoxical effect of defocusing the treatment from the key factors maintaining the eating disorder psychopathology, and subjecting the patient to treatments that are in fact useless and potentially harmful. Specifically, the most frequent therapeutic error that we have observed in our clinical practice is treating the physical and psychosocial consequences of malnutrition using a variety of drugs, without obtaining any clinical benefit. For example, oestrogen and progestins are prescribed to treat secondary amenorrhoea, anxiolytics, and/or antidepressants, neuroleptics, and mood stabilizers to treat anxiety, irritability, mood deflection, and insomnia—symptoms that are in most cases the consequence of malnutrition and/or the eating disorder psychopathology. Similar therapeutic misjudgements are often made with the adoption of psychological treatments that address the psychosocial consequences of the disorder, but not the specific psychopathology of the eating disorder directly.

The above issues prompted us to write this book to share with clinicians the strategies and procedures we have found useful in and assessing and treating "complex" eating disorder cases. We rely on enhanced cognitive behavioural therapy (CBT-E), an evidence-based treatment recommended for all eating disorder categories in both adults and adolescents, but our strategic and pragmatic approach to the management of the medical and psychiatric comorbidities that often coexist with eating disorders can be used by clinicians who adhere to different theoretical models.

That being said, we strongly suggest that multidisciplinary teams managing complex patients with eating disorders adhere to a coherent theoretical and therapeutic model. To this end, the book describes how we have addressed this challenge, developing an approach called "multistep CBT-E". This is a treatment, based on the evidence-based CBT-E, designed to be delivered at three levels of care (outpatient, day-hospital, and inpatient) by a "non-eclectic" multidisciplinary team in which all members received extensive training on CBT-E and are aware of the entire clinical picture of patients. In the non-eclectic multidisciplinary team, the physician's interventions to treat coexisting mental and general medical disorders (e.g. clinical depression, obesity, diabetes) or complications associated with low weight and/or purging behaviours are integrated consistently with CBT-E and coordinated with the other team members, following the pragmatic guidelines described in this book.

The book is divided into two main parts. Part One describes the eating disorder psychopathology, the limitations of the current classification system, the physical and psychosocial consequences of these disorders, and how to assess their nature and severity—essential knowledge for understanding whether a patient has a true or spurious comorbidity. This is followed by an overview of CBT-E and how to implement it at different levels of care.

Part Two describes the general strategies used to address comorbidity in patients with eating disorders, and the specific strategies and procedures for managing the

most common mental disorders (i.e. clinical depression, anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, substance use disorder, and personality disorders) and general medical conditions (i.e. obesity, type 1 diabetes, celiac disease, inflammatory bowel diseases, food allergies, and intolerance) coexisting with eating disorders. A clinical case vignette is provided for each disorder to illustrate the practical application of the strategies used to manage these complex cases.

Finally, the appendices include two validated self-report questionnaires: The Eating Problem Checklist (EPCL) questionnaire, designed to assess the psychopathology of eating disorders; and the Starvation Symptom Inventory (SSI), designed to measure malnutrition symptoms in underweight patients.

We hope that this book will prove a useful guide, not only for all clinicians who treat patients with eating disorders (e.g. psychiatrists, internists, endocrinologists, psychologists, dietitians, nutritionists, nurses, educators, physical therapists), but also for the many (e.g. gynaecologists, endocrinologists, gastroenterologists, haematologists, allergists, psychiatrists, psychotherapists, and psychologists) who, while not working in specialized centres, are involved in the management of medical and psychiatric comorbidities in patients with eating disorders.

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Contents

Abbreviations

AN	Anorexia nervosa
BED	Binge-eating disorder
BMD	Bone mineral density
BMI	Body mass index
BN	Bulimia nervosa
CBT	Cognitive behaviour therapy
CBT-E	Enhanced cognitive behaviour therapy
DSM-5	Diagnostic and Statistical Manual of Mental Disorders
ECG	Electrocardiogram
EDE	Eating Disorder Examination
EPCL	Eating Problem Checklist
HbA1c	Glycated haemoglobin
HRQOL	Health-related quality of life
ICD-11	International Classification of Diseases, 11th Revision
IGF-1	Insulin-like growth factor 1
IPT	Interpersonal psychotherapy
MMPI	Minnesota Multiphasic Personality Inventory
NICE	National Institute for Health and Care Excellence
OEDs	Other eating disorders
SSI	Starvation Symptom Inventory
SSRI	Selective serotonin reuptake inhibitor
PTSD	Post-traumatic stress disorder

Part I
Eating-Disorder Psychopathology, Comorbidity, and Cognitive Behaviour Therapy

Chapter 1
Eating Disorders: An Overview

Eating disorders are among the most common and serious health problems afflicting adolescents and young women in Western countries. They are less frequent in men. If not treated quickly and well, they interrupt the normal process of psychological and physical development, and cause considerable physical and psychosocial morbidity [1]. They may also lead to death in some cases [2]. Anorexia nervosa, in particular, has the highest mortality rate of any mental disorder, with a standardized mortality ratio of 5.9 over 12.8 years[1] [3], peaking in the first 10 years of follow-up [4].

1.1 Eating Problems and Eating Disorders

Most people who follow a diet or have binge-eating episodes do not have an eating disorder. The latter develops when the diet is so extreme and rigid, and binge-eating episodes so frequent, as to cause physical and psychological impairment and compromise the quality of life. In other words, alterations in eating behaviour must be of clinical severity for an eating disorder to be diagnosed.

In adults and adolescents, there are three main eating disorders: (i) anorexia nervosa, (ii) bulimia nervosa, and (iii) binge-eating disorder. However, community and clinical studies have shown that a large number of individuals with an eating disorder of clinical severity do not fall into these three categories. Such people have an

[1] The standardized mortality ratio is the ratio of observed deaths in the study group to expected deaths in the general population. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a ratio and is equal to 1.0, this means the number of observed deaths equals that of expected cases. If the SMR is greater than 1.0, there is a higher number of deaths than expected.

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eating disorder that in this book we have grouped into the broad category "other eating disorders".[2]

1.2 Anorexia Nervosa

According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a person must meet the following three diagnostic criteria if they are to be diagnosed with anorexia nervosa [5]:

1. Restriction of energy intake relative to requirements, leading to a significant low body weight in the context of age, sex, developmental trajectory and physical health. Significantly low body weight is defined as a weight below that is less than minimally normal or, for children and adolescents, less than that minimally expected.[3]
2. Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though at significantly low weight.
3. 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.

The presence of amenorrhoea, a criterion required by the previous DSM versions, is no longer necessary for the diagnosis of anorexia nervosa. This exclusion was justified by the observation that amenorrhoea is not predicted by psychopathological variables, only by body weight and excessive exercising, and that individuals who meet all the other diagnostic criteria of anorexia nervosa but do not have amenorrhoea respond in a similar way to the same treatment [6]. In addition, this criterion cannot be applied to women of pre-menarchal or post-menopausal age, those taking oral contraceptives, or, of course, males.

Indeed, although anorexia nervosa mainly affects female adolescents and young adults, about one in eight cases occurs in males [7]. It occurs more commonly among white populations than in non-Hispanic black and Hispanic populations [8],

[2] The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) combines feeding and eating disorders in a single diagnostic category. Feeding disorders mainly, but not exclusively, affect children and adolescents, and include the following diagnostic categories: pica, rumination disorder and avoidant/restrictive food intake disorder. Feeding disorders are not discussed in this book since these states present quite differently from the main eating disorders (i.e., there is an absence of the core overvaluation of shape, weight and their control, and no binge-eating episodes or compensatory behaviors). In addition to anorexia nervosa, bulimia nervosa and binge-eating disorder, the eating disorders include a large group of "other specified or unspecified feeding or eating disorders", which in this book we have grouped into a single category, which we term "other eating disorders".

[3] The threshold for defining a significantly low weight is debated and varies. Body Mass Index or BMI thresholds (kg/m^2) of 17.5, 18.0 or 18.5 are typically used. BMI-for-age growth charts are used to assess BMI in youths.

and its global incidence seems to be increasing, particularly in Asia [9] and the Middle East [10]. The most recent large epidemiological study found that lifetime prevalence of the disorder (i.e., the proportion of anorexia nervosa at any point in life) is approximately 0.80% in the United States [8], affecting 1.4% (0.1–3.6%) of women and 0.2% (0–0.3%) of men, according to a recent review of 33 studies [11].

In such individuals, low weight is achieved by adopting an extreme and rigid hypocaloric diet, sometimes associated with excessive exercising. About a third of people with anorexia nervosa have recurrent binge-eating episodes, many of which are subjective,[4] during which their attempt to restrict food intake is disrupted. Binge-eating episodes are often followed by one or more compensatory behaviours, such as self-induced vomiting and laxative and diuretics misuse.

In some cases, anorexia nervosa is short-lived and goes into remission with a brief course of treatment (especially in adolescents) or no treatment at all, but it tends to persist in many cases, and will require prolonged and complex specialized interventions [12]. In about half of anorexia nervosa cases, there is a migration towards bulimia nervosa and other subthreshold eating disorders [13]. At short-term follow-up, the remission rate is about 29%, which increases to 68–84% at 8- to 16-year follow-up [12]. Unfortunately, however, about 10–20% of sufferers do not improve with any treatment available to date, and develop a lifelong condition [14] that is today is called "severe and enduring" anorexia nervosa [15, 16]. In these cases, the disorder impairs health-related quality of life (HRQOL) more or less markedly and persistently, and is associated with increased need for healthcare and associated costs [17]. The crude mortality rate for anorexia nervosa ranges between 0% and 8%, with the most recent studies reporting a cumulative mortality rate of about 2.8% [12].

1.3 Bulimia Nervosa

Bulimia nervosa, originally known in North America as "bulimia", was first described in 1979 [18]. According to the DSM-5, a person suffers from bulimia nervosa if they meet the following diagnostic criteria [5]:

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   (a) Eating, in a discrete period of time (e.g., within any 2-h period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
   (b) 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).

[4] A small or moderate amount of food associated with sense of lack of control over eating during the episode, as opposed to objective binge-eating episodes, in which the amount of food consumed is, in fact, unusually large.