



Section 1

CLINICAL ASSESSMENT

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Chapter 1

INTRODUCTION TO CLINICAL ASSESSMENT FOR EATING DISORDERS

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The first section of this volume will outline multidisciplinary strategies for assessing people with an eating disorder (ED), including differential diagnosis between eating disorders, and assessing for psychiatric and medical co-morbidity. As a preface to this section, we will outline the most frequently used eating disorder diagnoses and how these may relate to the course of illness and prognosis. We also explore some of the difficulties with the diagnostic categorization of people with an ED.

EATING DISORDER DIAGNOSES

Eating disorders often attract considerable public and media interest, with many magazines commonly discussing celebrities' difficulties with their eating or their body sizes. Fairburn and Harrison (2003) pointed out that EDs are a significant source of physical morbidity, psychosocial impairment, and they carry the highest mortality rate of any of the psychiatric disorders (e.g. Herzog *et al.*, 2000).

Diagnostic classificatory systems may be an anathema to many readers of this volume. However, a basic familiarity with them, and an understanding of their utility and limitations, is important for clinicians undertaking eating disorder assessment and treatment; not least since treatment pathways (and indeed the commissioning of services) are frequently based upon diagnosis.

One of the most commonly used classificatory systems for mental health diagnosis (DSM-IV; APA, 2004) groups EDs into three main types: anorexia nervosa (AN), bulimia nervosa (BN) and atypical eating disorders or eating disorders not otherwise specified (EDNOS).

The term 'anorexia nervosa' is of Greek origin, which translates to a 'lack of desire to eat', and the first reported cases stem back to the nineteenth century. The word *bulimia* derives from the Greek *βουλῖμια* (*boulīmia*; ravenous hunger), a compound

of βους (bous), ox and λιμός (līmos), hunger, and is now understood as meaning an 'ox-like hunger'. Unlike AN, the history of BN is considerably shorter, with Gerald Russell publishing the first account of BN in 1979 (Russell, 1979). Like anorexia, recent interest in the popular media has become considerable, with famous cases disclosing their own struggles with the condition, including Diana, Princess of Wales, Geri Halliwell and John Prescott. Eating Disorders Not Otherwise Specified (EDNOS) is defined within DSM-IV applying to individuals with clinically severe EDs, but that do not conform to the diagnostic criteria for either AN or BN. (The current DSM-IV and proposed disorder diagnostic categories are outlined in Appendix 1.1 at the end of this chapter.)

The common theme across these diagnoses are extreme concerns about shape and weight (described by Russell (1970) as a 'morbid fear of fatness'), a marked tendency to evaluate one's own self-worth by body shape and weight, and an extreme preoccupation to be 'thin'.

Additional diagnostic categories have also been proposed. These include Binge Eating Disorder (BED) (APA, 1994) where there is no compensatory behaviour for bingeing; Multi-Impulsive Bulimia (MI-BN) (Lacey and Mourelli, 1986) where eating disorder symptoms present alongside, and are interchangeable with a number of self-destructive behaviours; and Machismo Nervosa (Whitehead, 1994) where the preoccupation is not with thinness but with gaining muscle bulk.

A number of authors have argued that current classificatory systems are unsatisfactory. For example, difficulties in identifying fear of weight gain in non-European samples and lack of amenorrhoea in very low weight women (Cachelin and Maher, 1998) have brought two of the key diagnostic criteria for AN into question. Similarly frequency and duration of binges (one of the core criteria for diagnosing BN and BED) may have limited clinical utility in predicting outcome or distress and so may need to be re-evaluated with regard to their role in diagnosis (Franko *et al.*, 2004).

Eating disorders diagnoses are likely to be relatively fluid over time. It is reported that 25–33% of those with BN have a history of AN (Braun, Sunday and Halami, 1994), whilst 54% of women with AN are likely to develop BN over a 15.5-year period (Bulik *et al.*, 1997). Despite the limitations of the current classificatory systems it would appear that the overarching category of 'eating disorder' does remain relatively stable over time, regardless of the initial, more specific, diagnosis (Milos *et al.*, 2005).

THE DISTRIBUTION AND COURSE OF EATING DISORDERS

People with EDs often do not disclose their symptoms to others and, as a consequence, it is difficult to ascertain their exact prevalence. This secretive nature of EDs is often due to the ego-syntonic nature of thinness within AN (Serpell *et al.*, 1999) and the shame associated with BN (Hayaki, Friedman and Brownell, 2002). However, despite these difficulties there is evidence that the occurrence of EDs has increased over recent years (Willi, Giacometti and Limacher, 1990; Turnbull *et al.*, 1996).

Polivy and Herman (2002) estimated that the incidence of EDs range from 3 to 10% of females aged 15–29 years, with the incidence of AN and BN ranging from 0.3 to 0.9% and 1 to 1.5%, respectively, among Western European and American young women (Hoek and van Hoeken, 2003; Hudson *et al.*, 2007). The increase in incidence rates may be, in part, due to better diagnostic practices, better detection and increased help-seeking behaviours, especially in AN (van Hoeken and Lucas, 1998). As de Beer

points out later in this volume (Chapter 27), relatively little is known about the prevalence and incidence of EDs in men, although it is generally thought to be much lower than that in women.

In terms of EDNOS, recent research has suggested that there is a prevalence rate of 2.4% (Machado *et al.*, 2007). Estimates suggest that between 20% and 60% of those seeking treatment will be diagnosed as EDNOS (Anderson, Bowers and Watson, 2001; Turner and Bryant-Waugh, 2004). Up to 50% of these clients go on to develop AN or BN over a four-year period (Herzog, Hopkins and Burns, 1993). This can present challenges to treatment services that have developed AN or BN specific care pathways. NICE (2004) implicitly recognizes this, when it suggests that clients with EDNOS should be offered treatment for the presentation that most closely matches an AN or BN diagnosis. It is important to note that the levels of psychosocial distress and the impact on psychosocial functioning associated with EDNOS appear to be as severe as that found in clients with AN or BN (Herzog and Delinsky, 2001). For a more detailed discussion of the challenges that EDNOS presents see Norring and Palmer (2005).

The course and outcome of EDs is extremely variable and appears to involve the complex interplay of a number of factors that dictate the nature of the course of the ED. Steinhausen (2002) argued that the age of onset, duration of illness, severity of weight loss and development of bingeing and vomiting appear to lead to a poor prognosis in AN. It also appears that for 10–20% of cases, AN becomes unremitting and intractable (Sullivan *et al.*, 1998), with 50% of the cases developing into BN (Bulik *et al.*, 1997).

For BN, the course is slightly different. Individuals with a history of AN often develop BN (Fichter and Quadflieg, 2007). Whilst for those without a history of AN, BN often starts later in life than AN. Here, BN frequently starts via dietary restriction which then descends into a vicious cycle of bingeing and vomiting with no associated weight loss (Fairburn, Cooper and Cooper, 2000). Prognosis for untreated BN is poor, as up to 50% of individuals meeting criteria for BN will continue to meet diagnostic criteria for an ED (normally EDNOS) 5–10 years after initial onset (Collings and King, 1994; Keel *et al.*, 1999). Similarly, atypical eating disorders have also been shown to have a poor prognosis, and they often develop into AN or BN (Herzog *et al.*, 1993).

Agras *et al.* (2009) in a four-year prospective study of 385 participants meeting DSM-IV criteria for AN, BN, BED and EDNOS at three sites, found that remission rates for clients with EDNOS and BED were similar and had the shortest times to remission, with BN having the longest time to remission followed by AN. At four-year follow-up 78% of the EDNOS group were remitted compared with 82% of the BED group, 47% of the BN group, and 57% of the AN group. Retrospective review of past ED diagnoses for the EDNOS group found that 78% of the EDNOS group had a past full ED diagnosis. Over the duration of the study 27% of this group developed either AN or BN, 14% continued as EDNOS, and 59% recovered without developing another ED diagnosis. Only 18% finished the study with no other ED diagnosis.

Mortality rates directly attributable to eating disorder diagnosis vary between diagnostic groups, and also appear to have been improving over time. Anorexia nervosa has been seen as having the highest mortality rate of all the psychiatric disorders, with 5–8% dying from conditions directly relating to their AN (Herzog *et al.*, 2000; Steinhausen, Seidel and Metzke, 2000). In a more recent literature review of 24 randomized controlled studies, Keel and Brown (2010) found crude mortality rates of 0–8%, and a cumulative mortality rate of 2.8% for AN, 0–2% and 0.4%

for BN, 0–3% and 0.5% for BED, with no deaths reported in the limited number of EDNOS clients without BED.

Keel and Brown (2010) also noted that there are relatively few reliable indicators of eating disorder outcome. In AN the longer the duration of illness prior to treatment or the need for inpatient admission predict relatively poor outcome; whilst relapse predictors include the client's desire for a lower body weight and treatment in general rather than specialist eating disorder services. Psychiatric co-morbidity and general psychiatric symptom severity, Avoidant Personality Disorder, and a family history of alcohol abuse appear to predict a poorer outcome in BN. Relapse predictors in BN are poor motivation to engage in treatment and inpatient admission.

A number of predictors of poor outcome have been reported in BED; however none have been replicated across studies. The main prognostic indicators in EDNOS have been low BMI, previous diagnosis of AN, and lack of close friends. Keel and Brown (2010) conclude that prognostic indicators for AN appear to be closely related to duration and severity of illness, in BN they are related to severity of co-morbid syndromes, and in BED and BN appear to be more related to greater interpersonal problems.

SUMMARY

Although there are debates about specific eating disorder diagnosis, the diagnosis of 'eating disorder' does appear to reflect the difficulties of a substantial minority of people in relation to issues of size, shape, weight, eating and 'eating-disordered' behaviours (such as purging). There appear to be significant similarities between diagnostic groups, and often people will cross over between diagnoses over time, either on their way to another eating-disordered presentation, or toward recovery. The good news is that mortality related to an eating-disordered diagnosis does appear to be falling. This is likely to be the result of better detection, assessment and treatment.

CLINICAL ASSESSMENT OF EATING DISORDERS

In the first section of this volume we have collected the perspectives of a number of authors outlining the components of a comprehensive assessment for a person with an ED. NICE (2005) recommends that clinical assessment of EDs should be multidisciplinary, and cover psychosocial and physiological assessment.

Chapter 3 by Goss *et al.* outlines the functions of psychological assessment in EDs, how the client's stance influences the assessment process, the use of clinical interview and self-report questionnaires and integrating psychological assessment with other assessments. Andrews (Chapter 2) notes that psychiatric co-morbidity is common and clinical risk relatively high in eating-disordered populations. She outlines how the mental state examination can be used during the assessment process and how this can help to identify these factors. In Chapter 4, Glover and Sharma focus on the assessment and management of physiological complications in the ED. They also address how these physiological complications can be managed, in 'routine' and 'high risk' eating disorder populations, including those with severely low weight, a diagnosis of diabetes, and in pregnant women.

Many clients with an eating disorder function with very little impact on their everyday lives. However, as Morris's chapter (Chapter 5) explores, difficulties in daily living can affect a significant minority of eating-disordered clients. She argues that a comprehensive assessment should also include the social and occupational aspects of the person's life. And identifies ways in which difficulties in these can be assessed and treated to improve the person's quality of life.

Perhaps the most challenging aspect of working with people with an ED is ambivalence or reluctance of many clients to engage in appropriate treatment. In Chapter 6, Kitson provides a helpful way of making sense of motivation to change, and how it may be enhanced when working with people with an ED.

The final two chapters of this section explore both the ethical and legal dilemmas faced by clinicians and the perspectives of the sufferer and the carer. Clinicians are often faced with a client who has high risk of medical or psychiatric complications of their ED, but remains unmotivated to address them. Giordano provides a very helpful introduction to these issues, and guides us through the complexities of the Mental Health Act, whilst exploring the ethical challenges that are likely to confront clinicians working in the area on a regular basis. Likewise, Tierney addresses the challenges of working with this client group from the perspective of the client and the carer. This is a very useful chapter for the clinician as it offers the all important insight into the world of the sufferer, whilst offering suggestions for overcoming these challenges.

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APPENDIX 1.1 CURRENT AND PROPOSED EATING DISORDER DIAGNOSES

DSM-IV Criteria for Anorexia Nervosa

The main diagnostic features of Anorexia Nervosa are that weight is below 85% of what would be normally expected for age and height of the individual. This is often operationalized as a body mass index (BMI) of 17.5 or below. Also, there is a significant and intense fear of weight gain and becoming ‘fat’, even when the individual is technically underweight. There is often significant disturbance in how the individual sees their own weight or shape, such as a complete denial of how underweight they actually are. Although this is likely to change in DSM-V, amenorrhoea (i.e. the absence of three consecutive periods) is a diagnostic feature of anorexia nervosa.

Diagnosis for anorexia nervosa often falls into one of two types:

- *Restricting:* There is a lack of either binge-eating or purging behaviour (e.g. vomiting, laxatives abuse or diuretics).
- *Binge/Purge:* There is regular engagement in binge-eating or purging behaviour (e.g. vomiting, laxatives).

DSM-IV Criteria for Bulimia Nervosa

In order to fulfil DSM-IV criteria for bulimia nervosa, there has to have been binge-eating and inappropriate compensatory behaviours at least twice a week for at least three months. A binge is defined as an episode of eating where an amount of food is definitely larger than what most people would eat in a discrete period of time (e.g. a two-hour period). Moreover, there has to be a perception that there is a complete lack of control over eating (e.g. a sense that one is not able to stop eating). Inappropriate compensatory behaviours are defined as behaviours that are used to prevent weight gain (e.g. vomiting, laxative abuse, diuretics, etc.). Finally, a diagnosis of bulimia nervosa requires that self-evaluation is either entirely or overly influenced by body weight and shape and these symptoms do not occur within an episode of anorexia nervosa (e.g. body weight is not below BMI 17.5).

DSM-IV Criteria for Eating Disorder Not Otherwise Specified (EDNOS)

The diagnosis of EDNOS is a ‘catch all’ diagnosis for the remaining people who have marked difficulties with their eating, but do not fulfil criteria for the other formal eating disorders (please see above). Examples could include:

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- 1 All the criteria for anorexia nervosa are met apart from:
 - the lack of amenorrhoea (for females);
 - despite significant weight loss, an individual's weight is still within normal range.
- 2 All the criteria for bulimia nervosa are met apart from:
 - the frequency of binge eating is not sufficient to meet diagnostic cut-offs;
 - binges are not of a sufficient size to be discernibly larger than normal amounts of food (e.g. vomiting after eating two apples).
- 3 Repeatedly chewing and spitting out, but not swallowing, large amounts of food.