Eating disorders: A 25-year perspective

Arnold Andersen, John Foreyt, Margo Maine & Leigh Cohn

To cite this article: Arnold Andersen, John Foreyt, Margo Maine & Leigh Cohn (2017) Eating disorders: A 25-year perspective, Eating Disorders, 25:5, 436-447, DOI: 10.1080/10640266.2017.1368874

To link to this article: http://dx.doi.org/10.1080/10640266.2017.1368874

Published online: 06 Nov 2017.

Submit your article to this journal

Article views: 1

View related articles

View Crossmark data
THE LAST WORD

Eating disorders: A 25-year perspective

Arnold Andersen⁹, John Foreyt¹⁰, Margo Maine¹¹, and Leigh Cohn¹²

⁹Professor Emeritus, University of Iowa, Carver College of Medicine, Iowa City, IA, USA; ¹⁰Director, Behavioral Medicine Research Center at Baylor College of Medicine, Houston, TX, USA; ¹¹Private Practice, Maine & Weinstein, West Hartford, CT, USA; ¹²Publisher, Gurze Books, Carlsbad, CA, USA

ABSTRACT
I founded Eating Disorders: The Journal of Treatment & Prevention 25 years ago, and its character, reputation, and success are highly attributable to Arnold Andersen, John Foreyt, and Margo Maine, the three original senior editors, whose perspectives follow in this article. Having made the decision to retire from the journal, I asked the senior editors to transition to the emeritus board along with me, which I explain further in my own Last Word, “Goodbye, Eating Disorders,” in this volume (Cohn, 2017). Over our 25 years of collaboration, the senior editors have acquired unique insights into the evolution of the eating disorders field; so, I asked them to contribute retrospective essays in which they also look forward within their primary areas of expertise—presented here in alphabetical order.

– Leigh Cohn, Editor-in-Chief

Cheers

Arnold E. Andersen, MD.

Cheers is a good title for this short piece, wrapping up in one word: greetings, farewell, thank you, and here’s to your health. So, cheers to Leigh Cohn for his vision of creating a clinician-oriented journal that has evolved with the field of eating disorders and obesity to become a premier publication. Leigh has been unfailingly encouraging to contributors and the editorial board. His editing clarifies, sharpens, and focuses manuscripts, bringing sparkle and luminosity. As a person Leigh is a man of integrity, intelligence, and warmth, moving on to becoming an artist of distinction.

Some people know from the third grade what career they will choose. As a first generation American, facing the bracing openness of endless opportunity without a guiding tradition, I only gradually found direction within medicine, then the field of psychiatry and more specifically eating disorders. In my third year of medical school, an Oxbridge style tutorial with Paul McHugh (then Professor of Psychiatry at Cornell before later being appointed Chair of Johns Hopkins...
Department of Psychiatry) opened up the brain–mind connections within psychiatry, with a focus on the limbic system’s role in motivated behaviors, especially eating and hunger, and their links to emotions. Research on the neurobiology of eating disorders, led by Dr. McHugh and colleagues, was just opening up the field, preparing me for later, unforeseen but seminal, events. After an intense interval of medical internship and a year of psychiatry residency, off I went to fulfill my service obligation at the National Institute of Health (NIH) at the height of the Vietnam War. At NIH, I provided the clinical arm of a research study on the neuroendocrinology of starvation, a welcome relief to the tedium of basic research on rat models of phenylketonuria in development. I diagnosed these patients to be suffering from anorexia nervosa, a field then considered to be an academic backwater (1970–1975) except for the work of a few Brits (Gerald Russell and Arthur Crisp) and an American (Hilde Bruch). Moving on to a final residency year and a faculty position at Johns Hopkins, I was invited to begin what I believe was the first inpatient program for eating disorders. Personal mentoring in London by Professor Gerald Russell cemented my interest in eating disorders and gave me confidence that this area held promise for a budding physician-scholar to establish his academic creds.

In the 1980s, progress and successes in the field came quickly and in giant steps: At Johns Hopkins, inpatient referrals and the development of a treatment team grew apace; Professor Russell first described bulimia nervosa as an ominous variant of anorexia nervosa; cognitive behavioral therapy (CBT), originally designed as a treatment for non-psychotic depression, was quickly applied and found effective for eating disorders, especially bulimia nervosa; and interest in eating disorders exploded with the media coverage of singer Karen Carpenter’s death from anorexia nervosa in 1983. Her wistful, haunting songs (“Close to You” and “We’ve Only Just Begun”) never fail to evoke a visual image of this starving, cachectic, talented artist, considered by her family to be a lesser light than her brother.

In the years that followed: the Academy for Eating Disorders was founded; binge eating disorder, a gender-neutral eating disorder, was described (though only found official recognition in the DSM-5 in 2013); my interest in males with eating disorders increased largely due to unsolicited referrals of confusing cases; eating disorders were recognized as a global public health concern; research in every aspect of eating disorders expanded rapidly (treatment, genetics, brain imaging, medical, sociocultural, gender, history, classification, phenomenology, family, etiology, sports etc.); preventive interventions were launched in schools; medical complications of eating disorders were increasingly described; recognition that eating disorders have a substantial genetic contribution brought some consolation to parents; mortality decreased; electronic media extend the work of diagnosis, treatment, and follow-up; and the first endowed chair for research in eating disorders was established at Johns Hopkins. Eating Disorders: The Journal of
Treatment and Prevention (EDJTP) documented these developments as they occurred.

Unfortunately, some areas of failure brought discouragement: A subspecialty board certification for eating disorders has not been established in psychiatry or psychology. Health plans need to increase funding for mental health diagnoses, especially carve-outs for eating disorders. Currently, there is a “revolving door” of premature discharges followed by re-admissions due to lack of healthcare coverage. A lack of interest in diagnosing and treating the medical symptoms of eating disordered patients persists among internists and family practitioners (“it’s psychiatric”). Males with eating disorders continue to be marginalized. Sociocultural pressure for extreme thinness in girls and women has not significantly decreased. Males have been increasingly objectified in media. Global obesity has become as common as starvation. Despite a mandate for CBT as the first line of treatment for bulimia nervosa by N.I.C.E. in the United Kingdom, clinicians are not adequately trained in CBT.

There are also areas of frustration and challenge without being failures: awareness of the complexity of the genetics of eating disorders; recognition of the unpredictable variability of brain changes due to eating disorders; debate regarding whether primary prevention and early “inoculation” in children is possible; conflicting evidence about neurotransmitter predisposition to eating disorders; uncertainty about animal models; stumbling blocks exist that make global prevention of obesity and eating disorders doubtful; how to mandate adequate funding by healthcare plans for eating disorders as a major combined physical and mental disorder; and strategies to increase societal acceptance of body size and shape independent of weight.

May I offer some verbs to early career clinicians/researchers as well as students with a potential interest in eating disorders: Practice! Teach! Research! Advocate! Approach your practice recognizing that every person with a disorder is interesting and challenging, not only the exciting, exceptional cases. This is a multifaceted field for several reasons. Eating disorders involve treatment of just about every other diagnosis in psychiatry and psychology—you treat anxiety, depression, personality, brain and mind alterations, substance abuse, OCD, PTSD, all while keeping familiar and cultural factors in mind. Nevertheless, eating disorders still have a high potential for enduring remission/cure. I urge you non-medical clinicians to understand the brain changes involved in eating disorders; and, for medically trained clinicians to recognize that an integrative, team care approach is necessary, effective, and satisfying (psychiatrists, avoid a medication-only practice!). In the field of eating disorders we are offered the challenge and realistic potential for restoring individuals to a humane life of physical, psychological, and social integrity, as well as urging society to diminish bias regarding weight and shape.

* * *
Binge eating disorder and obesity: Still a conundrum

John P. Foreyt

Writing my dissertation in 1968 on the treatment of obesity I read and relied heavily on Dr. Hilde Bruch’s seminal book, *The Importance of Overweight* (Bruch, 1957). Moving to Baylor College of Medicine in 1974, I was thrilled to see Dr. Bruch was a professor in the Department of Psychiatry there. She was medicine’s preeminent scholar in conceptualization and treatment of eating disorders and obesity; and I—along with her colleagues and students—basked in her knowledge and incredible insights in grand rounds, lectures, mentoring, and publications. When Kelly Brownell and I were putting together the *Handbook of Eating Disorders: Physiology, Psychology, and Treatment of Obesity, Anorexia, and Bulimia* (Brownell & Foreyt, 1986), I asked Dr. Bruch if she would write the foreword and also contribute a chapter on “Anorexia Nervosa: The Therapeutic Task.” She graciously agreed to do so. The chapter we published in memoriam was an unfinished draft she was working on for the book when she died on December 15, 1984. Dr. Albert J. Stunkard, the world’s preeminent pioneer in the field of obesity, who recently passed away, kindly wrote the foreword in her place, which he titled *A Tribute to Hilde Bruch*, acknowledging that more than anyone else Hilde Bruch was responsible for creating the field of eating disorders. Both Dr. Bruch and Dr. Stunkard have been my role models. Both have taught me that obesity and eating disorders are complex disorders with much in common.

I met Leigh Cohn on a conference shuttle bus in the late 1980s and was later honored when he asked me to serve as a founding senior editor on his new journal. Leigh recognized that it was important to the journal to include areas of overlap between the traditional eating disorders, anorexia and bulimia, and obesity, including disordered eating patterns, night eating, weight management, body image, self-esteem, quality of life, and related issues. At the time, I was especially interested in the role of binge eating, so I welcomed the responsibility of being the journal’s resident expert on such matters.

In the 1990s, my team conducted an 18-month prospective randomized controlled study comparing a standardized behavioral intervention for weight loss to a non-dieting approach and a control group in 219 overweight women who scored high on the Binge Eating Scale (Goodrick, Poston, Kimball, Reeves, & Foreyt, 1998). We found that both the behavioral intervention and the non-dieting approach led to significant reductions in binge eating at 6 months and maintenance of those reductions at 18 months compared to the control group, but neither intervention was successful in
producing either short- or long-term weight loss. The study was one example of the early stages of research examining the role of binge eating in the context of overweight. *Eating Disorders* was among the first to publish papers focusing on binge eating and body weight from both a research and clinical perspective and highlighting chronic binge eating as a potential eating disorder.

Over the past two decades, recurrent binge eating behavior has evolved from an “Eating Disorder Not Otherwise Specified” in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* to its own classification as an eating disorder in DSM-5 (American Psychiatric Association, 2013). Binge eating disorder (BED) is characterized by 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, along with 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). Other criteria include eating much more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not feeling physically hungry; eating alone because of feeling embarrassed by how much one is eating; and feeling disgusted with oneself, depressed, or very guilty afterward. Additional criteria include a feeling of marked distress regarding binge eating, the binge occurring, on average, at least once a week for 3 months, and the binge is not associated with inappropriate compensatory behavior (as in bulimia) (American Psychiatric Association, 2013). There have been more than 1000 research papers published supporting BED’s validity and consistency. Today, BED is the most common eating disorder in the United States with a lifetime prevalence of 3.5% of women and 2.0% of men (Hudson, Hiripi, Pope, & Kessler, 2007).

Obesity was declared a disease by the American Medical Association in 2013. Today 37.7% of adults in the United States are obese (Flegal, Kruszon-Moran, Carroll, Fryar, & Ogden, 2016). More than 30% of individuals seeking treatment for weight loss can be diagnosed with BED (Westerburg & Waitz, 2013). Although the prevalence of BED is much higher than that of anorexia nervosa and bulimia nervosa, there is less research on BED in comparison to other eating disorders. Interventions have included psychotherapy, CBT, self-help treatments, weight loss treatments, pharmacotherapy, and combinations of these and other treatments. A recent comprehensive systematic review and meta-analysis of randomized controlled trials of BED concluded that CBT resulted in significantly greater abstinence from binge eating at post-treatment than wait-list control. The drug lisdexamfetamine, the only approved drug by the Food and Drug Administration in the United States specifically for the treatment of binge eating, also was superior in producing greater abstinence than placebo.
Antidepressants were superior to placebo in producing abstinence at post treatment, along with reductions in binge-eating episodes, eating disorder psychopathology, and depression, but not necessarily with weight loss (Brownley, Berkman, & Peat et al., 2016).

The most effective behavioral weight loss treatment for obesity is an in-person, high-intensity (i.e., 14 or more sessions in 6 months), comprehensive intervention including a moderately reduced caloric diet, increased physical activity, and behavior therapy provided in individual or group sessions by trained interventionists (Jensen, Ryan, & Donato et al., 2014). For example, the Look AHEAD study was a long-term multicenter randomized clinical trial evaluating health effects of lifestyle intervention including diet, physical activity, and behavior therapy designed to produce weight loss compared to controls in 5137 obese individuals with type 2 diabetes (Look AHEAD Research Group, 2013). Weight loss was significantly greater in the lifestyle group compared to controls over a 10-year period, along with a number of additional beneficial changes in health, fitness, and reduction in cardiovascular risk. The trial is continuing as an observational study to further assess the effects of weight loss on overall mortality, healthcare costs, frailty, diabetic microvascular complications, quality of life, and other outcomes. The Look AHEAD trial is an example of state-of-the-science, effective lifestyle long-term weight loss, and maintenance intervention.

Interventions for treating individuals suffering with both BED and obesity have not been so successful (Palavras, Hay, Dos Santos Filho, & Claudino, 2017). Treatments for BED have reduced binge eating, but generally have not led to significant, sustained weight loss. Munsch et al. (2007) reported a randomized comparative trial consisting of 16 weekly treatments and 6 monthly follow-up sessions comparing the efficacy of CBT to behavioral weight loss treatment (BWLT) in 80 obese individuals with BED. Results showed significant improvement in binge eating with results favoring CBT at post-treatment, but no significant differences between treatments at 12-month follow-up. A commendable 6-year follow-up showed “a considerable worsening” of outcomes over time but still some improvement relative to baseline values with CBT and BWLT outcomes comparable (Munsch, Meyer, & Beidert, 2012, p. 783). Interestingly, the only characteristic predictive of favorable treatment outcome in the long term was individuals’ rapid response during the early treatment phase. The authors concluded that individuals not responding strongly during the first four sessions might be in need of more tailored interventions early in treatment. These results mirror findings in the obesity literature. Early responders significantly predict long-term favorable outcomes. Whatever the intervention, individuals who respond favorably early in treatment tend to show better outcomes at both post-treatment and follow-up. Those who do not respond early generally require a different approach.
What to treat first? As clinicians, faced with patients suffering from BED and obesity, do we treat these diseases sequentially or together? Patients seeking help for BED frequently report feelings of anxiety, distress, depression, loneliness, worry about body shape and size, poor self-esteem, and other negative affective states. Likewise, patients with obesity frequently report similar feelings. The causes of both diseases are multifactorial and idiosyncratic. CBT, with its focus on changing negative thoughts, feelings, and behaviors, seems to be a reasonable first-line, lifestyle intervention. Treating these psychological symptoms leading to improved self-esteem and self-acceptance is likely to result in beneficial lifestyle changes and improvements in health and well-being. For those not responding favorably early in treatment to CBT, clinicians should consider alternate interventions.

Dr. Bruch and Dr. Stunkard were both innovative pioneers and compassionate, masterful clinicians who revolutionized how we think about eating disorders and obesity. The focus of Eating Disorders has been similar. In the future, I am confident that the journal will carry on Leigh’s legacy, publishing not only scientific, rigorously reviewed papers but also opinions, observations, and clinical pearls that will continue to influence how we think about these crippling diseases. I am so proud to have worked with Leigh and his outstanding editorial board for the past quarter century.

* * *

Still bridging the gaps after all these years

Margo Maine, PhD, FAED, CEDS

At 25 years of publication, EDJTP is moving into young adulthood, with an impressive track record and significant contributions to the field. Having been involved since its inception, I continue to experience strong visceral memories of the energy—and the tensions—in the eating disorders field that led to the birth of this journal. I remember the International Conference on Eating Disorders meetings in the late 1980s and early 1990s, always patiently waiting for attention to be paid to the actual treatment process and to gender. During those years, men dominated the podium, while most female clinicians were relegated to passivity in the audience. Although I certainly learned scholarly information, it rarely translated into how I might help my patients or what I could do to prevent the development of an eating disorder in the first place. My experience was living proof of the massive gaps in our field, with the gaps between research and practice, and the gender gap, being most prominent. How could the vast majority of our patients be women, and yet gender was rarely discussed? How could men do the talking, to the almost complete exclusion of women? Why was the F-word (feminism) never mentioned? These things made no logical sense to me but also they simply felt wrong—at a deep, gut level.
Still, every two years, hundreds of female clinicians loyally attended ICED, eager to learn how to best conceptualize and treat these disorders. We often left with full heads but empty hearts. We learned facts, but did not necessarily get information about how to better treat eating disorders or manage the relational experience of being a therapist. Looking back, it is easy to see that we were in a parallel process with our patients for whom insight or knowledge alone is never enough to stop an eating disorder from progressing. At the time, my patience was fading and some of us were getting angry. As the culture imposed increasingly difficult demands on women, idealizing their bodies while simultaneously devaluing them, our frustration and fear about the ongoing increase in eating disorders and the threat to women’s health were palpable.

At typical conferences, the most exciting and dynamic ideas are heard in casual conversations—they rarely emanate from the podium. That certainly was the case in the early days of the eating disorder field. During those years, informal interchanges were intense—simultaneously heated and hushed. Again, I remember the energy at a visceral level, and talking at length with Leigh Cohn at an ICED about these undercurrents. Quick to integrate and reflect on the many threads, he began a set of conversations about a new journal to move our field forward. The title, EDJTP, was carefully crafted, reflecting the deep desire of the founding voices to devote significant attention to both treatment and prevention; and its goal was to include feminist perspectives, and to consider the international and cross-cultural manifestations of eating disorders.

From the start, EDJTP began bridging some of the gaps in our field. In total synchrony, our first Letter to the Editor (Gordon 1993) was from the highly esteemed, Richard Gordon, PhD, whose work on the sociocultural contributions to eating disorders has stimulated much thought and examination of the complex underpinnings of these issues. He articulated the need for “a forum in which issues such as dieting and exercise, the transformation in the female role and the contemporary female experience, and practical and social problems associated with weight and body shape can be focally addressed.” EDJTP stepped up to that task with our first edition by including topics such as: the sociocultural roots of contemporary body image in a consumer culture, clinical issues raised during a therapist’s pregnancy, social desirability, and “emotional eating,” bulimia nervosa in college communities, family risk factors for bulimia, the impact of ads for diet products on the incidence of eating disorders, and eating disorders in athletes. These topics were just becoming visible in professional conversations and conference presentations—EDJTP gave space and voice to their critical and nuanced examination.

As EDJTP has evolved, so has our field. I chose “evolved” rather than “matured” because I want us to be constantly innovating and incorporating
new perspectives and approaches. Mature sounds stagnant, something we can never be if we are to meet the challenge of addressing these insidious culture-bound illnesses. *EDJTP* is dedicated to alleviating the suffering of ED’s through treatment, and reducing the number of people affected through prevention. We can only achieve this through diligent and intentional openness, similar to what the Buddhist tradition calls a beginner’s mind. To date, and as we move forward, the words of Jon Kabat-Zin provide guidance, “In the beginner’s mind there are many possibilities, but in the expert’s mind there are few. (2005).” We must be both experts and leaders in the field, but totally open to learning and to the “many possibilities,” not just what is already known.

The eating disorders community has much to accomplish as we move forward. As culture-bound biopsychosocial conditions, eating disorders cannot be understood separately from the complex and multidimensional contexts in which they emerge. This requires that we abandon the traditional individual change model and its sole focus on the person we are treating. Instead, we must help those suffering to contextualize their disorder, and to understand that their experiences of objectification and the pressures surrounding weight, shape, gender, and appearance are actually examples of oppression. Eating disorders are not character flaws or just individual realities—instead, they are the toxic results of a diseased culture. And we must continue to foster a critical perspective of media images, especially for women, encouraging them to reject these messages or at least limit exposure to them and try to resist their impact. For those who have experienced trauma, sexual harassment, or any other form of discrimination, this approach will hopefully minimize internalization or self-blame related to those experiences. This biopsychosocial model broadens the lens to one of social justice, recognizes the cultural structures fostering body image despair, dangerous dieting, and impaired interoceptive awareness that lead to eating disorders, and empowers all who suffer from eating disorders.

*EDJTP* has shed light on many previously ignored and emerging issues, including male eating disorders and their unique body image issues, as well as how feminist principles may be useful in both conceptualizing and treating them (Maine & Bunnell, 2008). As we move forward, we must pay attention to other marginalized groups including adult and older women and racial and ethnic minorities, who are often not diagnosed or referred for treatment simply due to outdated beliefs about who gets eating disorders. In the past 25 years, western consumer culture and values have spread like wildfire. Today eating disorders are truly globalized, appearing on every continent, including Arab and Asian nations (Pike, Hoek, & Dunne, 2014), challenging our field to “know what we don’t know,” and to use our beginner’s mind to develop cultural awareness and sensitivity so we can best understand, intervene, and prevent them.

The little we know about eating disorders in the LGBTQI community presents another serious gap to the field. Compared to heterosexual peers, gay, lesbian, or
bisexual males and females report elevated rates of binge eating and purging by vomiting or laxative abuse. Based on self-report, transgender youth are four times more likely to have an eating disorder and elevated rates of compensatory behaviors compared to any cisgender group (Diemer et al., 2015). These newly recognized trends compel us to challenge the cultural issues surrounding gender, power, food, and weight, and to transform the many toxic environmental influences that create the contemporary weight centric and appearance-driven cultural obsessions.

In these past 25 years as EDJTP educated professionals across the globe about eating disorders, we have also seen a growing level of activism and advocacy. Organizations like the Academy for Eating Disorders (AED), Binge Eating Disorder Association (BEDA), Eating Disorders Coalition for Research, Policy and Action (EDC), International Association of Eating Disorder Professionals (IAEDP), and the National Eating Disorders Association (NEDA) have worked both separately and collaboratively to educate legislators, policymakers, and both public and professional audiences. Our tireless advocates range from family members and sufferers to researchers, clinicians, educators, and other concerned professionals. Finally, we saw some true progress in 2016 with the United States Congress passing the landmark 21st Century Cures Act, which includes language specific to the needs of the eating disorder community for the first time. As a journal that sheds light on a myriad of issues, including factors that contribute to and sustain eating disorders, treatment needs, research gaps, and the efficacy of prevention and outreach programs, EDJTP has enriched these efforts.

Twenty-five years ago, I assumed the role of a senior editor to the brand new EDJTP as a feminist psychologist specializing in eating disorders, committed to telling the truth and creating change in our field. I leave this position with the same feelings and commitments. I wrote The Last Word in the first issue of EDJTP, focusing on the need to empower women and transform our culture so eating disorders will no longer thrive. Today we need to expand our focus to include children, men, and women of all ages, all gender identities, and all cultures, ethnicities, races, and places. Eating disorders are now a global public health problem. The time has come for a globalized feminist approach to transform the toxic cultural messages and economic structures profiting from the despair about our bodies. We must stop blaming and pathologizing those that suffer with eating disorders. May EDJTP continue to shed light on the complexity of eating disorders, and help to deconstruct the environmental and systemic forces that foster them.
References


