Abstract

In the last several decades, research on the eating disorders has yielded important new knowledge, especially regarding the clinical characteristics and the treatment of individuals with Bulimia Nervosa. Challenging issues now confronting the field include how the eating disorders should be categorized, what factors underlie their development and persistence, and how they are best treated. New efforts based on the analysis of genetic factors, on the use of brain imaging and on the detailed analysis of behavioral disturbances hold promise for significantly advancing our understanding of these disorders in the next decade.

Keywords: Binge; Brain imaging; Genetics; Feeding; Nosology

Introduction

Research on the eating disorders in the last several decades has yielded significant progress in defining, understanding and treating eating disorders but also has failed to make inroads on some enduring and serious problems. This brief review will describe some thoughts about the future of eating disorders research in the next decade.

Nosology

Definitions of what constitutes an eating disorder, and of specific diagnostic categories, play a pivotal role in directing research. Clinical studies focus, almost exclusively, on individuals who meet accepted criteria for eating disorders. Therefore, changes in nosology may have a major impact on research directions and findings, and research in this arena remains active and important (Williamson et al., 2002).

Anorexia nervosa. Currently, two eating disorders, Anorexia Nervosa and Bulimia Nervosa, are defined in the DSM-IV and generally well accepted by clinical researchers. The core features of Anorexia Nervosa, a relentless pursuit of thinness leading to an inappropriately low body weight, were clearly delineated in the late 19th century and are incorporated in the current diagnostic criteria. It is unlikely that major changes will occur in these criteria in the near future, but several provocative questions have begun to be raised.

Historically, amenorrhea has been a required diagnostic criterion for women, and is required by Criterion D in DSM-IV. However, several authors have described individuals meeting all other diagnostic criteria, including low body weight, who continue to menstruate (Cachelin & Maher, 1998; Garfinkel et al., 1996). A change in this diagnostic criterion might have the advantage for clinicians of including individuals with very similar behavioral characteristics and treatment needs, but add an element of physiological heterogeneity to research studies.

In the DSM-IV, two mutually exclusive subtypes of Anorexia Nervosa are described: the binge/purge type, to describe individuals who regularly engage in binge eating and/or purging behavior, and the restricting type, who do not engage in such behavior and maintain their low weights solely by dietary restriction and increased physical activity. Individuals with the binge eating/purging subtype are more likely to develop fluid and electrolyte disturbances and to
the latest proposed eating disorder, Binge Eating Disorder.
and how to distinguish non-purging Bulimia Nervosa from
include how best to define ‘excessive exercise’ and ‘fasting’
Unresolved questions concerning the non-purging type
subtypes for Bulimia Nervosa: the purging subtype, to
was the case for Anorexia Nervosa, DSM-IV proposed two
clinical implications of this subtyping, some
on the restricting subtype, hypothesizing that these individ-
possess relatively specific risk factors. Research in the next
developed. This development, and the similar phenomenon
promulgation of Bulimia Nervosa, via the use of inappropriate compensatory behavior, such as
self-induced vomiting. The description of bulimia in 1979
and its inclusion in the DSM-III in 1980 sparked the development of a substantial body of literature
regarding the characteristics of this disorder and its
treatment. This development, and the similar phenomenon
which followed the definition of Binge Eating Disorder in
DSM-IV, dramatically illustrate how changes in nosology impact on, and can spur, clinical research.

Although the definition of Bulimia Nervosa has not been
without controversy, it seems unlikely that there will be
major changes in the diagnostic criteria in the near future. As
the case for Anorexia Nervosa, DSM-IV proposed two
subtypes for Bulimia Nervosa: the purging subtype, to
describe individuals who regularly utilize purging methods
such as self-induced vomiting or laxative abuse, and the non-
purging subtype which described individuals who compensate for binge eating by excessive exercise or fasting.

Resolved questions concerning the non-purging type
include how best to define ‘excessive exercise’ and ‘fasting’
and how to distinguish non-purging Bulimia Nervosa from
the latest proposed eating disorder, Binge Eating Disorder.

Binge Eating Disorder. Binge eating among the obese
was clearly described in 1959 by Stunkard (Stunkard, 1959).
However, this behavioral phenomenon received relatively
little attention until discussions began in the 1990’s concerning DSM-IV. Prompted in part by the clinical and
research utility of the promulgation of Bulimia Nervosa,
investigators suggested a new diagnostic category be
included in DSM-IV to describe individuals who engage
in recurrent episodes of binge eating but who do not utilize
the inappropriate compensatory mechanisms characteristic
of Bulimia Nervosa. In the nosological arena, the greatest
issues to be addressed in the next years surround Binge
Eating Disorder.

While there are a number of important but relatively
minor issues, such as the criterion for binge frequency, the
major unresolved issue is the value of Binge Eating Disorder as a diagnostic category. When it was initially
proposed, preliminary evidence suggested that individuals
with Binge Eating Disorder, most of whom are obese in
clinical samples, did less well in standard weight control
programs than did similarly obese individuals without
Binge Eating Disorder (Walsh, 1992). More recent data,
while limited, do not appear to support this finding (Gladis
et al., 1998). On the other hand, with impressive
consistency, investigators have found that individuals with
Binge Eating Disorder differ from individuals without
Binge Eating Disorder in exhibiting more symptoms of
depression and anxiety, and in consuming more food
under identical conditions in structured laboratory settings
(Castonguay, Eldredge, & Agras, 1995; Goldfein, Walsh,
LaChausse, Kissileff, & Devlin, 1993; Yanovski, 1993;
Yanovski et al., 1992). And, there are indications of
differences in the functioning of the upper gastrointestinal
tract (Geliebter & Hashim, 2001). Thus, it can be stated with
confidence that there are significant differences between
otherwise similar individuals with and without Binge Eating
Disorder. However, the behavioral disturbances character-
istic of Binge Eating Disorder are less severe than those of
Anorexia Nervosa and Bulimia Nervosa, at least raising
questions about whether individuals currently included in
this category might be as well described as obese
individuals with significant mood and anxiety disturbances.
Critical questions about the natural course of Binge Eating
Disorder, its psychological and physical characteristics and
complications, and its response to treatment need to be
answered in order to resolve the current uncertainty
regarding the utility of the diagnosis.

Eating disorders not otherwise specified (EDNOS). A
provocative characteristic of the DSM-IV system is that
individuals with clinically significant disturbances of eating
behavior who do not meet DSM-IV criteria for Anorexia
Nervosa or Bulimia Nervosa are categorized nosologically
as have an Eating Disorder Not Otherwise Specified. This is
far from ideal, as a large number, perhaps a majority, of
individuals presenting for treatment of what they perceive to
be an eating disorder are classified, in the DSM-IV system
as having an EDNOS. For example, Binge Eating Disorder
is currently only a suggested category within EDNOS.
Hopefully, the next revision of the diagnostic system will
address this deficiency.

Treatment

Anorexia Nervosa. A major disappointment is that recent
research has yielded relatively little that is new and useful in
the treatment of Anorexia Nervosa. This oldest eating
disorder remains impressively resistant to a wide range of
interventions, and arguably has the highest death rate of any
psychiatric disorder. Despite their abnormally low body
weights, individuals with this disorder are irrationally
distressed by the prospect of weight gain, and typically
only reluctantly agree to treatment. No psychological or
pharmacological intervention has been identified which
dramatically and reliably alters this dysfunctional thinking.

Some recent developments are hopeful. There is evidence
suggesting that a structured form of family intervention may
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