Psychiatria Danubina, 2023; Vol. 35, Suppl. 2, pp 217-220
Conference paper

Review

EATING DISORDERS AND PSYCHIATRIC COMORBIDITY

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SUMMARY

Psychiatric comorbidity is present in more than 70% of people with an Eating Disorders (ED), before or during the acute state of illness or in the long-term course. These comorbidities include personality disorders (>53%), anxiety disorders (>50%), mood disorders (>40%) and substance abuse (>10%). This work aims to analyse the different treatments available for patients affected by eating disorders and other psychiatric comorbidity.

Key words: *eating disorders - psychiatric comorbidity - anorexia nervosa - bulimia nervosa - binge eating disorder*

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INRODUCTION

Eating disorders are disabling, deadly and costly mental disorders (Treasure et al. 2020) and they are increasingly present in the adolescent and youth population of industrialized countries (Juli et al. 2021). Individuals of all ages, genders, sexual orientations, ethnicities, and geographies can be affected considering that ED impair physical health and psychosocial functioning (Treasure et al. 2020). Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V) and International Classification of Disease (ICD-11) describe six Feeding and Eating Disorders. These include Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Binge Eating Disorder (BED) (WHO 2019).

ANOREXIA NERVOSA

Patients with AN are more associated with cluster personality disorders C and they are characterized by anxiety, perfectionism, rigidity, obsessiveness, orderliness, having everything under control, harm avoidance (Steiger et al. 2008).

Anxiety disorders are very common in AN, in particular specific phobias, separation anxiety disorders, social phobia in addition to obsessive compulsive disorder (Godart et al 2000).

Up to 60% of patients with AN are also affected by a Mood Disorder, indeed several studies found an association between weight loss and Depression (Swanson et al. 2011). These patients present symptoms like depressed mood, loss of interest or pleasure, lack of energy, disturbed sleep, changes in body weight, low self-esteem, suicidal ideation. Thus, there is a symptom overlap between the two disorders and therefore the clinician should always ask whether the depression is a pre-existing disorder or is a consequence of AN (Herpertz-Dahlmann 2009). In addition, some researchers consider AN a protective factor against substance abuse (Kaye 2013).

BULIMIA NERVOSA

Subjects affects by BN have greater affinity with cluster personality disorders B like impulsiveness, novelty-seeking, feeling of emptiness, affective lability (Steiger et al. 2008).

The 50% of individuals with BN suffered from some type of mood disorder, and 66% from some type of anxiety disorder like specific phobias, post-traumatic stress disorder and social phobia. The mood disorder can precede or follow the diagnosis of BN and it is present in many cases even after the remission of the ED. Depressive symptoms also result in increased severity of bulimic symptoms which improve with antidepressants (Vaz-Leal et al. 2014). Bad moods have been seen to precede binge eating episodes which may represent an attempt to reduce emotional distress (Dingemans et al. 2017).

BINGE EATING DISORDERS

Personality disorders in patients with BN or BED are superimposable but are less marked in the latter (Steiger et al. 2008). In subjects with BED, loss of control is predictive of higher weight gain and drug abuse (Sonneville et al. 2013). Emotion regulation strategies in individuals with binging are not healthy and effective and they play an important role in the onset and maintenance of BED (Dingemans et al. 2017).

TREATMENTS

In Italy there are different levels of care: general practitioner or paediatric, outpatient therapy, intensive outpatient or semi residential care, intensive residential

rehabilitation, ordinary and emergency hospitalizetions. It is of primary importance identify and treat comorbidities that can reinforce and maintain the eating disorder.

CARE PATHWAYS

First level: General practitioner or pediatrician

The role of the general practitioner and/or pediatrician is most important in the treatment of eating disorders. Mainly because risk factors that may lead to the actual onset of the disease can be intercepted. In addition, the areas of intervention can be different: primary prevention, screening, early diagnosis, identification of new cases, physical risk assessment, referral to specialist centers and treatment of mild cases and follow-up.

Second level: specialized outpatient therapy

The place of choice for eating disorders is the outpatient clinic for a number of aspects. First of all, the treatment does not interrupt the patient's daily life, and second because changes are achieved in the patient's usual environment. Patients with acute psychiatric conditions and major medical complications cannot be included in this kind of treatment. However, not all patients respond to outpatient treatment, in fact that place may serve as a filter for subsequent levels of treatment. In addition to the diagnostic phase, the outpatient level of care also performs the task of periodic follow-up for subjects with important risk factors. The outpatient clinic, allows direct contact with the population and promotes epidemiological research. It is generally estimated that the duration of treatment should be 12-24 months for anorexia nervosa and 6-12 months for bulimia.

Third level: intensive outpatient clinic or day center

The intensive outpatient clinic or day center, aims to accommodate patients who do not respond to conventional outpatient treatment. The center is equipped in addition to the multidisciplinary medical team (psychiatrist, psychologist, nutritionist, nurses, educators) also with rooms where meals can be taken so that assisted meals are guaranteed. Such treatment is indicated for patients who have difficulty changing their eating habits, the pathway can thus be indicated as a first form of treatment. The intensive outpatient pathway is not recommended for patients with moderate-severe physical risk conditions, continuous substance use, major depression and suicidal risk, and acute psychosis. Unlike day-hospital treatment, which aims to achieve maximum change in the specific pathology, intensive outpatient treatment is designed to address only specific barriers to standard outpatient treatment. Treatment can last up to 12 weeks.

Fourth level: Intensive inpatient rehabilitation unit

Intensive inpatient rehabilitation is to be followed in the specialized eating disorders ward and provides the patient with an integrated program of nutritional, physical, psychological and psychiatric rehabilitation. This intervention allows patients to have allowances of only when their medical conditions are stable. Intensive rehabilitation can be delivered on a day -hospital basis usually used in cases where there is severe comorbidity, the patient's quality of life is onerous, previous lower-intensity pathways have not provided the desired results, and the risk to the patient's health status tends to increase. Specifically, we might see one of these conditions: failure to respond to outpatient treatment, presence of physical risk, presence of psychiatric risk, psychosocial difficulties.

Some integrated treatments for binge eating disorder practiced in Italy

Targeted treatments for binge eating disorder are practiced in Italy, which integrate nutritional rehabilitation intervention with psychological intervention. We can distinguish: Psychobiological approach based on TFC, One Day Treatment and Cognitive Behavioral Therapy together with weight loss therapy based on lifestyle modification.

Psychobiological approach based on TFC

This approach integrates cognitive behavioral therapy and nutritional rehabilitation. The goal of nutritional treatment is to address with a cognitive behavioral psycho-educational methodology the eating behavior through direct and continuous knowledge and experimentation. The patient is supported in his or her journey, and he is guided in the difficulties concerning appetite control and weight control. This approach can be used in the different levels of care.

One Day Treatment

The One Day Treatment approach is an outpatient intervention and it is a complex and structured treatment involving group intake of patients diagnosed with binge eating. The program takes inspiration from the One Day a Week studied and applied in Belgium at the University Psychiatric Centre K.U. Leuven Camps Kortenberg: this approach permits to intervene in a limited period of time on eating psychopathology .The intervention is based on a group setting and taking charge by a multidisciplinary team. The day includes both nutritional and psychological group activities.

Cognitive behavioral therapy together with weight loss therapy based on lifestyle modification

It is an outpatient treatment designed to address both the psychopathological mechanisms that are underlying in maintaining binge eating and weight loss. The program is based on cognitive behavioral therapy and lasts for about 20 weeks. The treatment involves a basic program of five modules but additional modules may be associated with these especially in certain clinical conditions in which bulimic episodes are maintained or in patients in whom obesity or overweight coexist.

INTERVENTIONS DEDICATED TO THE FAMILY

Eating disorders are complex disorders with a long course. Since the age of onset of the disorder is in adolescence, it becomes necessary to accompany family members during the patient's recovery journey. Such intervention is also suggested by the main National and International guidelines that have evidence derived from clinical studies, such as Family Based Treatment (FBT- indicated for adolescents with anorexia nervosa) or Cognitive Behavioral Therapy for Eating Disorders (CBT-ED, indicated for adolescents and adults with anorexia nervosa, bulimia nervosa and Binge eating disorder).

The purpose of interventions aimed at parents and family members of both patients who are coping with the disease and those who have ended treatment because they are cured is not to abandon families to the despondency that this disorder entails. It is essential to provide parents and family members with the necessary information so that they can learn about and recognize the disease. Family members regardless of the level of treatment patients face should always be involved, whether they are minors or adults with prior consent.

CONCLUSIONS

Pharmacological treatments alone are not indicated, but rather as an adjuvant to psychological ones and nutritional rehabilitation or when exist a psychiatric comorbidity. Selective serotonin reuptake inhibitors (SSRI), serotonin and norepinephrine reuptake inhibitors (SNRI) and antipsychotics are indicated. Fluoxetine is only approved by Food and Drug Administration for Bulimia Nervosa. Several studies have been shown the efficacy of Topiramate in reducing binge eating in patients with BN and BED. On the other hand, Olanzapine can reduce rigidity, obsessiveness, overactivity in patients with AN (Health's Papers Ministry 2017).

High association between ED and mood disorders or anxiety disorders suggests a common etiopathogenesis. The presence of mood disorders is believed to be a predictor of unfavourable course and worse response to treatment in several follow-up studies therefore accurate assessment and management of comorbidities could allow clinicians to identify key factors that maintain ED psychopathology.

Acknowledgements: *None.*

Conflict of interest: *None to declare.*

Contribution of individual authors:

Rebecca Juli: conceptualization, data curation, formal analysis, investigation, methodology, project administration, visualization, validation, writing original draft, writing review and editing, supervision.

Maria Rosaria Juli, Giada Juli & Luigi Juli: conceptualization, visualization, writing original draft, writing review and editing.

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