who eventually died as a result of suicide. In the words of Allison's mother, 'Living with an eating disorder is hard. Living with a suicide is worse' (cited in Deloitte Access Economics, 2013, p. 49).

Professor Patrick McGorry summarises the report's key findings on eating disorders as follows:

> *I believe their debilitating effects are comparable to psychosis and schizophrenia . . . We are witnessing a tragic waste of personal and economic potential. This report cries out for urgent action. We desperately need a coordinated, government led comprehensive response to this emerging crisis . . . Failure to deal with addressing these urgent needs risks us handing to the next generation the full burden of these dreadful illnesses (cited in Deloitte Access Economics, 2013, p. 1).*

Eating disorders are the focus of this chapter. Following a brief overview of historical approaches to understanding these disorders and the current classification system, the eating disorders of anorexia nervosa, bulimia nervosa and binge eating disorder will be dealt with in turn. For each of these conditions, a description of the disorder's prevalence, age of onset, course, associated problems, aetiology and main treatment approaches will be provided. Finally, some key challenges and controversies in the eating disorders field will be highlighted, including limitations of the available treatment approaches, the clinical and ethical issues associated with involuntary treatment, the categorisation of muscle dysmorphia as an eating disorder and efforts to prevent the development of these serious and often chronic conditions.

LO 6.1

Historical and current approaches to the diagnosis of eating disorders

The current, fifth, edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association [APA], 2013) includes a chapter 'Feeding and Eating Disorders', which refers to conditions that entail 'a persistent disturbance in eating or eating-related behaviour that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning' (p. 329). While each of these conditions will be briefly described, the focus of this chapter is on anorexia nervosa, bulimia nervosa and binge eating disorder.

ANOREXIA NERVOSA

Anorexia nervosa was the first eating disorder to be recognised. Conditions resembling anorexia nervosa can be found among accounts of fasting female saints during the medieval period (Bell, 1985). However, definitive clinical descriptions of the disorder did not appear until the 1870s, when the British physician William Gull (1874) and the French neuropsychiatrist Henri Lasègue (1873) provided detailed accounts of a condition whose essential features have remained unchanged to this day. Gull (1874) proposed the term **anorexia nervosa**, which refered to a loss of appetite (anorexia) as a result of a nervous (nervosa) or mental rather than a biological cause. For a period in the first half of the twentieth century, biological approaches to anorexia nervosa became dominant, when the disorder was thought to result from dysfunction of the pituitary gland (Simmonds, 1914). Yet a careful review by Sheehan and Summers (1948) demonstrated that the clinical features of anorexia nervosa and pituitary disease were in fact distinct. Psychological understandings of the disorder again became predominant, largely through the influential work of Hilde Bruch beginning in the 1960s. Diagnostic criteria used in this period were, however, loosely defined and the term 'anorexia nervosa' tended to be used to embrace all forms of weight loss without a biological basis.

anorexia nervosa Eating disorder in which the individual is significantly below a body weight that is normal for his/her age and height and suffers from a fear of gaining weight and from body image disturbance.

TABLE 6.1 Summary of the feeding and eating disorders contained in the *DSM-5*

EATING DISORDER	DESCRIPTION
Anorexia nervosa	• Significantly underweight • Fears gaining weight and/or engages in behaviours to prevent weight gain • Body image disturbance (e.g., self-worth is excessively influenced by shape/weight, lack of recognition of the seriousness of the current low weight)
Bulimia nervosa	• Binge eating episodes • Inappropriate weight-control behaviours (e.g., self-induced vomiting) • Self-worth is excessively influenced by shape/weight
Binge eating disorder	• Binge eating episodes • Marked distress regarding the binge eating • No current regular inappropriate weight-control behaviours (e.g., self-induced vomiting)
Avoidant/restrictive food intake disorder	• A persistent eating disturbance associated with failure to meet nutritional/energy needs • The eating disturbance cannot be explained by cultural practices, another eating disorder, body image disturbance, and/or another medical or mental health condition
Other specified feeding or eating disorder	• Disturbances of eating that do not meet criteria for anorexia nervosa, bulimia nervosa, binge eating disorder or avoidant/restrictive food intake disorder. Types include: 1. atypical anorexia nervosa where all of the criteria for anorexia nervosa are met except for current underweight 2. bulimia nervosa of low frequency and/or limited duration where all criteria are met except that the binge eating or weight-control behaviours occur less than once a week and/or for less than 3 months 3. binge eating disorder of low frequency and/or limited duration where all criteria are met except frequency and/or duration of binge eating episodes 4. purging disorder (recurrent purging to influence weight or shape) 5. night eating syndrome (recurrent eating in the evening or after awakening from sleep that is excessive and causes distress)
Unspecified feeding or eating disorder	• Symptoms characteristic of an eating disorder causing significant impairment or distress that do not meet full criteria for another eating disorder
Pica	• Persistent eating of non-food substances
Rumination disorder	• Repeated regurgitation of food which may then be chewed, re-swallowed or spat out

Source: Adapted from the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Copyright 2013, American Psychiatric Association.

LO 6.2

Anorexia nervosa

The first of the major eating disorders to be addressed is anorexia nervosa, a disorder characterised by emaciation; a fear of gaining weight or engaging in behaviours to prevent weight gain; and body image disturbance (e.g., self-worth based excessively on shape/weight).

THE EPIDEMIOLOGY OF ANOREXIA NERVOSA

Anorexia nervosa primarily affects females, with an age of onset that is generally younger than other eating disorders. Sufferers experience a number of associated psychological and medical problems.

MUSCLE DYSMORPHIA AS AN EATING DISORDER

It has been noted earlier in the chapter that eating disorders predominantly affect females. Yet this may be partly an artefact of our current diagnostic systems that fail to include within the eating disorders category the types of eating, shape and exercise concerns that are more characteristic of males, namely, concerns regarding one's degree of muscularity. The *DSM-5* includes the disorder 'muscle dysmorphia', which occurs almost exclusively in males and is characterised by excessive concern that one's body is too small or insufficiently muscular. While the *DSM-5* classifies muscle dysmorphia as a type of body dysmorphic disorder, Murray et al. (2012) have suggested that it should instead be classified as an eating disorder. They argue that muscle dysmorphia and anorexia nervosa comprise 'two sides of the same coin', with muscle dysmorphia entailing the relentless pursuit of increased muscularity (consistent with sociocultural messages regarding male body ideals) while anorexia nervosa entails the relentless pursuit of thinness (consistent with sociocultural messages regarding female body ideals). In support of this reclassification of muscle dysmorphia as an eating disorder, Murray et al. (2012) found that males with muscle dysmorphia and anorexia nervosa had comparable levels of body image disturbance, disordered eating and compulsive exercise. As well as their similarity in symptoms, muscle dysmorphia and anorexia nervosa may have similarities in the factors that drive these symptoms. For instance, just as research has demonstrated a link between eating disorder symptoms and constructs such as perfectionism, negative mood and low self-esteem, Murray, Rieger, Karlov, and Touyz (2013) found that these same factors predicted the severity of muscle dysmorphia symptoms.

The central feature of muscle dysmorphia is excessive concern that one's body is not muscular enough even though the individual is of average or even above average musculature.

PREVENTION OF EATING DISORDERS

The extensive suffering experienced by those with an eating disorder, their often poor response to treatment, and the fact that the number of affected individuals far exceeds the availability of specialised treatment all provide a strong rationale for developing programs that can prevent eating disorders from occurring in the first place. Unfortunately, most of these prevention approaches (32 out of 38 interventions in one review paper) have failed to produce lasting reductions in eating disorder symptoms (Stice & Shaw, 2004). Some studies even suggest that these programs can actually increase eating disorder symptoms such as dieting, perhaps because their focus on eating and body image encourages individuals to become preoccupied with such concerns (Carter, Stewart, Dunn, & Fairburn, 1997).

While it would be ideal to be able to prevent the occurrence of eating disorders, what (if any) are the most beneficial ways of doing so? Conflicting responses have been offered to this question. One suggestion has been to focus on general risk factors for psychological disorders (e.g., low self-esteem) rather than specific risk factors for eating disorders (e.g., dieting) so as to avoid a discussion of eating disorder topics, which may implant unhealthy ideas in some individuals. For instance, a school-based program entitled 'Everyone's Different' was developed to improve the self-esteem of adolescent girls and boys (O'Dea & Abraham, 2000). The program was delivered in the classroom over nine lessons and included components such as identifying one's unique qualities, discovering what factors can threaten self-image and using role-plays to explore different ways of responding to threatening situations.