35 years Treating Eating Disorders: Doing More with Less

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I began my first real job in February, 1983, as a staff psychologist of a recently established university-affiliated Eating Disorders Program. I had not received any specific training about eating disorders. I was a child clinical psychologist who had done research on pre-teens losing and maintaining weight loss, and liked to work with families. The relevant eating disorders literature, consisted of several books and a few dozen publications which could be mastered in a few weeks of diligent reading. Professional agreement on best practices for treating eating disorders was non-existent.

The criteria for an eating disorder diagnosis was much debated. Anorexia nervosa was known but was thought to be exceedingly rare. Bulimia had only recently been identified as a distinct clinical entity, although its name, diagnostic criteria and its relationship to anorexia nervosa was much debated.

Treatment options were hospitalization or outpatient therapy. The bulk of treatment occurred in the hospital, with the priority on addressing medical issues related to low weight and unhealthy weight control practices, and secondarily on psychological concerns. Outpatient care at its best consisted of psychotherapy, medical management, and nutrition consultation. Competent practitioners in any discipline were difficult to find, much less who actually worked together. The theories of etiology relied heavily on psychoanalytic formulations and dysfunctional family dynamics. While we were confident that we were helpful, even life-saving, there was very little data to confirm our convictions.

Relying on my vast experience, obtained in one year on the job, several realities became evident. Treating eating disorders required a multidisciplinary treatment team; no one could do it all alone. Treatment took a long time, and was expensive. There was no consensus about what constituted recovery, except that the patient regained weight and did not die. Relapse was discouragingly frequent,

unpredictable, and recurrent. The accuracy of my clinical predictions of recovery were not a whole lot better than chance. To my embarrassment, I did not even consider the need for public education and prevention programs.

Eating Disorder treatment in 2020

It remains true that treating an eating disorder is still a serious business. The mortality rate of eating disorders seems to be decreasing in recent years and yet anorexia nervosa remains the most lethal psychiatric condition. We now know that comorbidities like substance abuse, especially alcohol, suicidal ideation, and self-harm increase morbidity. The goals of treatment remain much the same, medical stabilization, improved nutrition, healthy eating, more accurate cognitions, better management of emotions, and improved relationships. Most are treated as outpatients and never see the inside of a hospital. Partial hospitalization programs are available for the more refractory and impaired cases. On average, treatment episodes are shorter, although for many recovery can take years, and require repeated episodes of treatment. In my opinion, somewhat supported by evidence, we are achieving more substantial and lasting recovery in fewer sessions at less intense levels of care.

There are encouraging advances. We actually have a solid understanding of what approaches work and for what variants of eating disorders. Whereas previously, clinical judgment and loyalty to a school of therapy were the primary considerations, now we have practice guidelines, reflecting the consensus of the experts in the field and an exponentially increasing volume of sophisticated research on subtypes of eating disorders, cultural variations, outcomes, and co-morbid conditions. In addition to the existing evidence-based treatments, more are being developed and evaluated. It is no longer one treatment size fits all.

Public education and prevention efforts have progressed from memoirs by celebrities to well-intentioned efforts to educate about and prevent eating disorders, which had the unintended consequence of increasing disordered eating. Now there are prevention programs that reduce the risk.

Gratitude and Appreciation

In 35 years the eating disorders field has progressed from being almost non-existent to a vibrant, prospering subspecialty, offering innovative treatments, expanding our knowledge in a variety of disciplines and domains, educating about a serious public health threat, and advocating for the common good. And, of course, the field still has a long way to go. There is no indication that advances in the field are slowing down, nor that the prevalence of eating disorders is declining.

At the risk of accusations of self-congratulation, the eating disorders treatment services offered at SLBMI have consistently been at the forefront of the field. SLBMI has been an early adopter of innovative new treatments and a contributor to adapting those treatments for a broad segment of the population. We have been willing to share our expertise with other professionals and organizations, training young clinicians, and educating the public.

What is perhaps not appreciated is that it has been accomplished with limited financial resources. Providing outpatient and IOP services, reimbursed by commercial health insurance is a low margin business. SLBMI is not subsidized by not-for-profit organizations or governmental agencies. The financial limitations have been generously compensated for by the abundance of professional expertise of the clinicians providing excellent and compassionate care. The willingness of highly competent professionals working as a team with a commitment to high quality care for patients, means they engage in many activities for which they are not financially compensated. Keeping abreast of the latest developments in the field, training and being trained, coordinating with other professionals, engaging with loved ones, scholarship, and public advocacy, to name just a few, result in excellent care but not

necessarily higher reimbursement. This kind of dedication can be requested and modeled, but it cannot be mandated.

I have been fortunate to be part of this collective effort. Many individuals have been willing companions in this endeavor; supporting, encouraging, commiserating, advising and being advised, holding me accountable and being held accountable. It cannot be purchased but at the end of the day, when you have a chance to reflect upon what was done, it is glorious.