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ScienceDirect

Comprehensive Psychiatry xx (2017) xxx–xxx

COMPREHENSIVE PSYCHIATRY

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Understanding eating disorders within internalizing psychopathology: A novel transdiagnostic, hierarchical-dimensional model

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Abstract

Background: Several problems with the classification and diagnosis of eating disorders (EDs) have been identified, including proliferation of 'other specified' diagnoses, within-disorder heterogeneity, and frequent diagnostic migration over time. Beyond problems within EDs, past research suggested that EDs fit better in a spectrum of internalizing psychopathology (characterized by mood and anxiety disorders) than in a separate diagnostic class.

Purpose: To develop a transdiagnostic, hierarchical-dimensional model relevant to ED psychopathology that: 1) reduces diagnostic heterogeneity, 2) includes important dimensions of internalizing psychopathology that are often excluded from ED diagnostic models, and 3) predicts clinical impairment.

Procedures: Goldberg's (2006) method and exploratory structural equation modeling were used to identify a hierarchical model of internalizing in community-recruited adults with EDs (N = 207).

Findings: The lowest level of the hierarchy was characterized by 15 factors that defined specific aspects of eating, mood, and anxiety disorders. At the two-factor level, Internalizing bifurcated into Distress (low well-being, body dissatisfaction, suicidality, dysphoria, ill temper, traumatic intrusions) and Fear-Avoidance (claustrophobia, social avoidance, panic symptoms, dietary restricting, excessive exercise, and compulsions). Results showed that the lowest level of the hierarchy predicted 67.7% of the variance in clinical impairment. In contrast, *DSM* eating, mood, and anxiety disorders combined predicted 10.6% of the variance in impairment secondary to an ED.

Conclusions: The current classification model represents an improvement over traditional nosologies for predicting clinically relevant outcomes for EDs.

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Although several improvements to eating-disorder diagnosis and classification were made with the publication of the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) [(*DSM-5*) [1]], there continue to be a number of issues that detract from the validity and clinical utility of eating-disorder diagnoses [for a review, see [2]]. Here we report a study to address certain limitations of traditional diagnostic approaches to eating pathology using a representative community sample of persons with eating disorders. The purpose of this study was to develop a transdiagnostic, hierarchical-dimensional model relevant to eating-disorder psychopathology that: 1) reduces diagnostic heterogeneity, 2) includes important dimensions of internalizing psychopathology that are often excluded from eating-disorder diagnostic models, and 3) predicts clinical impairment. Below we describe the relevant literature in pursuit of these goals.

1.1. Limitations of eating disorder diagnoses

Despite lowering the diagnostic threshold for bulimia nervosa, substantially altering criteria for anorexia nervosa,

Funding: This work was supported by the Clifford B. Kinley Trust; and the University of Kansas New Faculty Research Fund. The content is solely the responsibility of the authors and does not necessarily represent the official views of the funding agencies.

Conflict of Interests: None.

Ethical Standards: The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

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http://dx.doi.org/10.1016/j.comppsych.2017.06.009
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and including binge eating disorder as an official diagnostic category in *DSM*-5, approximately 40–60% of persons with an eating disorder are diagnosed with an 'other specified feeding or eating disorder' (OSFED) [3,4]. The continued proliferation of OSFED is particularly notable because one of the primary reasons for changing diagnostic criteria and adding binge eating disorder was to reduce the number of individuals previously classified as Eating Disorder Not Otherwise Specified in the *DSM*-IV. OSFED is a broad category comprised of various combinations of clinically significant eating-disorder symptoms that do not meet full criteria for anorexia nervosa, bulimia nervosa, or binge eating disorder. OSFEDs are diagnosable eating disorders and are associated with marked distress, clinical impairment, and medical complications and are typically equally as severe as full-threshold eating disorders. One form of OSFED occurs when eating-disordered behaviors are clinically impairing but uncharacteristic of anorexia nervosa, bulimia nervosa, or binge eating disorder. For example individuals who purge after eating a small or normal amount of food *and* are at a normal body weight [5] could not meet criteria for anorexia nervosa (which requires significantly low body weight), or bulimia nervosa or binge eating disorder (both of which require presence of large binge-eating episodes). Yet, engaging in repeated self-induced vomiting or laxative misuse after eating normal-sized meals or snacks is detrimental because purging is associated with increased risk for dental, gastrointestinal, electrolyte and cardiac problems, and premature death [for reviews, see [6,7]]. Any individual who engages in eating-disordered behaviors and experiences eating-disorder-related clinical impairment meets criteria for a diagnosable eating disorder regardless of whether symptoms cluster in accordance with the *DSM-5* categories.

Additional forms of OSFED include sub-threshold variants of eating disorders which involve symptoms that are mostly characteristic of anorexia nervosa, bulimia nervosa, or binge eating disorder with only minor exceptions. For example, an individual who binge eats and purges once every other week for three months has symptoms characteristic of bulimia nervosa, but symptoms occur at a lower frequency than required by the *DSM-5* (i.e., binge eating and compensating at least once per week, on average, for three months). Although sub- and full-threshold eating disorders represent putatively distinct categories, studies found that impairment levels, latent risk factors, comorbid disorders, age-of-onset, and duration of illness did not differentiate full- from sub-threshold eating disorders [5,6]. Moreover, sub- and full-threshold eating disorders shared a common genetic basis, with non-shared environmental influences contributing to specific disorder variance [8]. Diagnostic heterogeneity decreases the effectiveness of diagnoses by impeding clinical communication that would allow providers to understand and anticipate their patients' needs because the same diagnostic label can apply to patients with very different symptom presentations.

Another limitation of the current *DSM-5* classification system is poor longitudinal stability and frequent diagnostic "migration" among eating disorders. People with eating disorders commonly shift between anorexia nervosa and bulimia nervosa; bulimia nervosa and binge eating disorder; and between the restricting and binge-purge subtypes of anorexia nervosa [7–11]. Diagnostic migration may reflect arbitrary boundaries of *DSM*-defined eating disorders rather than a meaningful change in pathology or patient need [12]; indeed, a change in a single symptom (e.g., weight gain) can change a person's diagnosis from anorexia nervosa to bulimia nervosa or from anorexia nervosa to an OSFED. Providing different diagnostic labels to individuals who experience a fluctuation in a single or a few symptoms is problematic because it reduces the validity of the construct of a particular diagnosis in both clinical and research contexts.

Finally, in addition to problems within eating-disorder diagnoses, nationally representative, clinical, and community samples have shown that approximately 80% of persons with an eating disorder have a co-occurring internalizing disorder (i.e., mood, anxiety, trauma-related, or obsessive-compulsive and related disorders) [13–18]. High levels of negative affect and the presence of a comorbid non-eating internalizing disorder are strong negative prognostic indicators of long-term course, outcome, and treatment response for eating disorders [10,19–21]. Indeed, eating disorders have such strong phenomenological overlap with mood and anxiety disorders that several well-respected scholars initially suggested that bulimia nervosa should be included as a variant of a mood disorder when it was first introduced into the modern diagnostic nomenclature [for a review of this debate, see [22]]. Given that other studies have shown an important role for negative affect in predicting the onset and/or maintenance of eating-disorder psychopathology [23], recent treatment development efforts have focused on mitigating negative-emotion processes as the mechanism of change for eating-disorder psychopathology and associated depressive and anxiety disorders [24,25].

In summary, progress in the diagnosis and classification of eating disorders is hampered by the limited utility of heterogeneous OSFED diagnoses, arbitrary boundaries among eating disorders diagnoses, and exclusion of important etiologic and maintenance processes shared with mood and anxiety disorders. Not only do these shortcomings impede clinical communication and treatment planning, but they also limit behavioral and biological research progress, which requires valid eating-disorder phenotypes to ensure replication of research findings and to uncover new, substantive information about the nature of these serious mental-health conditions.

1.2. The hierarchical taxonomy of psychopathology (HiTOP): A new framework for eating disorders?

Kotov et al. [26] recently described a burgeoning literature and proposed an accompanying "working model" – The Hierarchical Taxonomy of Psychopathology (HiTOP) – that offered a potential solution to address many of the limitations

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