Securing Eating Disorders Treatment: Ammunition for Arguments with Third Parties

Compiled and Written by Margo Maine, Ph.D.

Argument # 1: A full-course of treatment is cost-effective for eating disorders.

Halmi et al (2000)

Between 1985 & 1998 readmissions of eating disorders patients have increased steadily as length of stay has become more brief and weight at discharge has been lower.

Halmi and Licino (1989)

Patients with anorexia nervosa who reached 98% of IBW prior to discharge from inpatient less likely to relapse than those who only achieved 83% IBW. (Program completion = abstinence from bingeing and purging and maintaining weight for 2 weeks).

Baron et al (1995)

Compared 14 patients with anorexia nervosa who achieved normal weight (96% IBW) to 8 patients who reached only 76% IBW.

	96%	76%
Length of stay	116 days	46 days
Menstrual disturbances	21%	62%
Rehospitalization	7%	62%
Persistent anorexic symptoms	19%	57%

Concluded that achieving IBW has better clinical course and may be more cost-effective in long run, especially in light of costs of medical problems (osteoporosis, infertility, dehydration, electrolyte imbalances, cardiac and other compromises).

Argument # 2: Specialized treatment for eating disorders is preferable and cost effective.

Crisp, Callender, Halek and Hsu (1992)

Specialized treatment reduces mortality.

Argument # 3: Recovery takes place over a long period of time.

Strober, Freeman, Morrell (1997)

"The course of anorexia nervosa is protracted" p.339.

76% of sample studied for 10-15 years after admission met criteria for full recovery, but time to recovery ranged from 57-74 months; 10% met criteria for partial recovery.

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Argument # 4: Treatment of bulimia is effective.

Reas et al (2000)

Patients with bulimia nervosa demonstrate a better recovery rate if they receive treatment early in their illness.

If treated within the first 5 years, the recovery rate is 80%.

If not treated till after 15 years of symptoms, recovery falls to 20%.

Argument # 5: Even successful treatment has an uneven course.

Fichter and Quadflieg (1997)

Six year follow-up of 196 female bulimic patients indicate 59.9% had achieved a good outcome; 29.9% poor, and 1.1% deceased.

The course of recovery is uneven, with a decline during the 2 years after intensive inpatient treatment, then later improvement and stabilization.

Argument # 6: Eating disorders are serious and lethal.

Sullivan (1995)

Conducted meta-analysis from 42 studies of patient mortality, finding 178 deaths in 3,006 patients.

54% from complications of ED
27% suicide
19% other/unknown.

Rate of .56% mortality/years is 12 times greater than general death rate for women aged 15-24 and suicide rate is 75 times greater.

Argument # 7: The mortality rate increases with the duration of symptoms.

APA (2000)

The mortality rate at 5 years is 5%, increasing to 20% at 20 year follow-up.

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Argument # 8: Comprehensive and long term treatment does "pay off."

Garfinkel (1995)

Outcome studies following patients for 5-10 years indicate mortality rate of 5%. Studies of patients followed for 20-30 years find 18% mortality rate from AN or suicide.

Treatment is useful! Of those followed 5-10 years, 50% of the sample had recovered, 25% improved with some residual symptoms, and 25% remain ill or die.

Argument # 9: Younger patients require intense and aggressive treatment.

Society for Adolescent Medicine (1995)

"Because of the potentially irreversible effects of an eating disorder on physical and emotional growth and development in adolescents, because of the risk of death, and because of the evidence suggesting improved outcome with early treatment, the threshold for intervention in adolescents should be lower than in adults". P. 477.

Irreversible risks are growth retardation, pubertal delay or arrest, impaired acquisition of peak bone mass, increased risk of osteoporosis.

Argument # 10: Utilization of mental health benefits may offset high medical costs associated with eating disorders.

APA Practice Guidelines (1993)

Reports these medical findings:

- Physical consequences of ED include all serious sequelae of malnutrition, especially cardiovascular compromise.
- Prepubertal patients may have arrested sexual maturity and growth failure.
- Even those who "look and feel deceptively well", with normal EKG's may have cardiac irregularities, variations with pulse and blood pressure, and are at risk for sudden death.
- Prolonged amenorrhea (>6 months) may result in irreversible osteopenia and high rate of fractures.
- Abnormal CT scans of brain are found I >50% of patients with anorexia nervosa.
- Bulimic behaviors may result in electrolyte, fluid and mineral imbalance, may be presenting cardiac risk; gastric irritation and bleeds; large bowel abnormalities; dental enamel erosion; peripheral muscle weakness, cariomyopathy, hypometabolism. Despite normal weights a bulimic presenting cardiac risk; gastric irritation and bleeds; large bowel abnormalities; dental enamel erosion; peripheral muscle weakness, cariomyopathy, hypometabolism. Despite normal weights a bulimic starving and severely malnourished.