Psychotherapy of eating and sexual disorders

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Eating disorders


http://go.to/funpic

The importance of eating disorders

- High morbidity: the prevalence of obesity (BMI > 30) is about 20%, the prevalence of subclinical cases is almost 50% in certain populations.
- The morbidity increases – the role of sociocultural factors.
- High mortality of anorexia.

  10 years after the onset: 8%, after 20 years 20%.

Epidemiology

The prevalence of obesity (BMI $\geq$ 30) in the Western civilizations is about 30%.

Hungary: 20%.

Point prevalence of anorexia and bulimia nervosa:

among 18-35 year old females: 1-4%.

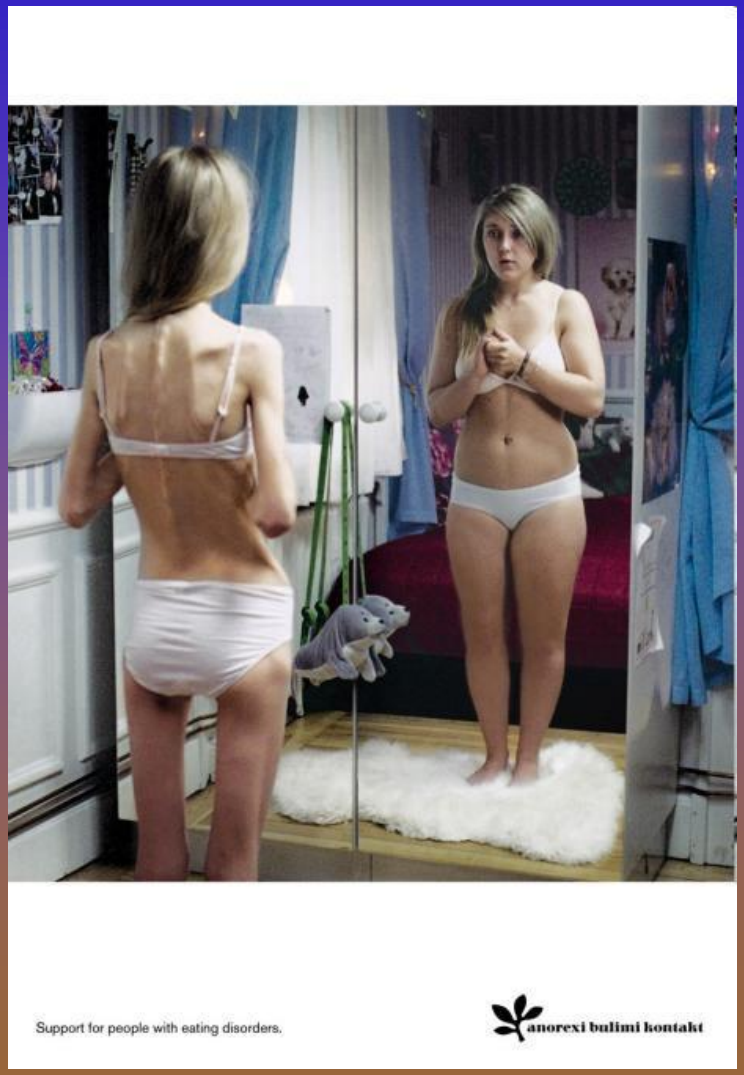
In Hungary: cca 30 000 eating disordered patients.

Anorexia nervosa (DSM-V)

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

Body image disorder



Bulimia nervosa (DSM-V)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- ♦ eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
- ♦ a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa

Newer forms of eating disorders

Binge eating disorder, purging syndrome, orthorexia nervosa, muscle dysmorphia, eating disorder body builder type, etc.

Treatment of eating disorders

Pharmacotherapy

Nutritive rehabilitation

Psychotherapy

Psychoeducation and self-help

Integrative programs

Pharmacotherapy

It should not be used as an exclusive treatment form

AN: antidepressants may have a role in the maintenance of weight after gaining weight

BN: antidepressants are useful regardless to the chemical structure(MAOIs, SSRIs, TCAs)

Psychotherapy

- Psychodynamic therapies
- Cognitive-behavioural therapies
- Interpersonal psychotherapy
- Family therapy
- Group therapies
- Body oriented therapy
- Hypnotherapy

Psychodynamic therapies

Hidden, unconscious conflicts in the background

E.g., fears from sexuality

Sexual abuse in the history: about 25-30% of the patients (it is non-specific factor)

Postponing of the adulthood (evolutionary theories)

Cognitive-behavioural therapies

Correction of cognitive distortions, schemas

Treatment of body image disorder

Self-monitoring, step by step approach

In bulimia: exposure plus response prevention

This is the most effective in bulimia

Interpersonal psychotherapy

Short (16-20 sessions) therapy

The interpersonal problems of the patient are in the focus

It is as effective as the cognitive therapies

Family therapy

This is the method of choice in young eating disordered patients.

The characteristic features of the psychosomatic families (*Minuchin*):

- Enmeshment
- Overprotectivity
- Rigidity
- Lack of conflict resolution
- Involvement of the child into the parental conflict

Group therapies

There are different methods

E.g., assertivity training, cognitive therapy groups etc.

Body oriented therapy

Special forms of group therapy

The aim is to treat the body image disorder

Dance therapy, sport is also used (e.g., to practice the bodily control)

Hypnotherapy

It is used mainly in bulimia

The hypnotic susceptibility of bulimics is higher than that of anorectics or the general population

It is advantegous in the therapy

A special form of the trance – the bulimic episodes occur also in a so-called trance state

Integrative programs: stepped care

In the first step generally self-help groups, psychoeducation are applied.

Later: pharmacotherapy, outpatient group therapy.

Next step: outpatient psychotherapy, family therapy.

Last step: intensive inpatient therapy in special units.

Outcome

High mortality in AN: about 8% after 10 years, 20% after 20 years

Rough estimation at follow-up: 50% is symptom-free, 25% improves with remaining sypmtoms, 25% does not change

Sexual disorders

A recent epidemiological study found overall rates for sexual dysfunction in men and women were 31% and 43%, respectively.

Each sexual dysfunction is characterized by the stage of the sexual response cycle that is affected and is defined by a change in sexual functioning that causes distress to the individual and interpersonal difficulties.

Masters and Johnson (1966) first described the stages of the sexual response cycle.

- Desire phase where one feels the urge to have sex.
- Arousal phase where one has increased physiological excitement such as higher heart rate and blood pressure.
- Orgasm phase where reflexive muscle contractions occur in the pelvis.
- Resolution phase where the body returns to its pre-arousal state.

Sexual dysfunction can occur in any of the first three stages of the sexual response cycle but does not occur in the latter phase.

Desire disorders consist of hypoactive sexual desire and sexual aversion.

Hypoactive sexual desire results from a person having little or no interest in sex or in engaging in sexual activity.

However, when sexual activity does occur, the person does not experience emotional distress.

Contrarily, people who experience **sexual aversion** feel negative emotions, such as disgust or fear, when they engage in sexual activity at the insistence of a partner.

Disorders that occur during the arousal phase of the sexual response cycle are female sexual arousal disorder and male erectile dysfunction.

Sexual arousal disorder is diagnosed in women when there is an inability to maintain lubrication of the vagina or genital swelling.

Erectile disorder is diagnosed when there is a failure to obtain or maintain an erection until completion of sexual activity.

Disorders that occur during the orgasm phase of the sexual response cycle are **female orgasmic disorder, male orgasmic disorder, and male premature ejaculation**.

Female and male orgasmic disorders are described as a complete absence of orgasm or a delay in the experience of an orgasm during sexual activity.

Though female orgasmic disorder is relatively common, the male orgasmic disorder is quite rare.

It is much more common for a man to present for sex therapy due to premature ejaculation.

This disorder is difficult to define, but it is generally classified as a male reaching orgasm with minimal stimulation and before he or his partner want it to occur usually prior to or shortly after entry of the penis into the vagina.

There are two sexual disorders that cannot be defined by the stage of the sexual response cycle in which they occur: sexual pain disorders.

Dyspareunia is genital pain that is experienced during sexual intercourse.

Vaginismus is defined by involuntary contractions of the outer third of the vagina so that entry of the penis or another object such as the finger cannot take place.

Psychodynamic therapy

Current psychodynamic therapy incorporates both Freud's early ideas as well as more modern ideas.

The next issues are in focus:

- Unconscious inhibitors of sexual functioning
- Problems of personality development
- Defense mechanisms

Cognitive behavioural therapy

These are based on learning theories.

Systematic desensitization: the client would be taught relaxation therapy techniques.

While practicing these techniques, the client would visualize a self-made hierarchy of sexual behavior.

Although this technique provided help for some clients experiencing sexual dysfunction, it was unsatisfactory for solving many sexual disorders.

Couples therapy

Couples therapists believe that sexual dysfunction experienced by one partner is the result of or is perpetuated by the interactions of the couple.

It was first stressed by systemic therapists that sexual dysfunction caused great distress to both members of the couple.

The disorder may also serve some helpful functions within the couple's relationship.

The sexual dysfunction exists in the relationship because it serves a purpose, and helping the partner to overcome his or her problem serves to change the balance in the relationship.

This shift, if not monitored by the therapist, can contribute to other marital problems.

Certain systemic problems that can serve to maintain a sexual disorder: lack of trust, fear of intimacy, power imbalance in the relationship, and an inability to reconcile feelings of love and sexual desire.