P. Varela-Casal[1]
M.J. Maldonado[1]
F. Ferre[1]

Study of the clinical profiles of patients with eating disorders in specific units

[1]Servicio de Psiquiatría y Unidades de Referencia
Hospital General Universitario Gregorio Marañón

Objective. The purpose of this study is to describe the clinical profiles of patients diagnosed of a specific Eating Behavior Disorder (EBD) who come to a specialized outpatient unit for patients over 18 years old with this disorder.

Method. This is an observational, cross-sectional and descriptive study in which 101 medical records of patients with an eating disorder diagnosis have been analyzed retrospectively.

Results. The clinical profiles observed showed 93.9% women, medium age 29.9%, in which 33% of the patients had an illness course of 2 to 5 years. Purgative forms were more frequently observed. A total of 19.8% had substance abuse disorders and 54.4% anxiety disorders.

Conclusions. Specific units for Eating Disorders should be included in the combined resources that not only allow for treatment of the eating behavior disorders but also for their psychopathological comorbidities, the prognosis and evolution of the disease depending on the latter.

Key words:
Eating disorders. Comorbidity. Health care planning.

Actas Esp Psiquiatr 2011;39(1):12-9

Estudio de los perfiles clínicos de los pacientes con trastorno de la conducta alimentaria en dispositivos específicos

Objetivo. Descripción de perfiles clínicos de pacientes diagnosticados de Trastornos de la conducta alimentaria (TCA) que acuden a un dispositivo ambulatorio especializado para mayores de 18 años.

Método. Se trata de un estudio observacional, transversal y descriptivo en el que con carácter retrospectivo se analizaron 101 historias clínicas de pacientes diagnosticados de TCA.

Resultados. El perfil clínico observado fue que el 93,6% son mujeres, con una media de edad de 29,9 años. El 33% presentaban una evolución de entre 2 y 5 años. Existe un predominio de las formas purgativas. El 19,8% presentan problemas con sustancias de abuso y el 54,4% de la muestra presentan trastornos de ansiedad.

Conclusiones. Las unidades específicas en el tratamiento de los TCA deben integrarse en un conjunto de recursos que permitan además del abordaje del TCA de la psicopatología comorbida y de la que dependerá el pronóstico y evolución de la enfermedad.

Palabras Clave:
Trastornos de la conducta Alimentaria. Comorbilidad. Organización sanitaria.

Correspondence:
F. Ferre
Servicio de Psiquiatría y Unidades de Referencia
Hospital General Universitario Gregorio Marañón
C/Ibiza 40, 28007 Madrid
E-mail: fferre.hgugm@salud.madrid.org

INTRODUCTION

Epidemiological data

Eating Behavior Disorders (EBD) are long-course mental diseases. In fact, epidemiological studies reveal that 5-10 years after the initial diagnosis, 1/3 to 1/2 of the cases continue to have symptoms.[1] The symptoms that persist are: poor regulation of eating behavior, characteristic cognitive disorders and behavior alterations associated to diet, weight and body shape.[2] These patients go through different clinical stages determined by the psychopathology and associated medical complications, which entail different care needs. EBD treatment is contemplated as a process that includes the participation of different professionals within different resources, coordination and continuity of care being key to the efficacy of the services and the benefits for the patient and family. During the disease process, not all the patients will need all of the resources, nor will they go through the

same trajectory. No resource is better than or superior to another and no resource has an isolated meaning.[3]

In recent years, there has been significant development in the study and investigation of EBD. This has been largely determined by the need for early detection, prevention and effective treatment that makes it possible to decrease the morbidity-mortality associated to these disorders that is considered to be approximately 6 and 15%.[4-6]

There are discrepancies regarding the existing data related to the incidence and prevalence of these diseases, above all in the adult age. This problem is determined by the different methodologies used in the studies to detect cases and by the low demand for care of these patients as the problem is frequently masked by organic problems. Due to this, they go for treatment to other specialists and not to the psychiatrist.[7] However, most of the studies reviewed coincide in that there is an increase of Eating Disorders Not Otherwise Specified (EDNOS). This group includes those patients who do not meet all of the criteria to diagnose Anorexia Nervosa (AN) or Bulimia Nervosa (BN), as well as Binge Eating Disorder (BED).[8] In spite of this, the relationship between this disease and the rest of the EBDs does not seem to be clear yet. Currently, the most frequent diagnosis in the adult population is EDNOS. This diagnosis accounts for 50 to 60% of the cases, followed by BN, which accounts for 30% of the cases and AN which accounts for 10 to 15% of the cases. However, in the adolescent population, although the most frequent diagnosis is still EDNOS, it is followed by the diagnosis of AN which has more than BN.[1]

One of the principal characteristics of EBD is diagnostic migration. While a small subgroup remains in the initial debut picture, most migrate between the different diagnoses (AN, BN and EDNOS). However, this migration is not random. It is a reflection of the fact that even though eating behavior disorders tend to begin with eating restriction, the strict control of the patients on their diet often breaks down in relationship to different circumstances and the patient develops binge eating disorder that may or may not be followed by compensatory behaviors for the weight control.[1]

EBDs are associated to high levels of comorbidity with other axis I and II psychiatric disorders according to DSM-IV-TR criteria, especially with anxiety, impulse control and substance use disorders. In relationship to anxiety, the prevalence of these disorders ranges from 25 to 75% for BN and 23 to 75% for AN.[9-11] Regarding impulsivity disorders,[12-14] a subtype of BN called multi-impulsive bulimia has been defined. In this subtype, in addition to the appearance of the typical eating disorder symptoms of these patients, there is also a tendency to affective and interpersonal instability, scarce tolerance to frustration, suicidal gestures and substance abuse. Some studies estimate that the prevalence of comorbidity between BN and substance abuse is 55% and in the case of AN 23%.[15-17] Although it seems that the diagnosis is independent, several studies have found that there is an association between severity and seriousness in the course of the disease with substance use or abuse.[17,18] However, it seems that the concurrence of both disorders is not associated to worse recovery of the eating disorder symptoms. According to the Wiseman study that analyzed the course of the appearance of the disorder due to substance abuse within the EBD context, the chronology in the appearance of substance use within the context of EBD does not seem to follow a determined pattern.[19]

Care resources in the treatment of EBD in the Community of Madrid

The model in Madrid for the treatment of eating behavior disorders is multidisciplinary and multiprofessional. It integrates different therapeutic perspectives and is oriented towards strengthening the coordination between the participating units: Primary Care, Mental Health Centers, Endocrinology Services, Nutrition, Brief Hospitalization Units, Day Hospitals, and other educational and social resources (including family association movements linked to this disease).

The specific outpatient facilities called "Eating Behavior Disorders Clinic" (EBD Clinic) originated within the framework of the Comprehensive Plan for Care for Eating Behavior Disorders that is carried out as part of the measures contemplated in the Social Agreement against Anorexia and Bulimia of the Madrid Community.[20]

Description of the Eating Behavior Disorders Clinic (EBD Clinic) of the Hospital General Universitario Gregorio Marañón (HGUGM)

The EBD Clinic of HGUGM arose as a specialized outpatient facility to promote treatments and quality care to adult patients with chronic course eating behavior disorders. It aims to develop a project for the evaluation, diagnosis and specific treatments of EBD, including clinical care, research, and teaching. The EBD Clinic has a basic team made up of a psychiatrist, psychologist, nursing staff and control assistant. It also counts on the part time support of an endocrinologist, nutritionist and other mental health care professionals within the health care area who collaborate in some programmed activities.

Admission criteria in this Clinic are the following:

- Patients over 18 years, whose principal ICD-10 diagnosis is Anorexia Nervosa, Bulimia Nervosa, or Eating Disorder

Not Otherwise Specified (that is, patients with psychopathology of eating behavior, which is sufficiently severe to require clinical care, but that does not strictly meet the criteria of Anorexia or Bulimia Nervosa).
- Patients with diagnosis of Personality Disorder that occurs concomitantly to an EBD, as long as the predominant condition at the time of referral is EBD. Thus, those patients who have two diagnoses and who, at the time of referral, have severe decompensation of their Personality Disorder, which justifies admission to another facility (for example, a Day Hospital, Brief Hospitalization Unit or Hospital Therapeutic Community) would be excluded.

Referral of the patients will be guided by the following therapeutic objectives:

- Promoting the motivation of the patient to receive treatment.
- Performing a psychopathological evaluation and detailed medical examination of the EBD.
- Comprehensive treatment: in which psychological, psychiatric and nutritional care are included. Within this treatment modality, individual and/or group session are performed, as required according to the case.
- Partial treatment: as support to the treatment performed in the patient's Mental Health Center, in such a way that the patient and/or family would attend some of the groups offered by the EBD Clinic.
- Prevention of relapses and/or follow-up: patients who have received discharge, due to improvement of their clinical condition, but who would benefit from specific follow-up are included within this category.

List of Services

- Individual Treatment: In the first visit, the nursing unit evaluates the anthropometric parameters (weight, height, BMI, brachial circumference) and analytic parameters, which based on the severity, are indicated by the attending psychiatrist, as well as complementary tests and specific consultations between units (bone densitometry, consultation with Gynecology, Consultation with Nutrition). After, in the first psychiatric interview, an evaluation is made of the patient's eating disorder, of the associated psychopathology and of the personality, given their high comorbidity with EBD.
  In the successive interventions and based on the severity of the patient, weekly checkups are made with periodic evaluation of the associated medical complications, follow-up of the associated psychopathology (anxiety disorders, affective disorders, obsessiveness, etc.), and individual interventions with the family setting of the patient for a better approach and support in the management of EBD.
- Group treatment: 4 types of interventions are implemented:
  1. Group having a therapeutic frame for relatives: with a fortnightly frequency, and headed by two clinical psychologists. The relatives are oriented towards identifying the problem, its causes, course, symptoms, and how they can participate in the therapeutic process, becoming aware of what the disease means, handling their ambivalence and feelings of guilt towards the disease, and they are motivated to introduce changes in the family system.
  2. Group having a therapeutic frame of patients: weekly, the clinical psychologist approaches those cognitive aspects associated to EBD in patients without comorbidity with the axis II.
  3. Group of personality disorders and EBD: also weekly, the psychiatrist works with self control in patients with high levels of impulsiveness, BN and associated borderline personality disorder traits.[21,22]
  4. Relaxation group: the nurse conducts two groups in the week during a period ranging from 6 to 8 weeks.

METHODOLOGY

Objective

The objective of the present study is to determine both the clinical and sociodemographical profiles of the patients who came to the EBD Clinic of the HGUGM of Madrid during its first 10 months of the functioning and to analyze the care activity of this facility.

Material and Methods

This is a non-interventionalist, cross-sectional, descriptive study performed retrospectively that has been conducted through the analysis of the care and through the systematic review of all the clinical histories of the patients in the Eating Behavior Disorders clinic of HGUGM of Madrid. Information was collected on the social demographic aspects of the patients and medical care given during the first year of the clinic. The inclusion period included the first 10 months of functioning (March to December 2008).

Subjects

The study included patients of both genders, over 18 years of age, referred from their reference Hospital, reference Mental Health Care Site (MCS), or Day Unit for Intensive

Table 1 Relationship between years of evolution and EBD diagnosis

YEARS OF EVOLUTION			DIAGNOSIS							
			Restrictive AN	Purgative AN	Purgative BN	Non-Purgative BN	Binge eating disorder	EDNOS	Other diagnosis	Total
CHRONICITY	< 1 year	Count	0	2	2	0	1	2	1	8
		% of CHRONICITY	0.0 %	25.0 %	25.0 %	0.0 %	12.5 %	25.0 %	12.5 %	100.0 %
		% of diagnoses	0.0 %	8.0 %	7.4 %	0.0 %	14.3 %	10.5 %	33.3 %	8.5 %
		% of total	0.0 %	2.1 %	2.1 %	0.0 %	1.1 %	2.1 %	1.1 %	8.5 %
	2-5 years	Count	3	9	9	2	0	7	1	31
		% of CHRONICITY	9.7 %	29.0 %	29.0 %	6.5 %	0.0 %	22.6 %	3.2 %	100.0 %
		% of diagnoses	75.0 %	36.0 %	33.3 %	22.2 %	0.0 %	36.8 %	33.3 %	33.0 %
		% of total	3.2 %	9.6 %	9.6 %	2.1 %	0.0 %	7.4 %	1.1 %	33.0 %
	6-10 years	Count	0	6	7	1	1	5	0	20
		% of CHRONICITY	0.0 %	30.0 %	35.0 %	5.0 %	5.0 %	25.0 %	0.0 %	100.0 %
		% of diagnoses	0.0 %	24.0 %	25.9 %	11.1 %	14.3 %	26.3 %	0.0 %	21.3 %
		% of total	0.0 %	6.4 %	7.4 %	1.1 %	1.1 %	5.3 %	0.0 %	21.3 %
	11-15 years	Count	0	3	7	3	2	4	0	19
		% of CHRONICITY	0.0 %	15.8 %	36.8 %	15.8 %	10.5 %	21.1 %	0.0 %	100.0 %
		% of diagnoses	0.0 %	12.0 %	25.9 %	33.3 %	28.6 %	21.1 %	0.0 %	20.2 %
		% of total	0.0 %	3.2 %	7.4 %	3.2 %	2.1 %	4.3 %	0.0 %	20.2 %
	16 - 20 years	Count	0	4	1	2	1	1	0	9
		% of CHRONICITY	0.0 %	44.4 %	11.1 %	22.2 %	11.1 %	11.1 %	0.0 %	100.0 %
		% of diagnoses	0.0 %	16.0 %	3.7 %	22.2 %	14.3 %	5.3 %	0.0 %	9.6 %
		% of total	0.0 %	4.3 %	1.1 %	2.1 %	1.1 %	1.1 %	0.0 %	9.6 %
	21-25 years	Count	0	1	0	0	0	0	1	2
		% of CHRONICITY	0.0 %	50.0 %	0.0 %	0.0 %	0.0 %	0.0 %	50.0 %	100.0 %
		% of diagnoses	0.0 %	4.0 %	0.0 %	0.0 %	0.0 %	0.0 %	33.3 %	2.1 %
		% of total	0.0 %	1.1 %	0.0 %	0.0 %	0.0 %	0.0 %	1.1 %	2.1 %
	> 25 years	Count	1	0	1	1	2	0	0	5
		% of CHRONICITY	20.0 %	0.0 %	20.0 %	20.0 %	40.0 %	0.0 %	0.0 %	100.0 %
		% of diagnoses	25.0 %	0.0 %	3.7 %	11.1 %	28.6 %	0.0 %	0.0 %	5.3 %
		% of total	1.1 %	0.0 %	1.1 %	1.1 %	2.1 %	0.0 %	0.0 %	5.3 %
	Total	Count	4	25	27	9	7	19	3	94
		% of CHRONICITY	4.3 %	26.6 %	28.7 %	9.6 %	7.4 %	20.2 %	3.2 %	100.0 %
		% of diagnoses	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %
		% of total	4.3 %	26.6 %	28.7 %	9.6 %	7.4 %	20.2 %	3.2 %	100.0 %

Treatment for EBD, and who have received a diagnosis of Eating Behavior Disorder (anorexia nervosa, bulimia nervosa, Eating Disorder Not Otherwise Specified) according to DSM-IV-TR criteria.

Table 2 Comorbidity between EBD and substance consumption

	CANNABIS CONSUMPTION(%)			COCAINE CONSUMPTION (%)			ALCOHOL CONSUMPTION (%)			
	NO	PAST	CURRENT	NO	PAST	CURRENT	NO	PAST	ISOLATED	DAILY
Restrict AN	4	0	11.10	4.5	5	0	7.1	0	3.3	0
Purgat AN	28	30.8	16.70	28.4	30	0	35.70	0	23.3	0
Purgat BN	26	30.8	33.3	28.4	25	42.9	14.3	50	35	50
nonPurg BN	8	7.7	16.70	7.5	10	28.6	3.6	0	11.7	25
Binge Eating D	12	0	5.6	9	0	14.30	17.9	0	1.7	25
EDNOS	16	30.8	16.7	17.9	30	14.30	10.7	50	25	0
Other diag	6	0	0	4.5	0	0	10.7	0	0	0

RESULTS

Origin

The total number of patients included in this study was 101. Most of the patients (71.3%) had been referred from their reference MCS compared to 8.5% from the Day Unit and 1% from the Hospital. Almost 20% came from uncommon ways on request of the interested subject per se (channeling of request, patient care services, etc.).

Clinical characteristics of the patients

Regarding the clinical presentation, the purgative forms of anorexia (25.5%) and bulimia nervosa (29.8%) are much more frequent than the restrictive and non-purgative ones (4.3% AN and 8.5% BN). Even though they are not an independent category within the DSM-IV-TR classification (although the need to consider it is as a separate entity in the next classifications is already mentioned in the present one), we have separated Binge Eating Disorder from Eating Disorder Not Otherwise Specified. Our intention was to avoid overlapping within the same category the 6 patients (6.4%) whose principal problems were binge eating without other eating symptoms with the 20 patients (21.3%) who did not strictly meet the criteria of anorexia and bulimia nervosa (for example, patients with restrictive and purgative behaviors of some severity but who did not meet the criteria of two weekly binge eatings required by the DSM or patients with symptoms of anorexia nervosa who, however, had normal body mass index since they had been referred to our unit after having undergone under treatment for a certain period of time and in whom there had already been some improvement in their symptoms).

Evolution time

EBDs are diseases characterized by their chronicity. In fact, on arrival to our unit, disease evolution time for 33% of our patients was already 2 to 5 years, followed by 21.3% whose evolution time had already been 6 to 10 years. Thus, at least half of the sample would be included in the evolution interval of between one year and 10 years, the chronicity percentage (years of evolution of the disease) being greater for the purgative AN and purgative BN diagnoses **(Table 1).**

Sociodemographic characteristics

Of the 94 patients with appointments in the clinic during the year 2008, 93.6% were women and 6.4% in men. Mean age of the patients was 29.99 years (SD 10.56). The age of the youngest patient seen in the clinic was 18 years while the maximum age was 75 years. A total of 89.4% of the patients seen in the clinic were under 40 years. Single patients were the most frequent in our sample, accounting for 71.3% compared to married patients (23.4%). It is also important to stress that more than half of the patients seen were university students (56.4%), 20.2% of whom had purgative AN.

In relationship to occupational activity, 49.7% were working, 19.1% of whom suffered purgative type BN.

Comorbidity between EBD and substance use

As has been explained in the introduction, the high rates of comorbidity with substance abuse of these patients are surprising. In our sample, 19.8% of the patients consume

one or more substances (cannabis, cocaine or consume alcohol in a harmful way). Sporadic consumption of alcohol was not considered pathological in this occasion given its social character and that it does not have repercussions in the sociolaboral activity of those consuming it.

In relationship to consumption of cannabis among patients with EBD, in those who currently consume it abusively and harmfully, 33% were diagnosed of purgative BN. This was followed by the patients diagnosed of purgative AN, non-purgative BN and EDNOS, each of which had the same percentage of 16.7% (Tab**le 2).**

In regards to the cocaine usage **(Table 2)** of the patients who currently consumed this substance, 42.9% were diagnosed of purgative BN followed by non-purgative bulimias. However, among the patients who admitted having had a past harmful consumption, 30% were diagnosed of purgative type AN and EDNOS, on the contrary to the current usage in which the frequency observed was greater in the patients with BN.

Alcohol was consumed regularly and harmfully **(Table 2)** by 4% of the patients from the EBD Clinic sample, 50% of which corresponded to diagnoses of purgative BN. Similarly, 77.8% of those patients who had sporadic alcohol consumption (59.4% of the sample) had been diagnosed of BN.

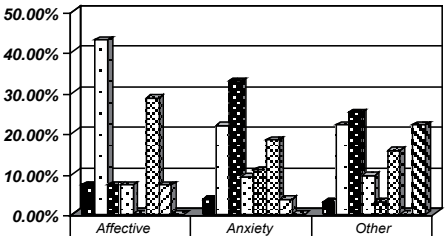
Comorbidity between EBD and anxiety and/or Affective Disorders

It is seen in this sample that the comorbidity of EBD is greater with anxiety disorders then with affective disorders (54.5 versus 13.9%). Anxiety disorders are the most frequent comorbidity within each EBD diagnostic category.

Among the patients diagnosed of affective disorders, the most frequent EBD is that of purgative type AN in 42.9% of the 13.9% of the patients of the sample fulfilling criteria for affective disorders as a comorbidity on axis I. However, within the 54.5% of the patients of the total sample diagnosed of anxiety disorder, 32.7% of the patients were diagnosed of purgative BN **(Figure 1).**

Results. Care activity

In regards to the medical care ratio, the patients came to more than 80% of the individual appointments. In regards to attendance to the groups, this ranged from 55.26% (EBD comorbidity group with Personality Disorder) and 72.41% (family psychoeducation group). In all, the global ratio of attendance was 82.43%.



	Affective disorders	Anxiety disorders	Other diagnoses
RESTRICTIVE ANA	7.10%	3.60%	3.10%
PURGATIVE AN	42.90%	21.80%	21.90%
PURGATIVE BN	7.10%	32.70%	25.00%
NON PURGATIVE BN	7.10%	9.10%	9.40%
ED	0.00%	10.90%	3.10%
EDNOS	28.60%	18.20%	15.60%
OTHER DIAGNOSES	7.10%	3.60%	0.00%

Figure 1 Comorbidity with anxiety/affective disorders

Regarding the number of visits per patient, during 2008, 51% of the patients attended to came to less than 10 visits in this clinic, 25% came to between 11 to 20, 14% to between 21 and 30, 5% between 31 and 40 and 5% to between 41 and 50. No patient had to be attended to more than 20 times in the clinic during the year 2008.

During their stay in the EBD clinic, the patients had to be referred for admission to the UHB in the Psychiatry Department of their reference Hospital on 11 occasions. Specifically, two patients required admission in the Psychiatry Department of the UHB two and three times, respectively, because of psychopathological decompensations in the comorbid affective pictures on axis I. The remaining six times corresponded to 6 patients, 5 of which corresponded to admissions referred for psychopathological decompensations with structured suicidal verbalizations and on one occasion, to nutritional causes. The 11 admissions described on 5 occasions were motivated by drug overdose within the context of major depressive episodes associated to EBD.

Regarding evolution, of the 94 patients who had been attended to in the year 2008, 81 continue in follow-up, 6 have been discharged or have been referred to other facilities for follow up, 2 have requested Voluntary Discharge, and 5 have dropped out of the treatment (Figure 2).

DISCUSSION

Although the prevalence studies on incidence reviewed show that EDNOS currently occupies the first position in regards to EBD prevalence, in our analyses, we detected

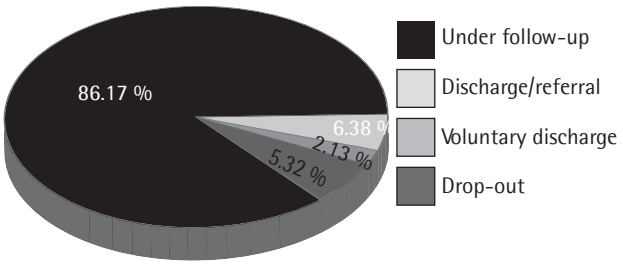


Figure 2 Evolution of the patients attended in the eating behavior disorder clinic during the year 2008. The data are expressed in relative frequencies.

that the most frequent forms of EBD are those of BN (38.3%) followed by AN (28.8%). The reason for this casuistic may be because our center is a facility specialized in the approach to these complex cases with high severity and that the patients mostly come from other facilities where they have not responded to treatment. Thus, it seems more likely that they could correspond to complex clinical pictures of AN and BN and not to incomplete pictures as EDNOS. In fact, these results replicate those obtained by Rockert and Kaplan study[23] where they analyzed the results obtained in an outpatient center for EBD in Toronto and where the mean age of the patients attended is 28.49 years, which therefore is an age comparable with that obtained in our results (29.9 years).

The data obtained also support the results of other studies where the frequency of EBD is much greater in women than in men.[24-29] The discharges do not constitute by themselves a final discharge from the Mental Health Services, but rather mean that when permitted by the patient's clinical stage, the patient is sent to their reference Mental Health Center, where it is understood that they will continue to receive care for EBD, but with less frequency. Keep in mind that in the EBD Clinic, mean attendance to the patient is one visit per week with their responsible therapist in individual session, and according to the case in question, they may also attend a group weekly. On other occasions, because of the limited attendance and compliance with the objectives with the Unit, these patients may be referred to their reference MHC when their lack of attendance has not been justified at least 5 times, this lack of attendance being counted as drop-out, after notification to the patient and the patient's reference psychiatrist.

Although the EBD Clinic was created as a reference facility to provide medical care for this type of patient, and although the limited disease awareness regarding this condition by those suffering it is known, the therapeutic contract and compliance are essential for the good evolution of the picture.

The results obtained in relationship to the high comorbidity of the EBD with the anxiety disorders coincide with the previous. However, there are few studies that evaluate the existence of eating disorder symptoms within anxious disorders. Only one study has evaluated this aspect. It found that in a sample of 257 patients with anxiety disorder, 12% had criteria for EBD.[30]

The appearance of the anxiety disorders generally precedes the appearance of EBD and the early appearance of these disorders is considered a predisposing factor for the development of an EBD.[31] The relationship between the disease prognosis and comorbidity with anxious disorders provide uncertain data. While some studies suggest a worse evolution of the disorder, others reject this idea.[10]

In relationship to the substance consumption,[16] the observational results obtained in this study coincide with other studies in which the prevalence of substance consumption is greater for BN, in which it seems that consumption is mainly focused on cocaine, amphetamines and tranquilizers. These studies relate the use of tranquilizers with the severity of the bingings and alcohol and cocaine with the severity of the purging.[15,18] This relationship could be explained from the dimension of impulsiveness in the bulimic symptoms which have been suggested to be related with the harmful consumption of substances. However, most of the studies, including this one, find limitations in the chronology of the appearance of the eating disorder symptoms and of the substance consumption, above all if these precede the consumption and are a risk factor for the appearance of EBD or appear afterwards.[32]

CONCLUSIONS

With the results obtained in the first year of functioning of this Clinic specialized in the approach of the more complex cases of EBD, we can conclude that there is a need for the creation and maintenance of these specific facilities for the approach to these psychiatric disorders in which there are severe complications, both of a medical and psychiatric type. It is deduced that a subgroup of patients with EBD characterized by important problems in the control of impulses, both on the eating disorder as well as affective level, or of the interpersonal relationships, require specific and intense care. This care should be integrated into a combination of resources that not only make it possible to handle EBD but also its associated traits, such as limited tolerance to frustration, difficulties in interpersonal relationships, toxic consumption and suicidal in parasuicidal gestures that would characterize an extensive group of

patients with multiimpulsive characteristics. These third level care resources should be able to count on the coordination of the entire health care network that would permit the flow of the patients based on their disease stage and the care needs they require. Finally, it must be concluded that at least from this facility, a new profile of EBD patients has been observed. These are long evolution patients with asymptomatic predominance of purging, with important comorbidity with anxiety and substance abuse disorders. And from the care point of view, they require high intensity of both individual and group therapeutic contacts to achieve some self-control and stability. Subsequent studies will show up to what point this type of facility is becoming a resource for the chronicity or for the rehabilitation and remission of the psychopathology of the eating behavior disorder.

REFERENCES

1. Fairburn CG, Bohn K. Eating disorder NOS (EDNOS): an example of the troublesome "not otherwise specified" (NOS) category in DSM-IV. Behav Res Ther 2005;43(6):691-701.
2. Olesti Baiges JPM, Martín Vergara N, de la Fuente García M et al. Prevalencia de anorexia nerviosa, bulimia nerviosa y otros TCA en adolescentes femeninas en Reus. AN Pediatr (Barc) 2008;68(1):18-23.
3. Hoek HW, Brook FG, Patterns of care of anorexia nervosa. J Psychiatr Res 1985;19(2-3):155-60.
4. Lahortiga-Ramos F et al. Incidence of eating disorders in Navarra (Spain). Eur Psychiatry 2005;20(2):179-85.
5. Emborg C. Mortality and causes of death in patients with eating disorders in Denmark, 1970-1993. Ugeskr Laeger 2001;163(25):3476-80.
6. Herzog DB et al. Mortality in eating disorders: a descriptive study. Int J Eat Disord 2000;28(1):20-6.
7. Nakamura K, et al. Prevalence of anorexia nervosa and bulimia nervosa in a geographically defined area in Japan. Int J Eat Disord 2000;28(2):173-80.
8. Ghaderi A, Scott B. Prevalence, incidence and prospective risk factors for eating disorders. Acta Psychiatr Scand 2001;104(2):122-30.
9. Schwalberg MD et al. Comparison of bulimics, obese binge eaters, social phobics, and individuals with panic disorder on comorbidity across DSM-III-R anxiety disorders. J Abnorm Psychol 1992;101(4):675-81.
10. Swinbourne JM, Touyz SW. The co-morbidity of eating disorders and anxiety disorders: a review. Eur Eat Disord Rev 2007;15(4):253-74.
11. Laessle RG et al. Major affective disorder in anorexia nervosa and bulimia. A descriptive diagnostic study. Br J Psychiatry 1987;151:785-9.
12. Fernandez-Aranda F et al. Impulse control disorders in women with eating disorders. Psychiatry Res 2008;157(1-3):147-57.
13. Corstorphine E et al. Trauma and multi-impulsivity in the eating disorders. Eat Behav 2007;8(1):23-30.
14. Bulik CM et al. Alcohol use disorder comorbidity in eating disorders: a multicenter study. J Clin Psychiatry 2004;65(7):1000-6.
15. Franko DL et al. Interactions between eating disorders and drug abuse. J Nerv Ment Dis 2008;196(7):556-61.
16. Holderness CC, Brooks-Gunn J, Warren MP. Co-morbidity of eating disorders and substance abuse review of the literature. Int J Eat Disord 1994;16(1):1-34.
17. Herzog DB et al. Drug abuse in women with eating disorders. Int J Eat Disord 2006;39(5):64-8.
18. Wiederman MW, Pryor T. Substance use among women with eating disorders. Int J Eat Disord 1996;20(2):163-8.
19. Wiseman CV et al. Substance dependence and eating disorders: impact of sequence on comorbidity. Compr Psychiatry 1999;40(5):332-6.
20. Madrid., P.d.S.d.l.C.d. Pacto social de la comunidad de Madrid contra los Trastornos del comportamiento alimentario: La anorexia y la bulimia. 2007; Available from: <http://www.madrid.org/cs>).
21. Cassin SE, Von Ranson KM. Personality and eating disorders: a decade in review. Clin Psychol Rev 2005;25(7):895-916.
22. Newton JR Freeman CP, and J. Munro, Impulsivity and dyscontrol in bulimia nervosa: is impulsivity an independent phenomenon or a marker of severity? Acta Psychiatr Scand 1993;87(6):389-94.
23. Rockert W, Kaplan AS, Olmsted MP. Eating disorder not otherwise specified: the view from a tertiary care treatment center. Int J Eat Disord 2007;40 Suppl:S99-S103.
24. Ruiz-Lazaro PM. Epidemiology of eating behavior disorders in Spain. Actas Esp Psiquiatr 2003;31(2):85-94.
25. Pelaez-Fernandez MA, Labrador FJ, Raich RM. Comparison of single- and double-stage designs in the prevalence estimation of eating disorders in community samples. Span J Psychol 2008;11(2):542-50.
26. Imaz C et al. Health care analysis of eating disorders in Valladolid. Actas Esp Psiquiatr 2008;36(2):75-81.
27. Hoek HW, van Hoeken D. Review of the prevalence and incidence of eating disorders. Int J Eat Disord 2003;34(4):383-96.
28. Mancilla-Diaz JM et al. A two-stage epidemiologic study on prevalence of eating disorders in female university students in Mexico. Eur Eat Disord Rev 2007;15(6):463-70.
29. Hay PJ et al. Eating disorder behaviors are increasing: findings from two sequential community surveys in South Australia. PLoS ONE 2008;3(2):1541.
30. Becker CB, DeViva JC, Zayfert C. Eating disorder symptoms among female anxiety disorder patients in clinical practice: the importance of anxiety comorbidity assessment. J Anxiety Disord 2004;18(3):255-74.
31. Bulik CM et al. Eating disorders and antecedent anxiety disorders: a controlled study. Acta Psychiatr Scand 1997;96(2):101-7.
32. Dawe S, Loxton NJ. The role of impulsivity in the development of substance use and eating disorders. Neurosci Biobehav Rev 2004;28(3):343-51.