I am often asked why the Wilkins Center was established. In 1981 I had a general medical practice in Greenwich, Connecticut. As one of the few female physicians in town, I saw many women, especially young women. Several appeared with anorexia nervosa.

The approach to eating disorders in those days was simple. Because anorexia was a psychiatric problem, the patient was referred to a psychotherapist. I found, however, that many therapists were reluctant to treat anorexics. A psychiatrist whose work I respected told me candidly that he did not find he could help such women. Others accepted patients for years of treatment, but the patients remained as ill as before.

I saw an anorexic teenager whom I referred after much difficulty to a child psychiatrist. When her sister became anorexic later that year, the best we could do was to find a therapist many towns away. Her parents commented that the two therapists gave conflicting
advice. The parents felt uninvolved and at a loss as to how to help their daughters. They observed that while the girls discussed their feelings in treatment, they remained unable to eat and continued to lose weight. One sister required a long-term psychiatric hospitalization and was discharged still unable to maintain a normal weight. This kind of experience contributed to the belief that eating disorders simply were not treatable.

The idea of a treatment center began to take shape. Perhaps we could bring to our community the techniques producing the best results elsewhere. I began to visit some of the early specialists in treating eating disorders: in New York, in Baltimore, in California, in Boston, in Canada. There was no consensus among them about what approach to use, but many had suggestions and generously shared their experience and support.

When the Wilkins Center for Eating Disorders opened in November 1982, we had a nucleus of professionals committed to improving care for patients with eating disorders. In the ensuing years, the Center has been involved in the care of more than three thousand anorexic and bulimic patients. The staff expanded quickly to almost thirty, allowing each member to provide the intensive care many patients required. We used offices throughout Westchester County, New York, and Fairfield County, Connecticut, so that patients might have frequent visits with less travel. While most continue to come from Connecticut and New York, we also treat patients from other states as well as from Europe, Latin America, and Asia, who elect to reside in the area temporarily to receive state-of-the-art treatment.

The professionals involved in the Wilkins Center developed an extraordinary level of commitment, cohesiveness, and expertise. Seminars, study groups, and supervision, as well as extensive clinical experience, promoted individual and collective development. The staff’s personal and professional closeness facilitated a team approach: Individual and family therapists, group leaders, physicians, nurses, and dietitians collaborated to provide coordinated and comprehensive care. High patient volume enabled us to target subsets with specialized needs: younger teens, high school and college students, single adults, married women, pregnant patients, and eating disordered mothers. Services also expanded to encompass the
needs of patients whose eating difficulties coexisted with other psychiatric problems, including substance abuse, personality disorders, or the effects of trauma.

The primary focus of the Wilkins Center has always been clinical treatment but that has expanded to include research and prevention. Affiliations were formed primarily with colleagues at Yale University, but also with those at Harvard University and Columbia University. Wilkins staff served as founders and leaders of national advocacy groups, government task forces, and professional organizations. The staff donated time to public education, at local schools, through media interviews and in television appearances.

Although the Wilkins Center initially targeted anorexic and bulimic patients who were typically close to normal weight or underweight, we were approached by an increasing number of patients who were overweight. Some seemed to have a biological problem—a genetic tendency to be heavy—compounded by an American lifestyle high in calories and low in exercise. Others, however, especially “compulsive overeaters,” shared many features of our bulimic patients. They were preoccupied with the pursuit of thinness, often with endless cycles of dieting and then bingeing. Depression (and sometimes alcoholism) was common in such patients and their families.

A new category of eating disorder was proposed in 1992: binge eating disorder (Spitzer et al. 1993). These men and women binge but they do not purge. They tend to fail traditional weight-loss programs but seem to benefit from treatments similar to those developed for bulimia (McCann and Agras 1990). People who fulfill the criteria for the “binge eating disorder” represent up to 2 percent of the general population, from 30 percent to 50 percent of patients in hospital weight-loss programs, and up to 70 percent of people in Overeaters Anonymous. Thus treatment developed in the past decade for bulimia may benefit a far larger population than originally envisioned.

With skilled specialists and expanding treatment options, the majority of patients with eating disorders can hope to get better. Treatment for eating disorders is not magical. It takes sophisticated care, hard work, and time, often far longer than we wish. Unfortunately the current revolution in health care may significantly restrict access to experts and limit both intensity and length of treatment. Yet with sufficient care, large numbers of patients can and do
recover. Many resolve adolescent issues, develop heightened self-esteem, improve relationships, and expand coping skills in ways that provide lifelong benefits.

This book is an effort to share some of what we have learned from our patients and one another, as well as some of the advances in the field of eating disorders during a pioneering era.

Eating disorders are complex syndromes occurring in diverse people and settings. They vary in the physical toll they take. Some patients are physically stable, others are in acute medical danger or developing chronic health problems. Some are fairly well nourished, others restrict or binge to the exclusion of any normal eating.

Psychological well-being also varies widely. Eating disorders may be precipitated by the developmental needs of adolescence or by an acute crisis. They may compound long-term difficulties with low self-esteem, obsessionalism, or depression. They may coexist with anxiety, panic attacks, or personality disorders. They may worsen in seeming paradox despite recovery from alcoholism, acceptance at college, or a wonderful social relationship.

Patients come with different attitudes toward treatment. Some may feel they have no problem or can recover “on their own”; others have had so much treatment that they have lost hope. One person may long to resolve basic difficulties in psychotherapy, while another, convinced that the problems are biological, may seek medication. Some wish to come alone; some prefer to be with parents or spouse; some seek the sharing and support of a group.

Families, too, vary in their understanding of eating disorders, past experience with treatment, and perceptions of what is best for their daughter. They may seek a suitable inpatient program or hope that intensive outpatient care will avert the need for hospitalization. Parents may have to juggle the demands of a child’s illness with the needs of their own marriage, their careers, aging grandparents, and other offspring. Emotional and financial resources and burdens differ from family to family.

To complicate this picture further, professionals, too, may vary in their approaches or may offer conflicting advice. If parents suspect an eating disorder, where can they go for evaluation? If a person seeks treatment, what kind and what setting is best? If a patient is in
therapy or on medication but continues to struggle, would a change jeopardize progress or speed recovery?

Over the past two decades we have been confronted by these issues every day. We have the luxury of comprehensive services: medical, nutritional, psychiatric, psychological, individual therapists of many styles, family and marital therapists, and a wide array of groups. All the professionals on the staff have extensive clinical experience and many years of specialization in eating disorders. Many have particular strengths: working with adolescents, with parents, with alcoholics, with victims of abuse, and so on.

Having worked together on hundreds of patients, we are used to collaborating. We can trust the physician to monitor medical problems. We expect the dietitians to be doing cognitive and behavioral work on the reality of eating. Therapists will be working to help patients understand what needs their symptoms are serving. Groups can lessen isolation. Staff professionals work in conjunction with one another, sharing observations, problems, and goals. Our answering machines fill with long messages as we share significant developments from a patient’s session. Though we work exclusively on an outpatient basis, we are able to provide the intensity of treatment, as well as the sense of being in a therapeutic community, that facilitates progress in hospital settings.

Each patient needs a treatment plan suitable to her needs. Would outpatient or hospital care be preferable? Should patients work individually or in family therapy? Will nutritional counseling be useful? Should medication be avoided or encouraged? When might group therapy be helpful? Not only must we decide what to recommend but we must enlist and maintain the patient’s involvement and the parents’ trust (if the patient is a child or adolescent) if treatment is to proceed and succeed.

Sound recommendations require a thorough evaluation. This includes a careful history, psychological assessment, review of physical findings, and laboratory tests. A plan is developed in conjunction with the patient and, if appropriate, with the patient’s family. Four to six weeks may be required for patient, therapist, and nutritionist to begin to work together enough to assess potential success. Throughout treatment, however, periodic review is necessary to adjust care, as needed, to a person’s current situation.
Eating disorders impact health and emotional well-being. They also complicate major and minor life decisions. Should she go to camp? Should she go to (or back to) boarding school or college? Is it wise to travel or study abroad? To ski, run, or play varsity sports? How should families handle food shopping and mealtimes? How do they respond to “I feel so fat”? Members of the treatment team collaborate with patients and families in working out the many immediate issues that continue throughout the extended time it may take to resolve eating disorder symptoms and then to ferret out their psychological underpinnings.

The following papers describe the approach of some of the Wilkins Center staff. They offer a variety of perspectives. But which is best suited to each patient and at what point in treatment? There is no cookbook recipe for treating eating disorders. The success of treatment hinges on its suitability for the person involved and its adaptation to her evolving needs over time. This requires the skills of experienced specialists in a good working alliance with the patient and the patient’s family.

References
