

# Stonebriar Psychiatric Services News & Views Anorexia

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## *Starving to Death in the Land of Plenty*

Last month in the newsletter we discussed the concept of bulimia nervosa, characterized by binge eating coupled with behaviors intended to prevent weight gain, such as intentional vomiting, excessive laxative use, or use of diuretics. This month I would like to address the eating disorder counterpart, which is anorexia nervosa. Anorexia nervosa is characterized by the intentional use of various behaviors whose purpose is to lose weight or maintain weight loss, coupled with an extreme fear of gaining weight with disturbance of body image, feeling fat when one may actually be dangerously thin and malnourished. By definition, the diagnosis requires that one's weight be at least 15% below the ideal range for one's height and age, coupled with amenorrhea, although many experts today question whether the latter needs to be present to support the diagnosis.

The individual may begin at or above one's ideal weight, but frequently the disorder begins with the types of diet that is common among teenagers and adults in our society. However, after perhaps receiving some complements on their loss of weight, it can get out of control and can become this dangerous illness. Eating disorders, including bulimia, are reported in up to 4% of adolescent and young adult women. Anorexia nervosa is estimated to occur in approximately .5-1% of adolescent girls and 10-20 times more often in females than males. The disorder may occur without meeting full diagnostic criteria in 5% of young women, which diagnostically is categorized as an eating disorder, not otherwise specified, and yet may have similar risks regarding health and psychiatric well-being. It no longer seems to be restricted to upper socioeconomic classes as originally reported, although it still seems to be more common in developed countries and in women who participate in various activities where thinness is desired, such as modeling, gymnastics, or ballet.

### *Truly a "Bio-Psycho-Social" Illness*

As with bulimia, the etiology of anorexia nervosa is multi-factorial with biological, psychological, and social factors playing a role. There seems to be a genetic predisposition as the incidence tends to be higher in certain families and in identical twins relative to fraternal twins. Mood disorders and other psychiatric illnesses, such as anxiety disorders or obsessive-compulsive disorders, tend to be more common in family members. With the onset of starvation, numerous physiological changes can occur which play a biological role in continuing the illness. Thyroid functioning may be depressed with starvation along with loss of menstrual periods due to lowered hormonal levels. However, some anorexic patients may maintain their menses in spite of low weights, but this does not indicate that their illness is less serious or less threatening. There may be abnormalities in neurotransmitter production which can affect mood, and a common, but serious, side effect of this starvation can be the loss of adequate bone formation resulting in early osteoporosis. As the weight loss increases, physical symptoms such as hypothermia can occur causing the individual to frequently feel cold. They may experience edema, low heart rate and blood pressure, as well as lanugo, the growth of a very fine hair over much of their body. The combination of purging, frequently with its associated metabolic changes, coupled with extreme low weight and malnutrition represent one of the most dangerous combinations in the eating disorder spectrum.

There can be a number of psychological factors which contribute to the development of anorexia nervosa. One important issue which is frequently present revolves around separating from one's family and becoming more independent. It is felt that is one reason why the onset frequently occurs at points of transition regarding independence, such as in early adolescence as one is becoming a young adult with one's physical and sexual development and the "leaving of childhood," along with late adolescence as one is frequently taking steps to move out on ones own into the adult world. As we mentioned last month, many bulimics tend to be more outgoing and at times sexually active, whereas those with anorexia often avoid relationships where that might be an issue. However, there is also a pattern of anorexia in which the diagnostic



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criteria are met but bingeing and/or purging is also present. Frequently these individuals may present with a mixed pattern of psychological issues. A key issue for many who struggle with an eating disorder revolves around a difficulty in trusting others to consistently meet their needs with a fear of being emotionally vulnerable. This is well described in a book by Steven Levenkron entitled Anatomy of Anorexia, which I would recommend as reading for all individuals and families struggling with anorexia.

Social factors may also play a significant role in the development of anorexia nervosa. Our society's emphasis on thinness and exercise can certainly affect a young girl's self-image and what she feels it takes to be a popular and successful woman. There is no specific family pattern identified with anorexia nervosa, although frequently there tend to be overly close, and yet troubled, relationships with parents.

### *Treatment and Prognosis*

In light of the complexity and medical implications of this illness, the treatment course is frequently long and difficult. As with bulimia, it should include early on a good physical exam and laboratory studies. One of the first decisions to be made is whether it can be treated as an outpatient or whether the individual needs to be in the hospital. Some of the factors that are considered in determining this include how rapidly the weight has been lost and to what degree, whether there are any significant physical findings such as very low heart rate or blood pressure, which may result in dizziness or fainting when the patient stands up, or whether there are any significant findings on laboratory studies or EKG. For individuals whose weight may be 30% or more below their ideal, extended hospitalizations are frequently necessary in programs specifically oriented to treating those with eating disorders.

Other alternatives for treatment include intensive outpatient programs, day hospitals, or regular therapy appointments with a psychiatrist or therapist and dietitian. Various therapy modalities may be used, including group, individual, and family therapy. Family therapy has been found to be particularly helpful with adolescents. One of the major difficulties in treating those with eating disorders, and particularly those with anorexia, is that frequently the individual does not want treatment and may be quite resistant to getting involved in the process. One of the initial goals in any treatment is to try and establish a therapeutic relationship with the patient in which she feels able to trust the therapist and eventually to understand that the therapist, even if encouraging her to gain weight, is ultimately acting in her best interest. The difficulty of this endeavor is well described in Levenkron's book.

Thus far no specific medication has been found which consistently yields significant or consistent improvement in the core symptoms of anorexia. Some studies have found Periactin and other medications which stimulate appetite to be helpful. However, many of these young women already live with constant hunger, and the idea of a medicine that tries to "make them eat" is frequently terrifying for them. If depression is present, anti-depressants may be helpful if one understands that you cannot achieve full therapeutic benefit until there has been some weight restoration. Some of the newer "antipsychotic" medications have also been helpful in low doses, and it is felt that this is partly due to alleviating some of the body image anxiety and possibly some of the distortion, which at times almost seems to take on delusional proportions. Needless to say there is still much research to be done regarding the treatment of these eating disorders.

Ten year outcome studies have indicated that approximately one fourth of patients recover completely, one half are markedly improved and functioning fairly well, while another fourth tend to be functioning poorly with rather chronic malnutrition or else have died. Keep in mind that there is approximately a 7-10% mortality rate with eating disorders, the highest of any psychiatric illness. It should also be remembered that approximately 50% or more of the individuals who began with anorexia may evolve into a clinical picture of bulimia, often within the first year or two of onset.

Although eating disorders may represent some of the most difficult psychiatric illnesses to treat and most dangerous with which to live, it should also be stressed that recovery is possible though difficult. The first step, as has been stressed previously, is recognizing and acknowledging that there is a problem that needs to be addressed rather than avoided.



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