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Anorexia Nervosa

The most shocking fact about anorexia nervosa is that it has the highest mortality of any psychiatric disorder. This does not even take into account the short and long term health problems experienced by the people who survive the condition. Anorexia nervosa has a prevalence of 0.3% in women. This may seem low, but this actually means that approximately 7000 women in the Irish Republic and about 150 women in Westmeath alone are currently battling this condition. Bulimia nervosa is five times more common than anorexia so based on statistics, this means that approximately 750 women in Westmeath alone currently suffer from this condition.

Anorexia nervosa is more than twice as common in teenage girls as older women; it has an average age of onset of 15 years; 80 to 90% of anorexia sufferers are female. Anorexia nervosa and bulimia nervosa are the most common causes of weight loss in young women. They are the most common admission to child and adolescent hospital services. Anorexia nervosa takes an average of five to six years from diagnosis to recovery. Up to 30% of patients do not recover. For the purpose of this article; I will refer to anorexia nervosa simply as anorexia.

Research

Ironically, despite the fact that anorexia is the most lethal of any psychiatric disorder in terms of physical health and fatality, there is relatively limited knowledge and research on the condition. This is mainly due to the secrecy and denial of those who suffer from the condition. The fact it is so difficult to get anorexia sufferers to engage in treatment means that asking patients to take part in research and studies on their condition is extremely challenging.

There is much more research on the physical problems caused by starvation so there is a well-recognised pathway for the treatment of starvation; the problem with anorexia is that the sufferer may not accept they need treatment so will not engage in treatment.

Signs and symptoms

The main psychological feature of anorexia nervosa is the extreme overvaluation of shape and weight. People with anorexia also have the determination to tolerate extreme hunger and self-imposed weight loss. Food restriction is only one aspect of the practices used to lose weight. Many people with anorexia use over-exercise and over-activity to burn calories. They often choose to stand rather than sit; generate opportunities to be physically active; and are drawn to sport, athletics, and dance. Purging practices include self-induced vomiting, together with misuse of laxatives, diuretics, and “slimming pills.” The practise of “body checking” is another feature of many anorexia sufferers; this involves repeated weighing, measuring, mirror gazing, and other obsessive behaviour as reassurance that they are still thin. Losing weight becomes an addiction and like any addiction the point of complete satisfaction (with one’s weight in the case of anorexia) is never attained. Eating becomes an “evil” thing in the eyes of the sufferer. In this way, it is not that dissimilar to other addictive or psychological type disorders such as alcoholism, drug addiction, gambling addiction etc. Initially the person is able to lead a fairly normal life. It is often only in the end stages when the person becomes so physically and psychologically unwell that it is obvious there is a problem and the person can no longer lead a normal life.

It falls to family members and primary care services (eg. patient’s GP) to recognise and manage relapses as well as first episodes of the illness. General practitioners may need support from a specialist in eating disorders, and early referral for more detailed assessment and advice gives the person the message that their illness is of genuine concern.

Physical signs of malnutrition and purging apart from a low weight include thinning hair, swollen parotid gland (this is swelling of the salivary glands which shows as a swollen face), enamel erosion, hypothermia, bradycardia (slow heart rate), lanugo hair (this is the growth of soft downy hair on face, back and arms), dry

skin, low blood pressure, cold hands and blue or uneven colour in extremities such as hands or feet, poor capillary return, carotenaemia (a yellowing of the skin caused by excess carotenoids, especially the palms of the feet and soles of the hands), insensitivity to pain, constipation, amenorrhoea (lack of periods in women) and shrunken breasts.

Causes

There is no one primary cause of anorexia but there are many factors that increase risk. There is some evidence of a genetic risk meaning that it may run in families; however there is not always an obvious genetic link. Anorexia nervosa is sometimes used as a coping mechanism against the like of developmental challenges, transitions, family conflicts, and academic pressures. Sexual abuse may precipitate anorexia but it doesn't cause anorexia to any greater degree that it triggers other psychiatric disorders. There is some evidence suggesting that anorexia is linked to family history of obsessive, perfectionist, and competitive traits, and possibly also autistic traits; more research is required.

Diagnosis

Suspicion that anorexia is a possibility usually initially comes from family, friends or schoolteachers (in the case of younger people). The weight loss may be well concealed by the person so at times the first presenting features that bring the person in contact with medical professionals are psychological or physical problems such as depression, obsessive compulsive disorder, infertility or amenorrhoea (absence of periods). Basic medical investigations, blood tests, electrocardiography, weighing, and measuring the patient provide an opportunity for the patient to return (to discuss the results) and can uncover psychological problems. If the patient refuses to be weighed it is worth persisting gently and exploring their fears.

Differences between anorexia and bulimia

Anorexia nervosa	**Bulimia nervosa**
Low weight	Normal weight
Presents early	Presents later
Rarely seeks help	May seeks help
Onset early to middle teens	Onset in late teens
Can start in younger children (pre-teens)	Rarely occurs in younger children
Can affect boys	Rarely in boys
Acute or chronic	Fluctuating course
No previous illness	Previous anorexia nervosa
Associated with anxiety, obsessive compulsive disorder and depression	Associated with depression, self-harm and substance misuse
Prognosis is poor without early intervention	Up to 60% respond to specific treatments

Assessing risk

The level of physical risk should be assessed at diagnosis. However there is no exact guidance available for safe cut off weight or body mass index. Studies show death is unusual where low weight is maintained by starvation alone. Death is more likely if the patient's weight fluctuates rapidly rather than being stable, even if the body mass index is consistently less than 12. Risk is also increased if the patient frequently purges or misuses substances to lose weight. Compulsory treatment for anorexia nervosa is clearly indicated by mental health legislation in acute emergencies where the patient is unable to accept treatment and immediate danger of death or irreversible deterioration is close. In most countries this means detention in hospital. Legal responsibility is not clear when there is an immediate danger of death or irreversible physical damage has occurred. Longer detention orders may be invoked to continue compulsory re-feeding to a healthier weight.

Tips for family members

- Recovery takes years rather than weeks or months. Psychological treatment is core to treatment as patients must be convinced that they need to attain a normal weight. Re-feeding alone will likely lead to relapse.
- Progress should be monitored by weighing. Monitoring needs to be managed skilfully so it does not become a battleground
- No cut off weight or body mass index exists because many other factors influence risk
- Substance misuse (including alcohol, deliberate overdoses, use of laxatives or misuse of prescribed insulin) greatly increases risk
- Weight fluctuations and binge-purge methods rather than pure starvation alone increases risk
- Depression, anxiety, and family arguments are usually caused by the disorder (rather than these factors causing anorexia); therefore the anorexia must be treated first before tackling other issues.
- Medication has little benefit in anorexia and the risk of dangerous side effects is higher in malnourished patients (Medication has more success in helping treat bulimia).
- Involving the family in treatment and care encourages calm firmness and assertive care. Family involvement increases the chances of recovery.

Psychotherapies

1. Individual therapy

Structured individual treatments are usually offered as a weekly one hour session with a therapist trained in the management of eating disorders and in the therapy model used. Therapies available include:

Cognitive analytic therapy
This psychotherapy uses letters and diagrams to examine habitual patterns of behaviour around other people and to experiment with more flexible responses.

Cognitive behaviour therapy (CBT)
A form of therapy that emphasises the important role of thinking in how we feel and what we do. CBT challenges the automatic thoughts and assumptions behind behaviour in anorexia.

Interpersonal psychotherapy
A talking therapy that focuses on relationship based issues and aims to provide new techniques in dealing with distress.

Motivational enhancement therapy
This psychotherapy uses interviewing techniques derived from work with substance misuse to reframe “resistance” to change as “ambivalence” about change, and to nurture and amplify healthy impulses.

Dynamically informed therapies
These therapies will only provide weight gain if the patient can be convinced of the risk of irreversible physical damage or death and acknowledges that certain boundaries (for example, that they must be weighed weekly, examined regularly by a doctor, and admitted to hospital if weight continues downwards) are observed. Therapies involved include talking, art, music, and movement.

2. Group therapy

Group therapy is not recognised as an effective therapy type for anorexia

3. Family involvement

The term “family work” covers any intervention that utilises the strengths and support of the family to tackle the patient’s disorder. “Family work” also tries to deal with the family’s stress due to the disorder. It includes family therapies, support groups and psychoeducational input.

Conjoint therapy
The Maudsley model of family therapy and similar interventions have been found to be effective therapies. Whole families (or at least the parents and the patient) attend counselling sessions together.

Separated family therapy
The patient and the parents attend separate meetings, sometimes with two different therapists. This form of therapy seems to be as effective as conjoint therapy, particularly for older patients, and involves lower levels of expressed emotion.

Multifamily groups
Such groups provide a unique way of empowering parents by means of peer support and help from a therapist. Several families, including the patients, meet together for intensive sessions that often last the whole day and include eating together.

Relatives’ and carers’ support groups
These groups range from self-help groups to highly structured sessions led by a therapist that aim to teach psychosocial and practical skills to help patients with anorexia to recover while avoiding unnecessary conflict. Most aim to provide information and advice about the nature of anorexia.

How effective is psychotherapy

Short term structured treatments such as cognitive behaviour therapy and interpersonal psychotherapy are effective in other eating disorders but are not nearly as effective with anorexia. Studies have found no difference in outcome when behaviour therapy and cognitive therapy is provided. Some studies have shown some benefits with these therapies.

Expert consensus favours long term, wide ranging, complex treatments using psychodynamic understanding, systemic principles, and techniques borrowed from motivational enhancement therapy and dialectical behavioural therapy (explained above). The guiding principle of motivational enhancement is to acknowledge and explore rather than fight the patient’s ambivalence about recovery. Treatment is more effective when the therapist and the patient work together to tackle anorexia.

Family work is the only well researched intervention for anorexia that has a proven beneficial impact. Family work teaches the family and patient to be aware of the perpetuating features of the disorder. Anger and fighting lead to entrenched symptoms but too much tolerance and lenience towards the condition can encourage the condition by allowing it to become accepted. A balance needs to be found which is why families need professional guidance. Studies indicate that therapies involving the family and the patient tend to provide better results in terms of psychological improvement but weight gain was greater when families were seen by the therapist separately from the patient.

Accepted best management

Coercive approaches may result in impressive short term weight gain but make patients more likely to identify with and cling on to the behaviour associated with anorexia. Overall prognosis for patients with eating disorders is not actually dependent whether treatment is received or not. Traditional regimens for anorexia have been proven to be counterproductive. This includes incarceration in hospital, with removal of all “privileges” (such as visitors, television, independent use of bathroom), which were given back as a reward for weight gain.

This method of approach rarely provided sustainable improvement and often exacerbated the issue as the patient resented the cruel conditions and rebelled against general consensus once independence was regained. Hospital admission has been shown to have poor outcomes. Long term prognosis is worse for patients compulsorily detained in an inpatient facility than for those treated voluntarily in the same unit, with more deaths in the first group.

Is drug treatment effective?

Drug therapy tends not to be an effective treatment option for anorexia. Antidepressants are frequently used to treat depressive symptoms but have limited success. Evidence shows that antidepressants can be very effective in the treatment of bulimia; however for reasons that are not fully understood, they tend not to be nearly as effective for anorexia nervosa. There are some reports of the benefit of antipsychotic medication such as olanzapine to provide weight gain. This is likely to be due to the relief of anxiety and increased appetite. Increased appetite is a recognised “negative” effect of antipsychotics, especially olanzapine, but this actually becomes a “positive” effect in the case of anorexic patients. Harmful cardiovascular side effects of antipsychotic medication tend to be more pronounced for malnourished patients due to electrolyte imbalances; therefore more careful monitoring is advised than normal.

Prognosis

Full recovery has been demonstrated even after 21 years of chronic severe anorexia nervosa. However, there is approximately a 20% mortality rate. Bone recovery takes years rather than months, so patients should protect the spine and pelvis in particular against activities such as gymnastics too early after weight gain. Psychological recovery can in many situations be more challenging than physical recovery. Short term therapy is less effective; longer term therapy is generally required.

Useful organisations

BodyWHYS

Bodywhys is a national voluntary organisation supporting people affected by eating disorders. They aim to ensure support, awareness and understanding of eating disorders amongst the wider community as well as advocating for the rights and healthcare needs of people affected by eating disorders including the families of those affected. They provide support and education through volunteers as well as providing support and advice through their helpline as well as online support through their website (www.bodywhys.ie). For more help and information, you can lo-call Bodywhys at 1890 200 444 or e-mail info@bodywhys.ie.

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References

References for this article are available on request. The article was written and researched by pharmacist Eamonn Brady and Eamonn will forward references upon request.