EATING DISORDERS

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Chapter by Professor Gerhard Jordaan.

"Perhaps we could have a society that values humanity rather than one that spends time at the gym, obsessed with appearance" Time Magazine, 22 November 1999.

Eating disorders are classified in the diagnostic manuals as: anorexia nervosa, bulimia nervosa and eating disorders 'not otherwise specified'. Anorexia nervosa is characterised by refusal to maintain a minimum (<85% of expected) body weight, an intense fear of weight gain, a disturbed body image and amenorrhoea for at least 3 months. Two types are described: the restricting type, and the purging type. Bulimia, on the other hand, is characterised by eating binges together with compensatory behaviour, which includes inappropriate methods (like purging) aimed at losing weight.

What causes these eating disorders?

The exact causes and pathogenesis of eating disorders are not known. Biological, psychological and social factors probably contribute to the development of these disorders in susceptible individuals. It is well known that Western society attaches great importance to physical appearance and weight, but it is also true that not everyone who diets develops an eating disorder. Certain findings suggest that *biological factors* play a role. There is evidence that the co-occurrence of eating disorders is higher in monozygotic than in dizygotic twins, and that there is a higher incidence of mood disorders in families of patients with eating disorders than is found in the general population.

Eating disorder patients frequently encounter problems with autonomy and self-image. Anorexia nervosa may sometimes be the only terrain in which an individual may feel safe and in control. In contrast, the patient with bulimia often experiences a feeling of being out of control.

Overall, the causes of eating disorders remain complex, and are an enigma to all who have had to deal with them. Although, as in substance abuse, it may appear that the individual has simply brought the condition upon her- or himself, it is remarkable how difficult it is even for the most motivated patient to escape from the clutches of an eating disorder.

Clinical features:

Anorexia nervosa usually has its onset between the ages of 10 and 30 years, but 85% have their onset between 13 and 20 years. Patients usually present with a surreptitious reduction in food intake, which is reported by family members. The appetite is initially normal, but patients become obsessed with food and fear weight gain. Obsessive-compulsive behaviour regarding food is common, and includes calorie counting, weighing of food and ritualistic exercise. The disturbed body image of anorexia nervosa is characteristic. Self-induced vomiting and the use of laxatives and appetite suppressants may be present. In addition, these patients often experience concomitant major depressive disorder and anxiety symptoms.

Physical complications vary considerably, but anorexia nervosa remains one of the psychiatric disorders with the highest mortality rate (5-18%). Loss of weight and amenorrhoea (the absence of menstrual periods in a woman of reproductive age) are the most characteristic physical changes. Other signs include bradycardia (slow heartrate), hypotension (low bloodpressure), and hypothermia (low body temperature). Downy lanugo hairs on the skin are common, while unexpected fractures may arise because of osteoporosis. Hypokalaemia (a condition in which the concentration of potassium (K^+) in the blood is low), especially when associated with cardiac arrhythmias and metabolic alkalosis (a metabolic

condition in which the pH of tissue is elevated beyond the normal range (i.e. 7.35-7.45), is a serious metabolic complication.

Although ***bulimia nervosa*** is characterised by uncontrolled eating binges, sufferers often experience a state of starvation. Bulimia patients also try, as do anorexic patients, to lose weight, but usually cannot sustain their dietary limitations indefinitely. Therefore, meals (especially breakfast) are often skipped, but are followed by binge eating episodes later on in the day, or even later during the same week. These "failed" attempts at dieting create tremendous feelings of guilt and contribute to the compensatory behaviour exemplified by self-induced vomiting, excessive exercise, and the abuse of laxatives, appetite suppressants or diuretics. Bulimia is often associated with co-morbid conditions such as major depressive disorder, impulse control disorder, dissociative disorder, anxiety disorder, substance abuse, and personality disorder. A history of sexual abuse is more frequently seen in bulimia than it is in the general population, but is similar to that found in other psychiatric disorders. Physical complications include electrolyte disturbances, gastric and oesophageal tears, hypokalaemia and tooth enamel erosion.

Course of illness:

Eating disorders have an unpredictable course, but tend to be chronic and recurrent. In general, it appears that bulimia has a better prognosis than anorexia. Patients with anorexia do better if they acknowledge the condition, have normal psychosexual development and possess a good self-image. As has been pointed out, the mortality rate of anorexia nervosa varies from 5% to 18% deaths per year.

Management and treatment:

The long-term results of conventional inpatient treatment of anorexia nervosa are not very good. In unmotivated patients, weight loss often recurs after restoration of their nutritional state and discharge. Hospitalisation is unaffordable to many medical aid funds and individuals. In many centres, day patient programs and outpatient management have become the treatment methods of choice. The goal of these

programs is to promote autonomy, self-control and self-image in the patients. Treatment comprises patient education regarding the disorder and the gradual initiation of cognitive-behavioural therapy, especially in bulimia patients. The patient is thus involved in the management plan and shares the responsibility for her/his own treatment.