NORTH BAY PSYCHIATRIC
ASSOCIATES

Eating disorders

Steven Balt, MD

Disordered eating takes many forms, from peculiar eating habits to compulsive overeating, to the "classic" eating disorders of anorexia and bulimia nervosa. Psychiatric help is essential when these unusual eating patterns start to interfere with one's life (i.e., relationships, school, work, etc) or when other health problems arise. Unfortunately, one common characteristic of the patient with an eating disorder is that he or she doesn't acknowledge—or even *recognize*—the impact his/her eating disorder is having on his/her life.

What are the eating disorders?

Anorexia nervosa is characterized by the deliberate refusal to maintain one's body weight, resulting in a body weight that is much lower than it should be, as well as a great *fear* of gaining weight or becoming fat. People with anorexia usually have a distorted view of their bodies, their weight or shape, and deny that their low body weight is of any significance. Anorexia is more common in women, with about 90% of cases in females, although it appears to be on the rise in men. Typically, it is seen in women and men who are active in dance, athletics, or modeling, and who have personality traits such as perfectionism, obsessive-compulsive features, negative emotionality, and harm avoidance.

In bulimia nervosa, patients engage in recurrent episodes of binge eating, ni which they feel they "lose control" over what they eat, and then try to compensate through self-induced vomiting, excessive exercise, fasting, or other means to prevent weight gain. As with anorexia, bulimia is found most commonly in people who have perfectionistic features and who have excessive concern for their body image or appearance—a concern that simply intensifies as the disease progresses.

What causes anorexia and bulimia?

Very little is known about the biology of anorexia and bulimia. As a result, there are few recognized medication interventions that can help to "normalize" appetite and food intake. Certainly, biological abnormalities are sometimes seen in patients with eating disorders, such as electrolyte imbalances and different patterns of brain activity when a person eats or thinks about food, but it is not clear whether these are *consequences* of the eating disorder or *causes* of the disordered eating pattern. It seems most accurate to say that disordered eating is usually a symptom of some underlying psychological problem, as successful treatment often requires an identification of the historical issues (e.g., trauma) or faulty beliefs (e.g., delusional body image) that give rise to the behavior.

Eating disorders as addictions or compulsions

Some recent literature has begun to look at eating disorders as addictive behaviors. The parallels between addictions and eating disorders are most obvious in the example of compulsive overeating

Revised 12/2010

(in fact, 12-step programs for overeaters have proven to be quite effective, similar to Alcoholics Anonymous), but they are also apparent in anorexia and bulimia: patients become addicted to a "process" (bingeing or restricting) and derive pleasure from the process itself, rather than the normal reward of food; they have faulty images of themselves and of their world; and they often deny that they have problems which are usually (but not always) obvious to people around them. Recovery involves not just abstinence from the disordered eating behavior, but also learning new ways to experience pleasure and avoid pain.

How are eating disorders treated?

As noted above, there are no uniformly effective medication options to help increase body weight in anorexics, or to decrease bingeing in bulimics. Patients with anorexia are often hospitalized when their body weight falls below a dangerous level or have other medical complications. Unfortunately, patients sometimes view these hospitalizations as "necessary evils" of their condition and have no desire to change their behavior; as such, they resume their intense dietary restrictions as soon as they are discharged. Even though bulimics are not hospitalized as frequently, they too may view any attempt to provide treatment or support as "interference" with their lives and the intensity of their disease may paradoxically increase when loved ones try to intervene.

As a result, the most effective intervention for anorexia and bulimia—as well as with any other form of disordered eating—is psychotherapy, to help the patient understand the impact of the disordered eating patterns on his/her life, and to learn to apply new coping skills to the life problems that underlie these maladaptive behaviors. Various therapeutic techniques, such as cognitive behavioral and interpersonal therapies, have been applied with good results, although relapse is quite common. Medications can be prescribed for such co-existing symptoms as depression, anxiety, insomnia, or impulsivity, or to increase appetite and promote weight gain. Importantly, however, the patient must agree to the treatment plan and understand the reasons for treatment. It may take some time to get to this point.

What is the long-term prognosis?

Statistics show that as many as 20 to 30% of patients follow a chronic, unremitting course of their illness, even after intensive treatment. It is also common to see patients worsen in the 1-2 years after treatment, before they stabilize. (This is another analogy with addictive disorders, in which relapse is common before patients get better.) As with compulsive overeating and obesity—and with addictions—there is no "cure," but people can *overcome* these disorders and live happy, productive lives. To do so requires more than just adherence to a medication regimen; it requires a change in mindset, outlook, and coping skills, and it's important to work closely with a professional who can help develop these skills and the tools to handle relapses, if and when they occur.

How do I get help?

Our philosophy is that it is important to seek help from a professional who can manage both the psychological and the medical aspects of an eating disorder, who is willing to be flexible in providing treatment that responds to an individual's personal needs, and who can *collaborate* with the patient in choosing treatment goals that are at the same time realistic and which help the patient make steady progress towards a healthier lifestyle. If you're ready to take the next step, please call us for a consultation.

Please be sure to check the NBPA website and blog regularly, as we will add up-to-date information about the biology of eating disorders, new treatment modalities, and useful tools to help you make the most of your treatment experience.

Revised 12/2010