Mental Health Association of Northern Kentucky

A LEADER IN PROVIDING ADVOCACY, EDUCATION, AND SERVICES THAT PROMOTE MENTAL WELLNESS

EDUCATION AND SCREENING OUTREACH PARTNER FOR THE NATIONAL INSTITUTE OF MENTAL HEALTH AND NATIONAL MENTAL HEALTH ASSOCIATION

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ANOREXIA NERVOSA

Diagnostic Criteria

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type :

Restricting Type : during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/Purging Type : during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Associated Features

- Depressed Mood
- Somatic / Sexual Dysfunction
- Guilt/Obsession
- Anxious / Fearful / Dependent Personality

Differential Diagnosis

General medical conditions; superior mesenteric artery syndrome; Major Depressive Disorder; Schizophrenia; Social Phobia; Obsessive-Compulsive Disorder; Body Dysmorphic Disorder; Bulimia Nervosa.

Medical Treatment

Basic Principles

The initial goal in the treatment of Anorexia Nervosa is to prevent death by starvation. The more severely ill patients need hospitalization initially that must be followed by a well-planned continued outpatient treatment program. Most patients are highly resistant to psychiatric treatment; hence are usually brought to a doctor's office unwillingly by concerned family or friends. The therapist must win the cooperation of the patient by emphasizing that treatment can free the patient from the obsessive thoughts about food and body weight that have become the sole focus of the patient's life. In addition, treatment can relieve the patient's depressive symptoms and insomnia, as well as improve physical well-being and social relationships.

Hospitalization

The patient's family and friends should be warned that the patient will resist hospitalization and will plead to be discharged. It is essential that the patient's family fully support the decision to hospitalize the patient. The family should understand that Anorexia Nervosa is a potentially lethal disease. In hospital, the patient should be weighed daily early in the morning after urination. The daily fluid intake and urine output should be monitored. If vomiting is occurring, serum electrolytes must be regularly tested (especially for hypokalemia). The bathroom should be inaccessible for at least 2 hours after meals (to prevent vomiting). The patient's diet should start at 1,500 to 2,000 calories a day and gradually increase (to prevent the possibility of stomach dilation and circulatory overload if the patient immediately starts binge eating). The patient should have six equal feedings throughout the day. Severely anorexic patients can be started on a liquid food supplement (e.g., Sustagen). Initially the patient should be placed on total bed rest and positively rewarded only when eating. As the patient cooperates by gaining weight, more ward privileges should be given. This behavior therapy program should be clearly explained to both the patient and family. After hospital discharge, there should be outpatient follow-up involving both the patient and family or friends.

Antidepressants

Antidepressants have been effective in treating Anorexia Nervosa. A double-blind study of 72 Anorexia Nervosa patients showed that Amitriptyline had a marginal effect on decreasing the number of days necessary to achieve normal weight when compared to a placebo.

Antipsychotic Drugs

Severely obsessive-compulsive, anxious, and agitated Anorexia Nervosa patients are likely to require chlorpromazine. Although clinical experience has supported the use of chlorpromazine with these patients, as yet there has been no controlled double-blind study to definitely prove its efficacy.

Other Drugs

Cyproheptadine (an antihistamine) has been shown on a double-blind study to marginally benefit patients with Anorexia Nervosa. However, this drug significantly slowed the recovery of a bulimic subgroup of patients with Anorexia Nervosa.

Other Somatic Therapies

In some cases, electroconvulsive therapy (ECT) has been reported to be successful, especially when there are strong depressive features.

Psychosocial Treatment

Basic Principles

Any psychotherapy is very difficult with an emaciated patient who is preoccupied with food. Research on normal volunteers has shown that only mild starvation (being 15 to 25 percent underweight) can physically cause depression, irritability, preoccupation with food, and sleep disturbance. Thus, psychotherapy must be coupled with other treatments that restore the patient's nutritional state to normal (e.g., behavior therapy, medication, and often inpatient hospitalization). Outpatient therapy as an initial approach has the best chance for success in anorectics who: (a) have had the illness for less than six months, (b) are not binging and vomiting, and (c) have parents who are likely to cooperate and effectively participate in family therapy.

Behavior Therapy

Initially, at least in hospital, behavior therapy is the treatment of choice. In hospital, positive reinforcements are used, consisting of increased physical activity, visiting privileges, and social activities contingent on weight gain. An adolescent needs at least a daily reinforcement for weight increase, which should be about 1/4 lb. or 0.1 kg per day. Making positive reinforcements contingent only on weight gain is helpful in reducing the staff-patient arguments over how and what the patient is eating, since weight is an objective measure. Binging patients must stay in front of other people for two to three hours after every meal to prevent self-induced vomiting.

Family Therapy

Family therapy can increase the family's understanding of the disorder and their ability to cope with the patient. The family must be helped to not make the patient's preoccupation with food a family preoccupation and battleground.

Individual Psychotherapy

Classical psychodynamically oriented therapy is not effective in Anorexia Nervosa. A more problem-oriented, supportive psychotherapy is required. Psychotherapy should inform and challenge beliefs around issues such as over evaluation of thinness and distorted ideas about food, weight, and dieting. Other themes that need to be dealt with are poor self-esteem, dependency problems, and a sense of ineffectiveness.

Group Therapy

Inpatient and outpatient group therapy with other patients suffering from similar eating disorders can be highly supportive.