

Treatment of anorexia nervosa: Insights and obstacles

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Abstract

Anorexia nervosa is a behavioral disorder characterized by ego-syntonic self-starvation, denial of illness and ambivalence towards treatment. Treatment refusal and drop-out rates are high and relapse is common. Treatment is best viewed as comprised of two phases, weight restoration and normalization of eating behavior followed by relapse prevention. Most patients verbalize a desire to change, however they seek treatment on their own terms, ideally with minimal or no weight gain. Successful treatment must therefore convince patients to overcome their drive to diet.

Evidence-based data on treatment interventions for anorexia nervosa are scarce and methodological problems afflict the few published, controlled trials. Taken together, clinical expertise and data from correlational and controlled trials suggest that chronicity and adult status are associated with a worse prognosis. Outpatient family therapy is effective in weight-restoring the majority of adolescent patients whereas older patients, or those with severe medical or psychiatric comorbidity, often require intensive treatment on an inpatient eating disorders behavioral specialty unit. Correlational data suggest that weight-restored patients are less likely to relapse.

Despite limitations of the current knowledge-base, several new areas of research hold promise in elucidating risk factors, in identifying the pathophysiology that sustains anorectic behavior, and in developing more targeted and effective treatments.

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1. Introduction

Increasing rates of obesity are disproportionately affecting children and young adults (see papers by Adair and Boushey in this issue). Similarly, data suggest that prevalence rates for anorexia nervosa in the adolescent and young adult population have increased over time [1–3]. Although much less common than obesity, with a prevalence in young women of 0.3% [4], anorexia nervosa has the highest lethality of all psychiatric conditions [5] and is associated with high levels of medical and psychiatric comorbidity and with significant functional impairment [6]. Anorexia nervosa is difficult to treat, relapse is common, and treatment is extremely expensive and on par with that for schizophrenia [7].

Like obesity, anorexia nervosa is a heritable condition. Heritability estimates range between 56–70% [3,8,9] and genetic

vulnerability is assumed to be due to multigenic effects modulated by environmental influences. Vulnerability genes may code for personality traits. Several heritable personality traits have been associated with anorexia nervosa including perfectionism and harm avoidance [10,11] and a recent large twin study identified early neuroticism as a prospective predictor of anorexia nervosa [3]. Once established, aberrant behavioral feeding patterns are likely sustained both by state-related physiological changes (e.g. starvation-induced delayed gastric transit times) and by psychosocial factors (e.g. pressure to diet).

This review will cover the treatment of anorexia nervosa, a topic which has remained a major challenge to both clinicians and researchers alike for reasons intrinsic to the disorder. A description of the clinical phenomenology and outcome of anorexia nervosa will be followed by an evidence-based review of treatment interventions. Data from three separate areas – clinical expertise, correlational studies and controlled trials – will be covered. The review will conclude with promising areas of research that could help clarify pathophysiological mechanisms sustaining anorectic behavior. Improved understanding of

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such disturbances could lead to new approaches to treatment or to better matching of patients to effective interventions.

2. The phenomenology of anorexia nervosa

Both obesity and anorexia nervosa are behavioral conditions in which the problem lies in what the patient “does” [12]. In anorexia nervosa however, the behavioral disorder is driven by an overvalued idea. Psychological preoccupation with fear of fatness or “motivated eating restraint” [13] is pursued beyond the bounds of reason and to the exclusion of other socially and developmentally appropriate activities, taking on the characteristics of a consuming passion [12]. Food restriction becomes conditioned and rewarding. The mechanism by which this occurs is unclear, and various theories have been proposed.

One hypothesis is that individuals with anorexia nervosa have an abnormality in neural systems regulating emotion which results in susceptibility to fear conditioning and resistance to its extinction in [14]. Others have proposed that neurocognitive deficits in set-shifting and implicit learning in vulnerable individuals may increase the likelihood of developing driven, stereotyped dieting behaviors [15,16]. Decision-making in a gambling task has also been found to be impaired in anorexia nervosa and has been hypothesized to represent an underlying deficit in planning real-life strategies and in the appreciation of long-term behavioral consequences [17]. In animal models various aspects of the characteristic behaviors expressed in anorexia nervosa have been associated with neural changes that may facilitate the maintenance of the disorder. For example, food restriction increases the rewarding effects of food and of drugs of abuse [18,19] and chronic exercise is associated with decreased mu-opioid sensitivity in female rats [20], suggesting that a disturbance in opioidergic activity could contribute to the escalating patterns of self-starvation and excessive exercise observed in anorexia nervosa. Physiological consequences of starvation, including delayed gastric emptying and prolonged gastric transit times, also sustain restrictive eating patterns as they result in early satiety and chronic constipation [21,22]. Finally, starvation is associated with excessive preoccupation with food, ritualized eating behaviors and starvation-induced depressive symptomatology [23].

Another, central feature of the psychopathology of anorexia nervosa is its ego-syntonic nature, which results in ambivalence towards, and refusal of, treatment. Although most patients with anorexia nervosa verbalize a desire to change, they seek treatment on their own terms. Motivation for help is driven by the desire to obtain temporary relief from the physical or psychological consequences of the behavior without gaining significant weight. As patients nourish their body, motivation for treatment fades and is replaced by intensified fear of weight gain and renewed cravings to engage in dieting behavior. Successful treatment is akin to a process of conversion, from seeing dieting as the solution to viewing it as the problem [24]. For patients who have been ill for years and have fallen off their normal developmental track, treatment must also address impairment in psychosocial function. The formation of a strong therapeutic alliance and role induction

are critical to engagement in treatment and to helping patients change their behavior.

3. Long-term outcome in anorexia nervosa

Long-term outcome studies indicate recovery rates of 25–70% [25–28] with adolescent patients tending to have the higher success rates [28,29]. Recovery is usually a protracted process, taking place over the course of 5–6 years and is characterized by a fluctuating course [28]. Progression from restricting anorexia nervosa to the purging subtype or to bulimia occurs in more than 50% of cases [27,30]. The prolonged course of recovery complicates analyses of the impact of a treatment intervention, since patients are often exposed to multiple treatment modalities over time. Furthermore, most follow-up studies have not distinguished the course of first admissions from that of treatment-resistant patients who failed prior treatment when analyzing outcomes. Poor outcomes in naturalistic studies may be explained in part by a subset of treatment-resistant high utilizers of health care resources. Markers of chronicity, including more severe eating disorder pathology, worse psychosocial function, history of a mood disorder and severe personality disorder, prospectively predict higher rates of treatment utilization at five years [31]. Additional design problems include a lack of consensus in the field on the definition of recovery, both in terms of target weight and symptom remission [32], the retrospective nature of most studies and an absence of clinical comparison groups or untreated community controls.

Attempts to identify prognostic factors for treatment success have met with mixed results. No factor has consistently been found to be predictive of outcome across studies, although low admission weights, past treatment failures, longer length of illness, comorbid psychiatric illness, extreme body image disturbance, purging behaviors and obsessive compulsive personality features have commonly been associated with an unfavorable prognosis [25,29,33,34]. There is no evidence that partial weight restoration improves long-term prognosis in anorexia nervosa, however several correlational studies suggest that full-weight restoration confers a better prognosis than does partial weight gain [35–37].

4. Treatment of anorexia nervosa — Clinical consensus

Recovery from anorexia nervosa is best viewed as a two-stage process consisting of weight restoration to a BMI of 19–21, followed by relapse prevention. Most clinicians believe that the majority of severely underweight adult patients are unlikely to respond to outpatient attempts at weight restoration.

Multidisciplinary inpatient behavioral specialty units for anorexia nervosa are clinically well-established as the most effective setting in which to achieve rapid weight restoration. Several published descriptions of such programs exist [24,38,39] and most dedicated specialty units achieve average rates of weight gain of 2–4 lbs/week using a behavioral protocol involving nursing observation and nutritional rehabilitation. Treatment is implemented by a multidisciplinary team and usually includes

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