Review Article

Association of Anorexia Nervosa with Depression

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Received: September 28, 2006 Accepted: January 21, 2007

ABSTRACT

Anorexia Nervosa is one of the important causes of depression. This paper also aims to evaluate prevalence of all types of mood disorders in order to yield comparable estimates of them in general. The possibility of anorexia nervosa as a depression equivalent or a depression spectrum disorder must be seriously questioned. (Rawal Med J 2007;32:76-78)

Key Words: Anorexia Nervosa, Depression, Comorbidity, SSRI

INTRODUCTION

Anorexia Nervosa is the refusal to maintain body weight at or above a minimally normal weight for age and height. 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 are all symptoms of anorexia nervosa. It usually occurs in postmenarcheal females and patients with amenorrhea. In the major depressive episode, appetite is usually reduced and many people feel that they have to force themselves to eat. Research evidence[1] shows that the family intervention in psychiatric disorders, such as schizophrenia, depression, anxiety and anorexia not only provides better out comes, but also increases patients' satisfaction with services.

PRESENTATION

Anorexia nervosa, meeting full *DSM-IV-TR* criteria, has been found to occur in 1 out of 100-200 females in late adolescence and early adulthood in the US. Mortality associated with anorexia nervosa is high; 6-20% of patients eventually succumb to the disorder. More than 90% of cases occur in females. However, it should be emphasized that males represent approximately 10% of anorexia nervosa cases, a fact that often is overlooked. Although more commonly the illness begins between early adolescence (13-18 y) and early adulthood, earlier-onset and later-onset are encountered. When seriously

underweight, many individuals with anorexia nervosa manifest depressive symptoms such as depressed mood, social withdrawal, irritability, insomnia and diminished interest ,in sex. Such individuals may have symptomatic presentations that meet criteria for major depressive disorder. Associations between anorexia nervosa and affective disorders have often been suggested on the basis of their etiology, primarily between anorexia and depression. Significant effects of body weight and beta-hydroxybutyric acid, respectively on depressed or dysphoric mood when controlling of severity of psychopathology of the eating disorder have been noted[2]. However, it is difficult to diagnose major depression in patient, with anorexia nervosa, particularly if primary depression can not be diagnosed prior to the onset of anorexia[3].

Symptoms of mood disorders, particularly depression are frequently associated with anorexia nervosa, although the nature of this relationship is unclear. On the Extracted Hamilton Depression Rating Scale, 40.7% of the patients with anorexia nervosa had scores in the moderately or severely depressed range.[4] At the same time, a review[6] of 11 studies of patients with anorexia nervosa provides evidence that both inter-current depressive and obsessive-compulsive features are most frequently reported overall diagnosis.[5] Bipolar II affective disorder appears to be a common finding in hospitalized patients with severe persistent eating disorders. These results suggest a stronger relationship while treating and assessing the patients having co-morbid depression and anorexia nervosa. Reports describe anorexia nervosa developing shortly after the onset of rapid cyclic manic-depressive disorder (MDD) and whose eating disorder and manic-depressive symptoms twice resolving simultaneously with lithium treatment.[7]

BIOLOGICAL ASPECTS

Depression in association with dietary restraint, and binge eating in female runners showed that bulimia, rather than anorexia, may be the most prevalent eating problem in them.[8] A study on 63 patients as a group was not significantly different in their lifetime or concurrent rates of depressive or anxiety disorders.[9] The influence of eating disorders on Alcohol Use Disorder (AUD) appears to be greater than the reverse.[10] A substantial number of patients who initially present with an eating disorders develop alcohol problems over the course of time, suggesting that the risk is an ongoing one that should be monitored by clinicians. Alexithymia and depression scores were significantly higher in anorexic and bulimic patients than in the healthy subjects.[11]

The genetic factors significantly influence the risk for anorexia nervosa and substantially contribute to the observed comorbidity between anorexia nervosa and major depression. [12] It is suggested that a pervasive genetic effect influences liability to symptoms of depression and eating disorder throughout development.[13]

MANAGEMENT

The use and effectiveness of antidepressants in anorexia has long been questioned and is still a controversial issue. Decreases in eating disorder symptomatology following antidepressant treatment may be related to changes in depressive symptoms.[14] While some patients with eating disorders respond to antidepressants medication, this does not demonstrate that eating disorders are a form of major depression.[15] Comorbidity between eating disorders and mood disorders is a major issue when evaluating and treating patients with anorexia nervosa or bulimia nervosa. Few studies have included control

groups, and, it is not clear, yet, disorders are more common among women with an eating disorder than among women from the community.[16]

The frequency of depressive symptoms in anorexic patients, the response of some anorexic patients to antidepressants or Electro Convulsive Therapy, the occurrence of comparable physiologic abnormalities in major depression and anorexia nervosa, and family studies of incidence increasingly link depression and anorexia. Recent studies have found that lasting symptomatic improvement and remission require the addition of psychological treatments in the form of cognitive and interpersonal therapy[17] and shows that therapeutic alliance in both patients and parents treated with family based therapy (FBT) is generally strong and likely contributes to treatment retention and treatment. The studies show a higher incidence between the two disorders both in the longitudinal and cross-sectional researches.[15]

CONCLUSION

Well-defined and carefully controlled studies are needed in which patterns of depressive symptoms can be studied in anorexic patients. Such studies will contribute to the understanding of the relationship and may clarify important mechanisms of relevance. There is a lot to be determined yet and the relationship is premature to be called as empirical.

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