Therapeutic Outcome in Anorexia Nervosa

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There are no controlled studies of the outcome of treatment for anorexia nervosa. An early study showed that biologically recovered anorectics were, as a group, socially phobic four years following the completion of treatment. This position is more sophisticated and mature than that at the time of their original anorexia and is shared by many "normal" people. A recent study evaluated treatment in terms of strict criteria for good outcome: all the patients had been severely ill with anorexia nervosa when first seen. Four to seven years later, 84% were holding a body weight above the pubertal threshold but of these, 2% were obese and 18% were well below average adult weight. Sixty-four percent, therefore, were sustaining a normal and stable body weight and the majority of these had regular menses. Quite a number were preoccupied with body shape, but their psychosocial adjustment was reasonable. In contrast, 14% remained severely ill and only 2% had died. These findings suggest that treatment aims at altering the long term cause of the disorder for the better is probably effective in (a) helping about 20 to 30% of the population recover who would not otherwise have done so; and (b) in preventing some deaths.

In order to evaluate the outcome of treatment in anorexia nervosa one must first satisfactorily define "outcome," "treatment" and "anorexia nervosa," and then conduct an appropriately designed study involving random allocation of such "patients" to the general or specific treatment/no treatment experience. If outcome is defined as anything other than including just immediate and slight weight gain, then there is no such study reported in the literature. Most major follow-up studies used measures of body weight, eating behaviour, reproductive function, sexual and social adjustment, and have defined "recovery" in terms of the individual's close approximation to normality in all these respects. Such follow-up studies, some more thorough and detailed than others, have been widely reported over the past 20 years.

Although some or all of the patients in these studies had received treatment, there has been no means of evaluating its impact. Nor is it certain that the patient groups were similar in the various studies except that they all had what is widely accepted as "anorexia nervosa." Indeed, recent studies have demonstrated certain clinical features associated with poor prognosis and these may well have been differently represented in the various groups of patients studied and reported. It is not always possible, from the reports, even to determine whether the severity of the disorder was similar or not in the different groups.

This paper will discuss my own opinions about the nature and evolution of anorexia nervosa, the nature of our treatment approach and, so far as possible, a judgement of its short and long term effects.

The Nature and Evolution of Anorexia Nervosa

Figure 1 indicates some aspects of the evolution of anorexia nervosa. The emphasis is upon the pivotal significance of puberty and the phobic avoidance stance within the condition. The anorectic shows the same desperate need to control and manipulate her or his environment as does the "hysteric" in order to protect her fragile social adjustment. The avoidance stance, in relation to biologically mature body weight, reflects her condensed terror of its social consequences and her inability to handle these difficulties in any less primitive (neurotic) way. Low body weight control may be sustained mainly by carbohydrate avoidance, a form of "starvation" unique to anorexia nervosa, or else by the binging/vomiting/purging syndrome, which confers a very different metabolic stance but which is nevertheless still subpubertal, though less stably so. This latter stance is significantly associated with premorbid impulsivity, especially with respect to eating and sexual behaviour. It is a feature of the chronic condition, sometimes also being associated with behaviour such as shoplifting, and it leads to complications such as epilepsy, periodic edema, severe abdominal discomfort, and gastric dilatation. It is more likely than other variants of the condition to lead to premature death, either by suicide or profound metabolic decompensation. Other factors associated with poor prognosis include late age of onset, poor childhood adjustment, impaired parental (marital and personal) psychosocial adjustments, lower social class back-

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ground and probably also premorbid borderline personality structure, and being male.

In the natural course of events approximately forty percent of individuals with severe anorexia nervosa will be found recovered six years after initial accurate clinic screening, and about five percent will be dead. However, there are probably a number of anorectics who avoid medical attention altogether and others who linger, misdiagnosed, in a variety of clinics. These latter groups may evolve differently — we do not know.

Treatment Approach

Our treatment approach, established now for more than 20 years, has been used in over 300 anorectics who were treated on an initial inpatient basis involving, as part of the program, restoration of body weight back to matched population mean levels (1,2,3). It can be seen (Figure 2) that mean body weight increases under these circumstances from 38 kgs to 54 kgs on average. It is obvious that no anorectic would persist in such a circumstance if she were simply and in isolation to experience this 'being done to her.' For success to be possible the anorectic needs to be identified with the process. The treatment approach is based on the premise that (a) the disorder is rooted in a phobic avoidance mechanism; (b) that the thing being avoided is adult body weight, which is seen by the anorectic as alien, inflicted from without, and terrifying; (c) that this weight has in the past presented overwhelming psychosocial challenges to the anorectic and her family; and (d) that the anorectic may so far have little in the way of more sophisticated potential coping devices available within her.

Anorectics see their state as egosyntonic. For them it is socially adaptive. Others wishing to change them must aspire to help them become "patients" — people feeling themselves afflicted with the disorder which they hope those others will be able to help them shed.

Adolescent maturational challenges reflect family and wider social dynamics impinging on the former development and ultimately upon the experiences promoting the anorexia nervosa itself. They are the same challenges that others, more resourceful, might cope with or otherwise respond by falling ill in other ways, depending on their own and their families' biological and psychosocial makeup. If an anorectic is to be helped to grapple with this challenge then she must first enter the arena once more, that is achieve normal adult body weight; and second, develop other coping mechanisms. Neither step can be achieved easily without the other, and the second step will be much easier if she is not long established in her anorexia nervosa and if changes are also possible within the family. This will require positive shifts of attitude rather than any further manipulation such as is crudely separating the anorectic from her family. Elsewhere I have recently again described in detail our initial approach to the anorectic family (3). We strive to engage all parents (and occasionally spouses and others) in treatment, and succeed in about 85 percent of instances. In other cases, parents are dead, or too geographically remote from us or, occasionally, too hostile for this to happen. Not all parents by any means have a globally brittle personal or marital adjustment. In one way or another the maturation of this particular offspring has challenged them, and has exposed their Achilles' heel. In the initial outpatient consultation this dynamic needs to be identified and we strive routinely to achieve this before we have even met the anorectic. The subsequent encounter will be enriched by such knowledge and this, combined with some understanding that the clinician has of the psychological mechanisms at work within anorexia nervosa, can be used to advantage in attempting to gain the anorectic's trust from the outset. The anorectic will need to come to terms with the dual nature of any subsequent treatment and will initially be terrified at the prospect of the major weight gain. Trapped into this consultation she will have been envisaging at the most some small weight gain up to an immediate subpubertal level, say 40 kgs. She can be assured that, though in bed, eating a
normal diet and gaining weight at the rate of 1½ kgs a week, she will be protected from over-eating, and no one is going to tell her that she "looks well" when she has gained the weight. (On the contrary all staff will recognize that, at this stage, the patient feels more sustainedly chaotic, terrified and despairing than ever.) She will be involved in intensive psychotherapy directed at her need to cope in the first instance with her refound adult body shape, for herself and others to come to see her as more than merely this, and for her to develop new coping resources.

This initial inpatient program lasts about four months and allows, apart from the weight gain, the establishment of important psychotherapeutic relationships and friendship with the patient and the family through the mechanisms of individual, family, group and milieu psychotherapy. Early interpretation of the transference can be crucially important in order to allow the anorectic to explore the new environment. All staff seek to befriend the patient during this period, allowing a rich range of hopefully potentially happy identifications. The parents are included in this milieu approach. Projective art, clothes-making and trust groups are the special responsibility of the occupational therapist. Progressive mobilization leads to discharge from inpatient care and continued outpatient psychotherapy over the subsequent two or so years. The initial weight gain promotes pubertal changes. It is important to recognize that these biological maturational changes are occurring within the patient and are usually evident in her physical status, her demeanour and her changing behaviour.

The long term outpatient psychotherapy is concerned with continually helping the anorectic to construct her destiny in terms of other than her body shape. If this does not begin to happen then it is unlikely that the anorectic can indefinitely sustain a mature body weight in the face of her continued panic and preoccupations.

Outcome of Treatment

What of the outcome of such treatment? There are no controlled studies. Our recent follow-up study (4) used measures similar to those developed and used by Morgan and Russell (5). These allow specific and general measures of both physical and psychosocial status. In trying to decide what "recovery" is, should one be aiming at ideal or normative standards? For instance, psychosexual adjustment is by no means always adequate within the general population. A previous study from this unit (6) showed that biologically recovered anorectics were, as a group, socially phobic four years later — a more sophisticated and mature stance than that reflected in their original anorectic position and indeed one shared by quite a few "normal" people. Another recent study (7) has shown that "normal" adolescent females eat in a most irregular way with a highly variable calorie and carbohydrate content day-by-day, sometimes with consequent substantial fluctuations in body weight. For the purposes of completing the Morgan and Russell ratings we used strict criteria. For example, for "good" outcome, weight needed to be close to general population "norms" and stable, menses present, and dietary intake stable, including adequate amounts of carbohydrate. In addition, psychosocial adjustments needed to include satisfying engagement within peer relationships coupled with a reasonable capacity to cope with rejection. Figure 3 shows the outcome in terms of body weight for all patients including a small proportion who did not enter treatment with us. All these patients had been severely ill with anorexia nervosa when first seen. Four to seven years later, 84 percent were maintaining a body weight above the pubertal threshold but, of these, two percent were obese and 18 percent were still well below average adult weight. Sixty-four percent therefore were sustaining a normal, stable body weight and the majority of these had regular menses. A substantial number were still preoccupied with and sensitive about body shape, but their psychosocial adjustment was reasonable. In contrast, 14 percent remained severely ill and only two percent had died. These figures suggest that such treatment, as outlined above, aimed at altering the long term course of the disorder for the better, and was probably effective in (a) helping about 20 to 30 percent of the population to recover who would not otherwise have done so, and (b) preventing some deaths.

References

6. Stonehill E, Crisp AH. Psychoneurotic characteristics of patients with anorexia nervosa before and after treatment
Résuème

Il n’existe pas d’études contrôlées sur le résultat du traitement de l’anorexie mentale. L’une des premières études a conclu que des anorexies physiquement guéris demeuraient, en tant que groupe phobiques sur le plan social, quatre ans après la fin du traitement. Leur attitude est plus évoluée et plus mûre qu’à l’époque où ils sont devenus anorexiques et elle est d’ailleurs celle de beaucoup de gens “normaux”. L’étude récente a évalué le traitement selon de sévères critères de réussite: au début du traitement, tous les malades étaient gravement atteints d’anorexie mentale. De quatre à sept ans plus tard, 84% d’entre eux maintenaient leur poids au-dessus du seuil pubéraire mais 2% d’entre eux étaient obèses et 18% pesaient beaucoup moins que l’adulte moyen. Donc, 64% conservaient un poids normal et stable et la majorité avaient des règles régulières. Un bon nombre se préoccupaient de leur silhouette mais leur adaptation psychosociale était suffisante. Par contraste, 14% étaient demeurés gravement malades mais il n’y avait que 2% de décès. Ces conclusions permettent de penser que le traitement visant à modifier pour le mieux la cause profonde du mal réussi probablement a) à aider à guérir de 20 à 30% d’une population qui autrement n’en sortirait pas; et b) à prévenir un certain nombre de décès.