

# DOSSIER: General Practitioners and Teenage Girls Suffering from Eating Disorders

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*General practitioners can feel powerless in the face of anorexia or bulimia, which are common reasons for consultation. The disorders require multidisciplinary management with clinical, psychological, biological, familial, social and, if necessary, transcultural aspects, which can be difficult to implement when symptoms are unacknowledged.*

*General practitioners are often faced with no spoken request for treatment, the refusal to accept that there is a problem and other unknowns such as the length of the illness, the variety of possible outcomes and the equally vague notion of recovery. They must then make decisions on referral, time and place of hospitalisation or ambulatory care. Family liaison and therapeutic alliances also fall to them.*



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The systemic aspect of anorexia nervosa, perhaps more so than in any other teenage condition, requires practitioners to be aware of family liaison, therapeutic alliances and the proposed intervention: the teenager, the illness and the family who opens its door to us all need to be approached on tiptoe.

Therefore, any heavy-handed medical intervention risks damaging the relationship and being iatrogenic in somatic terms, with particular reference to refeeding syndrome. "Primum non nocere", the precept of Hippocrates, becomes more meaningful than ever before.

## PSYCHOPATHOLOGY OF EATING DISORDERS

The first authors declared anorexia a form of hysterical neurosis resulting from an intrapsychic conflict. The disorders occurred in young women in whom sexual desire regressed to the oral stage and shifted to the appetite, which was suppressed in the place of underdeveloped genital sexuality. The hypothesis was confirmed by the observation of "recovery by marriage".

Increasing observations have described and explained the mental functioning of female anorexic patients. It is now agreed that anorexia is the late expression at puberty or the start of adulthood of early development changes that compromise the natural dynamic of separation-individuation. Psychopathological causality has therefore moved to the dependence-autonomy conflict. This ambivalent conflict reflects the paradox of adolescence: the physiological need for autonomy alongside the pathological persistence of dependence. Eating disorders are thought to overpower food intake, the first expression of the mother-child bond, on which impulses during feeding are based. This first bond is said to be regressively revoked in the hampered dynamic of the separation-individuation process.

### FOCUS

In its ascetic dimension, anorexia can take on the appearance of masochistic behaviour that disconcerts healthcare professionals, who are used to treating subjects who are victims of their condition. The DSM-IV behavioural description could suggest that refusal is voluntary. Yet authors now agree on multifactor causality, of unconscious determinism, resulting from the interrelationship between a subject (psychopathological, somatic and genetic factors) and her environment (social and family factors). In bulimia, the excessive intake of food followed by vomiting is also beyond the voluntary control of the patient and can in turn become addictive.

### **DSM-IV CRITERIA FOR ANOREXIA**

Refusal to maintain body weight at or above a minimally normal weight for age and height: Weight loss leading to maintenance of body weight <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.

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

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

Amenorrhea (at least three consecutive cycles) in postmenarchal girls and women. Amenorrhea is defined as periods occurring only following hormone (e.g., estrogen) administration.

Type:

– Restricting type: During the current episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behavior (self-induced vomiting or 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 (self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

### **ROLE OF GENERAL PRACTITIONERS**

With their changing profile, the disorders can resemble chronic conditions. Therapeutic alliances are vital here and the role of general practitioners (or paediatricians) can become central. They may come to embody the limit that must be put on disorganisation of the regulation of dietary urges. Somatic medical care then re-establishes the limit on excessive dietary restriction, like bulimic excess. Somatic risk governs the implementation of limits on the irrationality of dietary behaviour. Supported by the medical profession, they are based on normal values for vital signs: discontinuation of exercise, obligatory hospitalisation, stoppage of work, etc.

#### *Establishing the diagnosis:*

Crudely, the distinction can be made between pure restrictive anorexia and mixed forms including binge eating with vomiting and/or use of laxatives. It is also important to evaluate the physical hyperactivity aspect (intensive exercise, forced marches, etc.). The issue of differential diagnosis is rarely raised, but it may be necessary to know how to do so (see the text box below).

### **DIFFERENTIAL DIAGNOSES OF ANOREXIA NERVOSA**

#### **Digestive illnesses:**

- Inflammatory bowel disease (Crohn's disease, haemorrhagic rectocolitis)
- Celiac disease
- Oesophageal motility disorders (achalasia, gastroparesis)
- Gastritis, gastroduodenal ulcers, oesophageal neoplasia
- Malabsorption syndrome
- Hepatic vesicular and pancreatic conditions

**Tumours of the central nervous system:**

- Hypothalamus (craniopharyngioma, glioma, pinealoma)
- Brain stem
- Temporal or frontal
- Posterior fossa, diencephalon, mesencephalon...
- Pituitary gland (macroadenoma)

**Endocrine conditions:**

- Type I diabetes
- Hyperthyroidism
- Adrenal insufficiency

**Intra-abdominal tumours**

*Retracing the history:*

Before retracing the history of the eating disorder, we must find out about the patient's childhood and family medical history (particularly the history of eating disorders), height/weight curve, development during puberty and dietary history prior to the eating disorder.

*Specifying the reason for current treatment*, particularly when faced with longstanding situations that have not always been managed. Conversely, we may meet families who consulted many professionals and/or institutions soon after the onset of the first symptoms. In all cases, it is important to understand the functioning of the patient and family through anamnesis in order to provide the best possible response.

*Intervening in situations of great physical danger* (terminal malnutrition, hydro-electrolytic disorders, binge eating, etc.), as well as taking into account the risks of suicide in entrenched situations and chronic complications. The mid- and long-term effect of anorexia is multivisceral and can be life threatening (death rate: 0 to 17.8% according to studies).

*Help patients and their families*, as far as possible, to be part of a short- and longer-term treatment plan at the initial consultations. This implies hearing the diagnosis of anorexia and agreeing to be part of the plan. Ambulatory management remains the strategy of choice for the majority of patients. Hospitalisation is reserved for the most serious situations in which it is not possible for patients to remain at home for medical and/or psychiatric and/or socio-familial reasons.



## MANAGEMENT OF EATING DISORDERS

### Hospitalisation or ambulatory care?

Practices vary. In English-speaking countries, hospitalisations are limited to the medical management of malnutrition over approximately four weeks. Such short hospital admissions are thought to be motivated primarily by financial considerations. Some studies have shown that prognosis improves when the patient's weight on discharge is close to normal weight, which strengthens the argument for long-term hospitalisations (often several weeks). This is the case in France, where funding does not govern treatment methods. The indications for hospitalisation are based on medical and psychiatric criteria (amount and speed of weight loss, physical tolerance, depression, chronicity, etc.).

The organisation of hospitalisation can be complicated by resistance from patients, and occasionally their family, as well as healthcare teams when they have not been trained. Ideally, hospitalisation is proposed in a ward that is specialised or trained in treating such patients. The waiting lists of specialised services can mean that they are impossible to access, in which case the patient is hospitalised in a community, psychiatric or medical ward (paediatrics, endocrinology, gastroenterology and internal medicine).

### PHYSICAL SEPARATION FOR PSYCHOLOGICAL INDIVIDUATION?

Although the hospitalisation of anorexic patients was, for a long time, based on protocols in which separation was the cornerstone of treatment, conventional methods are now being challenged once more. Separation was not only used as a positive behaviour reinforcer offering a reward (lifting of separation) for an improvement in behaviour (weight gain), but was also considered as creating a situation enabling the individuation process of psychological development. Some services no longer separate teenagers from their family during hospitalisation, but have not stopped working on the separation-individuation dynamic. Others have adapted their protocols to retain hospitalisation conditions where separation makes sense, which is accepted as a factor of improvement for patients and their families. Finally, some are attempting to clarify indications for hospitalisation without separation, which they describe as "experience of limited separation", for patients who have not responded well to a separation-based protocol. Nevertheless, a weight agreement between the patient and team remains necessary to define the expected change.

**MID- AND LONG-TERM EFFECTS OF ANOREXIA:**

**Chronic complications:**

- Delayed puberty, abnormal ovulation, sterility
- Osteoporosis
- Heart rhythm disorders, cardiac insufficiency
- Digestive motility disorders, gastro-oesophageal complications of vomiting
- Gum disease, tooth decay
- Tubulopathy linked to chronic hypokalemia

**Socialisation issues**

**Difficulties forming a sex life and loving relationships**

**What about ambulatory care?**

When hospitalisation is not indicated, therapeutic alliances are vital for stimulating a request for treatment and directing patients toward ambulatory care. As with any mental illness, it is risky if not unwise to try to resolve symptoms at any cost, in this case normalising weight or dietary behaviour, at the risk of increasing the patient's resistance and losing contact with her. Anorexics complain endlessly about their weight and figure even though they are too thin. More than denial, it is question of body dysmorphic disorder, an excessive preoccupation with an imagined or a minor physical flaw.

Although it is quite useless to try to convince them, it is nevertheless possible to treat them by listening to their complaint whilst implementing the necessary treatment. When therapeutic alliances are fully established, practitioners can state their indications: regular medical monitoring; paraclinical, psychiatric and/or psychotherapy examinations and other physically-based treatments in accordance with the presentation and initial request of the patient and her family; immediate implementation of "practical" measures on a case-by-case basis. These measures aim to protect teenagers from a life-threatening danger (discontinuation of exercise, adaptation of schooling, etc.) whilst making it possible to establish the treatment framework by having patients and their family face the reality of the illness. In most cases, dietary management and work around family meals appears justified.

In terms of ambulatory psychological or psychiatric care in the field of eating disorders, various psychotherapeutic techniques can be offered: family or transcultural therapy for the children of migrants, behavioural therapies, psychoanalytical therapies or group therapies. No method has yet demonstrated its superiority beyond the family therapy that is preferentially indicated in anorexia in young teenagers.

## CONCLUSION

Eating disorders in teenage girls have a variable clinical expression, from a brief episode to chronicity. General practitioners must consider this when they see young teenagers. Denial makes them avoid questions, whilst shame and guilt prevents them from opening up. Early detection and the implementation of multidisciplinary care make it possible to improve the prognosis and outcome.

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