Anorexia Nervosa: Self Sabotage in Adolescence

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Adolescence is a time to find oneself and create an identity. For many adolescents, it is a time when the physical clashes with the psychological. As doctors, we need to look at anorexia from a biopsychosocial perspective, and discover why this disease is so important to these troubled teens.

Twenty or 25 years ago, we could not talk about anorexia nervosa in adolescence because of the rarity of the disease. In the 80's ---and more in the 90's---any adolescent-medicine programs in North America were overrun by female teenagers who had lost weight, were amenorrheic, and who professed to be happy to be like that Anorexia nervosa empowers its victims by giving them the ability to destabilize any relationship ---including their relationship with their doctors.

When the adolescent medicine program at Sainte-Justine Hospital started in 1974, anorexic teenagers were admitted to our ward, so we were in close contact. The team felt that our approach ---more oriented towards the endocrinologic aspect of the disease--- was not giving us a complete picture. So, we decided to get involved in the disease from a biopsychosocial perspective. This new viewpoint meant taking the time to sit down and discover why this eating disorder was so important to these teens. It became evident fairly early on that anorexia nervosa empowers teenagers; therefore, we had to avoid confrontation. The risk in confronting such teenagers is that they may become more resistant and more closed to any intervention.

The first step in treating teens with anorexia is to establish a good therapeutic alliance with the patients by respecting their realities and their rhythms of change, which are very slow because of their absolute denial of their thinness. To be successful, we had to look at anorexia nervosa as a developmental problem ---something like an impasse at this specific moment in life. Adolescence itself is a complex biopsychosocio-cultural period. It is my perception that anorexia nervosa is a chronic disease that begins in adolescence and has different manifestations throughout life.

Why during adolescence?

Why anorexia during the teen years? Perhaps anorexia manifests in adolescence because these are the years of a person's greatest metamorphosis. The body changes dramatically, with the teenager almost doubling in weight and increasing in height by 20% between 10 to 18 years of age. The female teenager particularly has many changes to accept and integrate. For many very young adolescents, anorexia nervosa reflects an incapacity to accept and integrate pubertal changes.

From another standpoint, perhaps, anorexia may begin at this crucial time because adolescence, psychologically, means setting distance between oneself and others while developing one's own identity. Adolescence requires the developmental tasks of separation and individuation ---tasks well defined by Erikson and Blos --which anorexics cannot perform. Because of this inability to develop, teenagers may start to control their food intake and realize that, for the first time, they can be "somebody" by doing this. The patient "wins" by losing weight, by controlling her appetite and by limiting her food intake. This control over what the patient is doing provides him or her with such a sense of strength and good feelings that getting the patient to quit is very difficult. Often, control over appetite fills a person's emptiness; losing this sense of control forces the patient to confront the emptiness, which is immediately followed by a sense of sadness and impending disaster. How can a teenager give up a pleasure (control) for something unknown, uncertain and likely to bring about pain?

Perhaps the teen years are so volatile for anorexics because these teens are influenced by society's cultural pressures. In the last two decades, thinness has been associated with success. The medical community has talked about things like body mass index and weight percentiles, but has forgotten to talk about genetic weight, the weight people actually are and the weight that gives people their own particular appearance. Weight has been discussed as something one can easily control; this is not realistic. I often meet girls who started their eating disorders after being told by their doctors to watch their weight.

How does self-sabotage begin?

I believe that anorexia nervosa manifest differently according to the stage at which it occurs. Being anorexic at age 12, 13 or 14 may be different than being anorexic at age 17, 18 or 19. The difficulties of accepting puberty changes, developing autonomy and finding out which one is (often impossible) can play different roles in the genesis of this disorder. The intensity of each contributing factor may vary according to the different stage of adolescence. Garner and Garfinkel's theory provides a dynamic comprehension of the disease; the contribution of the biologic, psychologic and sociologic components is well accepted in their theory. I expand on this theory by considering anorexia nervosa as an activity of " self sabotage " (auto-sabotage).

Anorexia nervosa is a difficulty of maturation, a major problem in the process of separation/individuation; it is similar in some manifestations to what we see in other " self-sabotage " behaviours (e.g., drug abuse, dropping out of school, etc.). Anorexia nervosa may assume features of an addictive disorder. We have found many similarities between the anorexics we are seeing today and the drug users of the late '70s, including the following: the conduct of self sabotage, the pleasure this disease fives victims, the denial of any problem, the reluctance to consult, the non-compliance to prescription and the limitations of interventions because victims are not ready to let go of the disease.

It is important to know the complexities of this disease before meeting with the anorexic teenager; if ones do not know these complexities, intervention can actually harm patients

and their families. The patient may decide to leave the clinic, making his or her situation worse. We must prevent this from happening.

The first clinical visit

Any unexpected hospitalization should be prevented if possible. If a patient is going to be admitted, the admittance must be negotiated beforehand and be part of a therapeutic strategy known to the patient. Try to set the first appointment as soon as possible after the first call is made to the clinic, usually by the patient's mother. After a recent review of 205 consecutive calls requesting an appointment for anorexic treatment at our clinic, we found that 83% of calls came from parents (usually from the mother), 20% from a professional and 7% from the teenager herself. When one knows how anorexia develops, one begins to understand that the parents' decision to reach out and ask for help is something that has been contemplated for weeks. Because the anorexic is usually a brilliant child, is successful at school and has thoughts about food that seem "healthy", parents often wait, hoping to see a change in the child's behaviour. The change that parents so desperately seek, however, does not happen; the anorexic teenager just eats less and less. By the time the parents make the call, they have already done their best; the teenager needs help immediately. Our clinic tries to give these families an appointment within three weeks; if you exceed this time, do not be surprised to see the parents and their anorexic teenager in the emergency room.

At the first visit, try to ensure that things go easily; adapt to the teenager and her situation. Recognize that the call for the appointment came from the family and not the teenager ---her presence was probably negotiated between them, and we do not know what they discussed together ---it is therefore important to limit the number of professionals who meet the teenager during the first visit. The nurse who took the original call will meet the patient and collect any information. After this is complete, the pediatrician is introduced to the teenager, explains his or her role and performs a physical examination. The first physical examination is usually a partial one, unless the teenager responds positively to key questions. The most important part of the examination is sensitizing the teenager to the physical repercussions of her disease; explain that part in detail, showing and explaining findings to her (e.g., why her skin is so dry, her hands cyanotic, her blood pressure low, her heart rate low, why she is constipated, etc). Touch her fingers to illustrate her slow recirculation time; this usually impresses the teenager. Until witnessing such a demonstration, the teenager has not realized all the physical repercussions of anorexia on her body. After talking with the teen, explaining findings and discussing these things with the parents, one's diagnostic impression is usually given. Explain why you are sure of your diagnosis using the Diagnostic Statistical Manual of Mental Disorders IV criteria as a guide, since anorexia nervosa must be an objective diagnosis and not a diagnosis of elimination. Making or confirming the diagnosis is the major goal of the first visit. For the teenager, this is probably the first time that somebody outside the family is telling her that something is wrong with her behaviur.

After explaining why the teenager is found to be anorexic, give your first prescription. One of the main objectives of the first visit is to create a positive alliance with the

teenager, so it is wise to be cautious with an " anorexic prescription". Ask the teenager to think about why she developed the disease. Why is anorexia such an important part of her life? Do not let the teenager leave before giving her a brief explanation of the disease and some of its causative factors. Ask parents to keep their daughter out of the kitchen and to excuse her from meal preparation. Parents should be warned that this is difficult to do and often proves to be an impossible task.

To accomplish all of this and do it correctly takes at least one to one-and-a-half hours. In our setting at Sainte-Justine, compliance with keeping the second appointment and subsequent others is between 90% to 94%. We believe that this success rate is due to the care and time taken with the initial visit. The second visit comes one to three weeks after the teenager's first visit, according to the assessment of her physical state and the situation within the family. The priority is the teenager; she is the one who is sick and needs attention.

A chronic condition with different stages

Anorexia is a chronic condition that evolves through different stages. The actions or interventions of the physician must be different and appropriate for each of these stages.

Stage I: Restricting Food Intake

This is the phase when the teenager decides to lose weight and does; it is the period between the beginning of her diet and the first appointment at the clinic. This phase usually lasts between four to six months. It is very difficult to establish a therapeutic alliance with affected teens during this period. The teenager is actively anorexic and her mind is taken over by thoughts of losing weight and controlling her body. Family members feel helpless, totally impotent; it is the same for physicians. It is important to avoid conflicts during this period, although most of the time, that seems impossible.

I usually tell the anorexic teenager that her situation resembles a hockey game in which she is shooting at her own net. I explain that if she wants to win, she must shoot at the other net. I then assure the teenager that I will not go on the ice to withdraw the puck or handle her hockey stick for her. This is clear from the beginning.

As a clinical safety margin, the teenager must have a heart rate of over 50 beats per minute to be followed as an outpatient. Usually, one has the security of such a margin.

Stage II: The Stagnation

The teenager's weight hits rock bottom; she cannot lose any more, but she is not ready to gain weight. This can be a long period filled with a great deal of frustration. The teenager promises to gain weight but does not. This phase is one in which it is important to prevent your intervention or prescription from creating iatrogenic effects. For example, the teenager may drink a lot of water to increase her weight, with the resultant risk of hyponatremia and convulsion or rapid gastric dilatation.

During this phase, the importance of the anorexic behaviour will slowly decrease. The teenager's mind will revolve less and less around the preoccupation with food and weight control. This is a time for clinicians to develop a respect for the teenager. If you must, adapt your approach, try to get the teenager to quit her anorexic habits as soon as possible, on her own and for herself.

Stage III: Regaining Weight.

After a while, the teenager becomes "incompetent " in her rigid eating control; this is a terrible period for her. The patient cannot " control" herself anymore, she experiences bulimic episodes, she gains weight and she no longer feels successful; this is a terrible feeling for her. The patient hates herself; she is not happy and may feel depressed even while all the people in her environment are happy. The family may believe that the disease is over and that the ex-anorexic patient is now a normal, happy teenager, but this is not the case. . The ex-anorexic is suffering; she does not know who she is. Feelings of emptiness and failure become more apparent and take up a lot of space in the patient's mind; she will cry, and may experience suicidal thoughts.

Physically, the patient is improving in this phase, but psychologically she is worse; this is one paradox of anorexia. It must now be explained to the parents that because their daughter is improving physically, she is going through another crisis that must be managed. During this phase, the time between appointments should be shorter. These frequent visits seem strange to family members, who are relieved that " the worst " is past.

This is a very difficult stage. Doctors may not have the ability to control the speed or direction of the patient's weight-regaining phase. Perhaps it is more important to recognize and try to prevent bulimic episodes. This part of the disease is a tough challenge.

Stage IV: Confronting the Reality of Life

The teenager is now physically "corrected "; her menses may not have come back yet but she probably does not see this as a major problem. The patient's weight is near normal, with or without bulimic episodes. Bulimic episodes, if present, are less intense, less severe and less frequent. Now, however, the patient is 18, 19 or 20 years old and is beginning to experience difficulties in choosing a life path or career. The patient may be doing well at school but does not know which discipline to go into at university; she may have difficulty establishing relationships with others, especially boyfriends.

It is the physician's job to remind these patients that anorexia nervosa is as much a problem of identity as weight, and that to pursue a life after adolescence requires one to develop an identity. This is often the anorexic patient's major psychological defect, and the reason she will face different problems after anorexia " leaves " her life.

Conclusion

To treat anorexia nervosa, one must understand its evolution; this can guide the physician to the most effective and efficient manner of intervention. The best approach is one that can be adapted to the different stages of the disease process. In a period of budgetary restriction, it is important to find better ways to introduce each of the professionals involved in a team approach. The pediatrician, family physician and nurse practitioner all have a specific and major role to play during stages I, II and perhaps III. The psychologist and/or psychiatrist begin to play a more useful role during stages III and IV. The complexity of the adolescent anorexic and this disorder creates a need to regularly review one's approach to this disease, examine it and continuously adapt it. Anorexia needs to be discussed openly. Nobody has the exact answer, but we can stimulate our thinking though discussion.