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EDITORIAL

Current perspective of eating disorders☆

Panorama actual de los trastornos de la conducta alimentaria

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Eating disorders (EDs) are a group of conditions associated with highly persistent changes in feeding-related behavior which cause severe physical and psychological and functioning consequences. The most common EDs include anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder, which usually start in adolescence or early adulthood. The most recent classifications of mental disorders, such as the DSM-5,[1] include within EDs other disorders more typical of childhood such as avoidant/restrictive food intake disorder. AN is defined as self-imposed weight loss associated with an exaggerated evaluation of self weight or body figure; its severity is established based on the body mass index. BN consists of the occurrence of regular and frequent binge episodes associated with behavior to compensate for the potential weight increase such as vomiting or the use of laxatives. Changes related to the overvaluation of figure and weight also occur. Binge eating disorder is characterized, like BN, by regular binge episodes, but patients have no compensatory behaviors and therefore eventually have overweight and obesity. They also show no changes related to body image. Avoidant/restrictive food intake disorder, usually occurring at younger ages, consists of a decreased intake for different causes, usually psychological, which leads to a weight loss that may be extreme, but there is no impaired body image or fear of weight increase. The grouping of EDs in a different way, including those with no overvaluation of weight and figure, is a conceptual change that implies that this is not a necessary symptom, and this has led to a protracted discussion among experts.[2] All these EDs are disorders that deserve to be given greater attention due to their high prevalence, and also because in many cases they are not adequately and timely diagnosed. In the general population, the approximate lifetime prevalence rates of AN, BN, and binge eating disorder in women are 1%, 2%, 3.5%, respectively.[3] The numbers for each disorder may vary depending on the use of more or less strict diagnostic criteria.[4] Obesity is not included among the psychiatric disorders because it is considered that genetic, physiological, behavioral, and environmental factors that may vary between the individuals who suffer from it contribute to its etiology. There is however a significant association between obesity and some mental disorders such as binge eating disorder. EDs involve a significant interference with social, work, family, and personal functioning, and also markedly affect quality of life. On the other hand, their endocrine, biochemical, bone, cerebral, and cardiological complications, amongst others, are very marked, and may eventually be severe. The high mortality, especially in AN, is also relevant. Women with AN have a 5.2-fold greater chance of premature death from any cause, and an 18.1-fold greater chance of dying from suicide than women aged 15–34 years in the general population.[5]

As regards the *etiology* of these disorders, several social, cultural, psychological, and genetic factors are considered to be involved.[6] In developed countries, social and cultural pressure to be thin and have an ideal body cannot be underestimated, because this increases the number of subjects who place themselves at risk by going on diets and changing their behavior in other ways in order to lose weight. Psychological aspects such as low self-esteem, high perfectionism in the case of AN, or impulsiveness in BN may also be relevant. Adverse experiences such as school, family, or social abuse in childhood and adolescence, either physical,

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emotional, or sexual, increase vulnerability to different psychiatric disorders, including EDs. Neurobiology and the different hormones regulating hunger and body weight are also altered.[7] For instance, there are reports of structural and functional abnormalities in cerebral neuroimaging, serotonergic and dopaminergic changes in cerebrospinal fluid, or the dysregulation of hormones such as leptin or ghrelin, among many others,[8] which may vary depending on the specific ED. These changes may be reversed in most cases, especially in adolescents, if treated early. By contrast, while the disorder lasts, such changes may be involved in its maintenance and especially in the long-term physical consequences.

On the other hand, there is a high heritability rate in EDs affecting aspects such as the body mass index and regarding the rapid development of an ED after some trigger such as going on a diet or suffering a stressful life event. Epidemiological studies suggest a greater risk of AN in first degree relatives of patients, and heritability is up to 80% according to some twin studies. However, genetic studies have not been able to find definitive and reproducible results,[9] and its genetic base appears to be related to different biological and psychopathological variables. Thus, an association has been found with specific genes which are relevant in weight regulation, and also with other genes related to different neurotransmission mechanisms such as dopaminergic and serotonergic pathways, which may influence symptoms such as mood, impulsiveness, addictive behavior, binge eating, or perfectionism.[10,11] It therefore appears that the answer with regard to ED etiology is an interaction of genetically determined individual characteristics and environmental pressures that lead to risk behaviors such as diet or vomiting. Epigenetic changes in DNA structure not coded in its sequence, but implying durable changes in genetic expression and which may be transmitted to future generations also appear to be relevant. This may occur, for example, after periods with a severe lack of food (during wars or droughts) or at times of significant stress.[12]

As regards treatment, it should preferably be conducted, whenever possible, on an outpatient basis or in a day hospital, in order to interfere as little as possible with the general functioning of patients, many of whom are adolescents. Hospital admission should be reserved for cases where medical or psychological risk exists or which have not responded to less intensive treatment. A joint approach by different professionals taking into account the nutritional, medical, and psychological aspects is required.[13] Nutritional recovery and management and correction of any biological changes are indispensable. The most successful psychological approach in controlled studies has been cognitive-behavioral therapy; in adolescents, a family approach should be added. Drug treatment may be helpful administered concomitantly with the psychological approach, but evidence of its efficacy is variable depending on the ED.[14] Results in AN are not encouraging, although selective serotonin reuptake inhibitors may help improve the symptoms of depression, perfectionism, or irritability. They do not help in recovering weight, but may contribute to prevent recurrence. Studies with antipsychotics have not been able to demonstrate their efficacy, although they appear to be helpful in cases refractory to treatment and clear thinking and behavior disturbances. In BN, selective serotonin reuptake inhibitors and some antiepileptics such as topiramate have been shown to be effective in different controlled studies. In binge eating disorder, in addition to the drugs mentioned for BN, other drugs such as orlistat, which helps to reduce weight in these patients, have also been used. Long-term follow-up is required to maintain improvement and prevent recurrence. The prognosis of these disorders is often not good: some ED chronically persists in approximately 20% of cases, and 30% continue to have some symptoms despite improvement. In patients receiving early treatment during adolescence, the prognosis appears to be better.[15]

To sum up, EDs are common disorders if the different diagnoses they encompass are considered, and may be associated with severe complications. Mutually interacting biological and psychological factors appear to be involved in their etiology. The early diagnosis of EDs is important to increase the chances of improvement with treatment, which should necessarily address the different symptoms, as much the physical as the psychiatric and psychological.

Conflicts of interest

The author states that she has no conflicts of interest.

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