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Psychiatric Consultation with Eating Disordered Patients

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Psychiatric consultation may play an important role in the evaluation and treatment of many patients with eating disorders. Any clinician working with eating disordered patients quickly becomes aware that the range and intensity of their symptoms and eating behaviors vary widely. A psychiatric consultation may be indicated for those patients whose symptoms are persistent or severe, whose clinical presentations are complicated or atypical, who present with symptoms of other disorders along with their eating symptoms, or who fail to respond to conservative management. The consultation can help to clarify diagnostic questions and may help to guide the treatment more effectively. In some instances the consultation can result in the prescription of medication that can advance the treatment.

Patients and families may be hesitant to consult with a psychia-

trist. They may be fearful that the referral is an indication that the eating disorder is extremely serious or that the patient is suffering from some additional serious mental illness. Sometimes that may indeed be the case because the patient's symptoms are more serious or more resistant to treatment. However, as noted above, for others the referral is often not so much because the clinician feels the patient is deeply disturbed but because of a sense that the patient's problems are in some ways puzzling and difficult, and that another perspective may be useful. The psychiatric consultant may provide this new perspective in a single consultation or may become a member of the treatment team, prescribing and adjusting the dose of medications that help to relieve symptoms and speed recovery. It is important to recognize that the psychiatric consultant will not supplant the primary clinician nor control the treatment's overall direction. The consultant gives advice and makes recommendations in collaboration with the other members of the treatment team, but final responsibility for the patient must rest with the primary clinician.

Even in comparatively uncomplicated eating disordered patients, psychiatric consultation may play a useful role. This is particularly true for patients suffering from bulimia. Substantial research evidence and much clinical experience has demonstrated that many (but not all) bulimic patients are helped by treatment with antidepressant medication. It is not clear why this should be so, and it does not mean that bulimic patients who respond to the antidepressants are clinically depressed. Even in those patients who have no depressive symptoms, the antidepressants often reduce the intensity and frequency of urges to binge and purge. It is important to understand that the medication is *at best* a useful adjunct to treatment and, most emphatically, is *not* a substitute for counseling. Indeed, it is quite rare for the medication to produce a complete remission of symptoms, but the reduction of impulses to binge and purge can give a needed boost to the psychotherapeutic work, helping the patient to gain control of symptoms and stabilize eating behaviors.

Patients are often reluctant to consider using medication as part of their treatment, and parents are often reluctant to start an adolescent on a psychotropic medication. These concerns are under-

standable. The decision to use medication is not a trivial one and should be carefully evaluated. Patients and parents are entitled to a detailed explanation of the pros and cons of a medication trial–a "risk/benefit" analysis. Only if it is clear that medication might substantially benefit the patient and enhance other aspects of treatment should it be considered. This should be true for any prescribed medication, whatever the nature of the illness.

Often patients and families are more concerned about medications used to combat psychiatric illnesses than they are about medications used for medical illnesses. There is often a fear that using medications to assist in the treatment of psychological problems involves some fundamental alteration of the patient's personality or selfhood.

The use of psychiatric medication may be seen as "using drugs to alter one's mental state." In this conception, medication for a psychological problem is viewed as using a chemical to solve a behavioral problem that should be solved by the patient's willpower and understanding—a medical form of drug abuse. Other patients fear that the medication will fundamentally change their experience of themselves, effectively making them into someone not authentically themselves. Still others are concerned that they may become dependent on the medication indefinitely in order to control their eating symptoms.

In fact, there is little to warrant these kinds of concerns. The antidepressants are not drugs of abuse—they do not create a euphoria or "high" and they do not cause psychological dependency or addiction. There is no evidence that they in any way fundamentally alter a person's sense of self. There is also no evidence that these medications produce long-term harm. Early reports that some antidepressants predisposed certain patients to suicidal behavior proved unfounded. Antidepressants are generally intended for use over a limited period of time while the treatment progresses. Ultimately, when eating symptoms have been under control for a reasonable period of time, the medication can usually be gradually tapered and discontinued. For patients with very severe illness characterized by a long and chronic course with severe symptoms, more extended treatment with medication may be necessary.

A variety of antidepressants have been used in the treatment of

bulimia and all appear to work equally well. As a result, clinicians usually choose as the first-line treatment an antidepressant that has the most desirable side effect profile, typically one of the medications known as a selective serotonin reuptake inhibitor (SSRI). Prozac is the best-known of this class of antidepressants, but there are now many other equally effective agents available. The SSRIs are generally safe and well tolerated. They are not habit forming, induce no dependency, and do not produce a euphoria or "high." The most common side effects are gastrointestinal, such as upset stomach or diarrhea. In a few cases, these agents may cause patients to feel anxious or "jittery," whereas others may find them sedating. In a minority of patients, these medications may reduce sexual desire and can also interfere with sexual responsiveness. For most patients the side effects are minimal, and many disappear with time.

Eating disordered patients are often particularly concerned about the possibility of medication inducing weight gain. Generally this is not a problem with the SSRIs. In some patients they may cause a small initial weight loss, though this is usually temporary. Weight gain is not a common side effect of these medications. Generally the psychiatrist can minimize side effects by altering the dose or by switching to a different medicine if necessary.

Given all these factors, most clinicians treating patients with severe or persistent bulimic symptoms will recommend a trial of an SSRI. Generally these medications require a week or more to produce beneficial results. Since most clinicians prefer to begin antidepressant treatment at a low dose and raise the dose gradually to a level that is maximally effective, an antidepressant trial often takes four to six weeks. It is important to note that not all patients are helped by these medicines. When a reasonable trial of the medication indicates that it is ineffective, it is discontinued. However, a majority of bulimic patients report that the medication leads to less difficulty in controlling impulses to binge and purge and that it decreases frequency of binge/purge episodes.

For patients with anorexia nervosa, the use of medication is more problematic. For anorexic patients who also have bulimic symptoms, the SSRIs may be useful, although emaciated patients may have physical complications that make the use of the medications more

difficult. For anorexic symptoms themselves (restriction of caloric intake, excessive exercise, and preoccupation with food, eating, and weight), medications have generally proven ineffective. This is not for lack of trying. Indeed, over the last decades nearly every medication that seemed remotely likely to be helpful has been tried. Many medications have weight gain as a side effect, so they seemed a logical choice to treat anorexia. Unfortunately none of them produced the desired effect in anorexic patients. Limited research shows that anorexic patients who have regained normal weight may be better able to retain that weight when placed on an SSRI, but these findings are preliminary.

Of course, eating disordered patients may also suffer from other emotional and psychiatric problems in addition to their eating symptoms. These are referred to as comorbid illnesses, meaning that they are distinct illnesses that coexist with the eating disorder. These coexisting disorders may exist as separate disorders, and often they were present before the onset of eating symptoms. In other patients, they may be brought on by the stress of the eating syndrome. For example, a prolonged struggle with eating symptoms may lead to depression. In cases where the comorbid illness precedes the onset of the eating problems, it may worsen as the stress of the eating disorder takes its toll on the patient's energy and endurance. In such cases a psychiatric consultation is particularly important, since it is essential that each problem be identified and specifically addressed in the overall treatment plan.

Common comorbid conditions in eating disordered patients include depression, anxiety or panic disorders, obsessive-compulsive disorders, substance abuse, and personality disorders. Some of the symptoms may be similar to eating disorder symptoms, requiring careful evaluation and detailed exploration of the patient's complaints. For example, typical symptoms of depression include a markedly depressed mood characterized by feeling sad, empty, irritable, or apathetic. Additional depressive symptoms include inability to enjoy oneself, disturbed sleep patterns, decreased energy, agitation, significant weight loss or gain, feelings of worthlessness, decreased ability to concentrate and think clearly, indecisiveness, and suicidal ideation. Clearly some of these symptoms also regularly occur in eating disorders, and it may take a careful psychiatric eval-

uation to distinguish which symptoms belong to which problem. Like bulimic symptoms, depressive symptoms also often respond to treatment with antidepressants. Where such treatment is indicated, the response to antidepressants may help restore a level of motivation and energy that makes it possible for the patient to make better use of the psychotherapeutic treatment. Clearly, where depression exists along with bulimia, there is an even stronger indication for treatment with an antidepressant, since the medication may help the patient with both conditions.

Similarly anxiety disorders share some symptoms in common with eating disorders. Anxiety disorders are common psychiatric disorders and are typically characterized by consistently excessive anxiety and worry persisting over time, symptoms that are not responsive or minimally responsive to reassurance. Other symptoms include restlessness, difficulty concentrating, sleep disturbance, irritability, and fatigue.

Anxiety disorders may also involve anxiety attacks, which are episodes of intense fear or discomfort with associated symptoms such as pounding heart, sweating, trembling, sensations of shortness of breath, dizziness, and feelings of detachment or unreality. These symptoms are often terrifying and can lead patients to avoid anxiety-provoking situations and constrict their lives in an effort to avoid recurrent panic attacks. Patients in the midst of a panic attack may fear that they are having a heart attack or are otherwise in mortal danger. A number of medications can be useful in the treatment of anxiety disorders. In the past, these disorders were treated with tranquilizers such as Valium, Ativan, or Xanax. Although these medications may be useful in some selected patients, in general we try to avoid them because of the tendency to sedate patients and to induce dependency. Currently a number of newer medications exist that are safe and effective in the treatment of these disorders. These include the SSRI antidepressants discussed above (which are often also effective in controlling anxiety), as well as other medications that are usually first-line treatments for anxiety in eating disordered patients, such as BuSpar. These medications are often useful in controlling anxiety without producing sedation, and they are not addictive. After a period of treatment, the medication usually can be slowly tapered and discontinued.

Obsessive-compulsive disorder is another anxiety disorder that may accompany an eating disorder. Indeed, perhaps one-fifth of anorexic patients have some significant obsessional symptoms. Obsessions are recurrent and persistent thoughts or impulses that are experienced as unpleasant, intrusive, and inappropriate (not ordinary worries about real problems). Compulsions are repetitive behaviors, such as hand washing, checking, counting, or praying, in order to reduce distress or to prevent some imagined dreaded event. Since eating disordered patients are often preoccupied with food and exhibit eating behaviors that appear obsessive, the clinician may wonder whether obsessive-compulsive disorder may be an important aspect of the problem. In fact, among anorexic patients, the one-fifth who have clinically significant obsessive symptoms, have behaviors that go well beyond the usual eating disorder food and weight preoccupations. These obsessive/compulsive symptoms vary greatly but are typically rigidly ritualized behaviors such as counting bites or counting the number of times food is chewed. Other rituals might be cutting food into particular shapes, spitting out food according to some ritualized schedule, or a compulsion to tap fingers or feet a particular number of times before each bite or after each swallow. Medication may help to relieve these symptoms, though generally the medications, even when they reduce obsessive/compulsive symptoms, usually have little or no effect on the patient's nonobsessive anorexic attitudes and behaviors.

These are not the only comorbid symptoms and illnesses for which psychiatric consultation may be useful, but they are the most common. Some patients present more unusual or complex symptom pictures, but the general principles elaborated above still apply. It is important to keep in mind what the psychiatrist can and cannot do. The consulting psychiatrist can provide an expert opinion about the patient's condition from a specialized perspective. The psychiatrist's role does not involve oversight of the therapy as a whole, nor can the psychiatrist offer opinions about the specifics of the therapy itself. When patients have concerns about the effectiveness of the therapy, a second opinion should be sought to evaluate the course of treatment and make recommendations. While this second opinion can be rendered by a psychiatrist experienced in the treatment of eating disorders, other senior professionals can also provide this service.

When meeting with the psychiatrist, the patient should understand that, for the most part, the therapist and psychiatrist will communicate freely, exchanging whatever information is required to make the consultation effective and precise. However, both parties are bound by the same obligation to respect the patient's privacy and to observe confidentiality.