

## Chapter 27

# Anorexia Nervosa in Adults

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### INTRODUCTION

**A**norexia nervosa is no longer considered to be an exclusively adolescent disorder. Although many clinicians recognize its occurrence in adults, the literature on this subject is still very scarce, and research is almost nonexistent.

Probably the most common form of adult anorexia nervosa is the continuation into the adult life of the syndrome that had begun in the patient's teens. In a yet unknown proportion of adult patients, however, a typical full-blown anorexia nervosa picture developed "de novo." But the question remains whether it is really "de novo," since the majority of cases demonstrate that some preoccupation with food or body shape preceded the actual establishment of the syndrome or that previous nonanorectic psychopathology clearly impinged on adult life [1].

In the present chapter we will focus first on the diagnostic problems raised by the occurrence of anorexia nervosa and related disorders in adults. The older patients face us with two major aspects that could be of great importance in clinical practice: the age at onset of the disorder and the duration of illness. Current research suggests that both factors might not only influence the form of the clinical picture the patient presents, but also determine to a great extent its long-term outcome. For this reason, the older and/or chronic patient represents a specific challenge to the clinician, particularly with regard to treatment efficacy and tertiary

ary prevention. From a scientist-practitioner perspective it is argued that both researcher and therapist have to rely on a dynamic and dimensional conceptualization of eating disorders.

### HISTORICAL BACKGROUND

Lasègue [2] based his classic paper "De l'Anorexie Hystérique" (1873) on eight cases, all women, the youngest being 18 and the eldest 32. Very briefly, Lasègue noted some details on a married woman "hysterical for a long time and 30 years of age when the anorexia occurred." But, no doubt, this was a case of hysterical refusal of food that has nothing to do with the modern notion of anorexia nervosa. It is interesting to mention here that the few sentences Lasègue wrote on this elder woman have been omitted in the English translation of his paper [3].

Another case that is frequently mistaken for being a historical description of anorexia nervosa is the one reported by Naudeau [4] in 1789: It is about a 35-year-old woman who suddenly was suffering from pain attacks followed by a strong aversion to food, which was correctly diagnosed by Naudeau as being "une affection hystérique." As these cases show, one has to be careful with the examples in the older literature claimed to be anorexia nervosa, especially when it concerns adult women.

The same applies to Ryle's [5] report on 51 cases seen during 16 years of consulting practice, including a series

of 13 cases between 31 and 59 years (average 44 years). Though we may doubt the diagnosis in these cases, Ryle was the first to pay attention to these older-than-usual anorexics: "I have thought fit...to include a group of older women because the clinical picture seemed to me essentially similar and the patients equally deserving of proper understanding and treatment" (p. 894). "The physical and psychological stigmata were not to be distinguished from those encountered in the younger group excepting in so far as maturity and environmental influences modified the type or form of individual reaction" (p. 896).

The details Ryle gave on two cases of these "nervous, voluble, sparrowlike women with sparrow's appetite" do not seem to justify the diagnosis of anorexia nervosa according to modern criteria. Similar diagnostic doubts concern Berkman's [6] review of 117 patients diagnosed with anorexia nervosa at the Mayo Clinic between 1925 and 1932, including four postmenopausal women. This is equally true for the monograph by Bliss and Branch [7], who mentioned a woman in her 40s and two others who first lost weight in their 50s.

In France, Laboucarie and coworkers [8,9] reported on large series of so-called anorexia nervosa patients, but they included all types of weight loss or anorexia (loss of appetite) due to psychological reasons. Hence, no wonder that 10% of their cases were older than 30 years.

As King [10] rightly observed, most of the older cases (including women past their menopause) belong to a secondary atypical group. But, like in males, one might suppose that the diagnosis of primary anorexia nervosa is easily overlooked in adults because of one factor deviating from the classic picture of the syndrome: In boys the gender is misleading, in adults it is the age. Nevertheless, Garfinkel and Garner [11] argue that maybe the disorder has always been common in post-adolescence, since studies by Kay and Leight [12] and Halmi [13] reported that 30% and 13%, respectively, of their patients were over age 25 at onset.

### DIAGNOSTIC PROBLEMS

The syndrome method of diagnosis of anorexia nervosa has many strengths and weaknesses; it leads to several classes of qualitatively and quantitatively atypical presentations of the syndrome [14]. The Feighner criteria [15] exclude patients older than 25 years at the onset of the syndrome. But, as Andersen [14] emphasized, there arises a clinical problem of recognition of otherwise typical syndromes if such criteria are seen as defining criteria rather than as exclusionary criteria to be disregarded when appropriate. Probably because of

these problems, the age-of-onset factor has been deleted in the DSM-III criteria [16] for anorexia nervosa.

While it remains true that anorexia nervosa is overwhelmingly a disorder of adolescence (with a usual range from 12 to 25 years of age), several clinicians have the impression that it is developing more frequently in older women [11]. But due to a lack of epidemiological studies in this respect, the increase of reports on adult anorexia nervosa might equally well reflect a better and more accurate diagnostic assessment in an era of growing awareness of the disorder.

Interestingly enough, anorexia nervosa in young adults has not caught the attention in the literature, except for some casual reports [1], whereas more clinicians seem to have been struck by the occurrence of anorectic behavior in middle-aged females. Since 1970, several anecdotal case descriptions of women developing postmenopausal anorexia appeared in the literature:

1. Kellett et al. [17] described a 52-year-old woman with typical symptoms of anorexia nervosa including abuse of slimming tablets and purgatives and self-induced vomiting. The patient's previous medical history revealed periods of weight loss, bulimia, amenorrhea, and disturbed body image, which, however, were never diagnosed as anorexia nervosa or an anorectic-like condition.
2. Launer's [18] patient, a 70-year-old housewife, presented with weight loss of unexplained origin, fear of fatness, refusal to eat, and denial of her emaciated state. Though she was a lifelong consumer of laxatives and exhibited a limited food intake for many years, the absence of amenorrhea, pronounced weight loss, or marked anorectic behavior in her previous history justified the assumption that she had not developed the full clinical picture of anorexia nervosa before the actual episode.
3. Vecht-van den Bergh [19] reported on four cases of anorexia nervosa in women older than 35 years: in only one case (a 50-year-old married woman) the syndrome developed "de novo" without a previous history of weight/eating disturbances. In a 36-year-old woman it was clearly a relapse of a condition that started in the patient's teens, whereas in the two other cases (45 and 56 years old), it appeared to be an exacerbation of a rather chronic history of eating problems.
4. Andersen [14] discussed the case of a 53-year-old married female with a 22-year history of typical anorexia nervosa. This case combined both late onset and chronicity.
5. The case of a 47-year-old woman described by Maillot et al. [20] concerned, in fact, a typical ex-

ample of chronic anorexia nervosa that went undiagnosed for many years.

6. A variant of the latter example has been published by Oyewumi [21] who stresses that, especially in mild cases of long-standing and recurrent anorexia nervosa, the condition might go undiagnosed in adolescence and be picked up at a later age when the condition becomes worse.
7. Another variant is the case of a 67-year-old woman recorded by Böning [22]: Her anorexia nervosa appeared to be a relapse of a condition that first occurred in the patient's adolescence followed by a period of almost total remission during several years.
8. Finally, one of the rare examples of typical anorexia nervosa in a middle-aged man has been reported by Mintz [23].

Dally and Gomez [24] report on a number of cases beginning after the age of 40 and they called it "anorexia tardive" referring to the French author Carrier [25] who in his dissertation first used the term "forme tardive" to describe these older-than-usual patients. But Dally and Gomez are not clear as to the question whether the anorexia tardive is a variant of primary anorexia nervosa or just a secondary form. They report that virtually all patients with an age at onset of 19 years and older are atypical anorexics: "The older the patient the more likely she or he is to have atypical features, ie, to have secondary anorexia nervosa" (p. 18) [24]. The authors emphasize that especially in older patients other reasons of weight loss have to be excluded, in particular depression. But, "the patient with anorexia tardive has a bird-like alertness which belies serious depression" (p. 155). Hence, Dally and Gomez suggest that anorexia tardive is of primary nature, although it may be atypical in its presentation (see Andersen [14]).

Several cases of anorexia tardive in the literature are, in fact, atypical presentations of an atypical syndrome:

1. Bernstein [26] recorded a lady of 94 who stopped eating, but her prompt recovery with electroconvulsive therapy suggest the existence of an underlying affective disorder.
2. Lützenkirchen and Böning [27] extensively discussed the case of a 45-year-old woman in whom it was difficult to come to one diagnosis, because she suffered from both an anorectic syndrome and depression.
3. Three case reports of older men (28-30) concerned psychogenic weight loss without enough clinical evidence for the diagnosis of anorexia nervosa.

According to Sours [31], other examples of anorexia tardive are the thin spinster, emaciated for a lifetime and now in her fifth and sixth decade, and those anorectic individuals who conceal lifelong starvation behind a

feigned malabsorption syndrome, which they claim resists treatment. Exceptionally, anorexia tardive may be preceded by other psychosomatic illnesses as in the case of a 40-year-old woman who manifested, in succession, bronchial asthma, peptic ulcer, regional ileitis, and finally, anorexia nervosa [32].

From a clinical point of view, the diagnosis of anorexia nervosa in late life faces two major problems: the definition of onset and the exclusion of previous episodes of anorectic-like conditions. Both aspects are, of course, interrelated. What is meant by onset of disorder? Does this mean the behavior leading to the loss of weight, or is it the onset of weight loss itself? Or, when does "normal" fasting end and when do pathological anorectic symptoms begin? [33] These questions are important in order to distinguish the cases with late-onset "de novo" from those with a previous history of mild, concealed, undiagnosed, or overt anorexia nervosa.

We have the impression that a real "de novo" development of anorexia nervosa after the age of 40 is very rare, whereas it may be more common in women between 25 and 35 years old. In the latter cases it is often linked to marital problems or pregnancy [34]. In most cases of anorexia tardive, a thorough clinical assessment (that has excluded other causes of emaciation) will reveal that the condition appears to be either an exacerbation of a chronic eating disorder or a relapse of anorexia nervosa after a period of (probably partial) remission.

According to Crisp [35], an anorexia nervosa syndrome supervening in older age is much more likely to be associated with a major degree of premorbid obesity: "The obese person is likely to have been struggling to reduce weight for years and may indeed have lost some down to near normal or normal levels, but only at the price of vigorous dietary control. Only later does anorexia nervosa emerge. Under such conditions it can be seen that, whatever age she may be at the time of onset, she has been wrestling with problems of an adolescent order" (p. 32). This clinical experience, however, forces us to reconsider the rather static way of diagnosing eating disorders, as we will discuss further on.

A final remark regarding clinical assessment in older-than-usual patients: the real age of onset is not always easy to establish when patients tend to deny or "forget" the occurrence of previous episodes of anorexia nervosa or related disorders [36]. For this reason, Bruch [37] warns that in some patients the reported age may be too high: "In three married women with a reported onset at age 25 or 26 years there was justified suspicion of an earlier episode, for which the information was vague and inaccurate" (p. 236). In some cases it is only during the course of treatment that patients come to "remember" having had similar symptoms in their youth. Sometimes

an old history of anorexia nervosa is only discovered through the information from previous therapists or close relatives who have been a witness of the patient's behavior in that period.

### THE CHANGING CLINICAL PICTURE

Comparing patients seen from 1970 to 1975 with those seen from 1976 to 1981, Garfinkel and Garner [11] found a trend toward increased average age of onset from 17 to 18 years. The same comparison showed that the age at presentation had significantly increased during the same period: from 19.3 to 22.2 years. This means, according to the authors, that the interval between onset and referral has increased despite the growing public awareness of the disorder. Garfinkel and Garner seem to overlook, however, that an important selection factor may have influenced these changes [38]. In specialized centers known for the treatment of anorexia nervosa patients, a "negative selection" may operate in such a way that patients with long and intractable illnesses tend to be referred.

This brings us to the question of whether there is a relationship between age at onset and/or duration of illness on the one hand, and form and/or severity of the clinical picture on the other. Such a relationship is suggested by the following three groups of clinical evidence:

1. Reports about unusual and severe cases (not necessarily anorexia nervosa patients) of purgative abuse [39], addiction to diuretics [40], or enema abuse [41] show that the patients concerned are mostly middle-aged (or even older) women, usually with a chronic disorder.
2. The majority of patients with bulimia or bulimia nervosa (excluding anorexia nervosa patients) are in their 20s; only a small minority are schoolchildren [42].
3. Most comparisons between the abstaining ("dieters") type of anorexia nervosa on the one hand, and the bulimic ("binge eaters") or related ("vomitters/purgers") type of anorexia nervosa on the other, demonstrate that patients of the second type are frequently older at onset or presentation and/or display a longer history of their eating disorder.

Since this chapter is about anorexia nervosa, we will discuss the research data that contribute to the third group of clinical evidence for the above mentioned relationship. Garfinkel et al. [43] reported no differences between the bulimia and the restrictor group of anorexia nervosa patients in age at onset or duration of illness, "arguing against bulimia simply representing a manifestation of chronicity." Beumont et al. [44] did not

observe differences in age at onset between dieters and vomitters/purgers, but the latter displayed a longer delay from onset to presentation of symptoms (4.4 versus 1.1 years). This is very close to our own findings [45]: Comparing dieters to a combined group of binge eaters and vomitters/purgers, we found the latter were significantly older at admission (22.2 versus 18.4 years) and exhibited a significantly longer duration of illness (4.1 versus 2.0 years). According to Casper et al. [46], who similarly remarked an older age in their bulimic patients compared with dieters, this fact is "suggestive of bulimia as a sign of chronicity. An alternative, albeit hypothetical, explanation would be that a certain degree of physiological and psychological maturation is a necessary requirement for bulimia to develop."

Our own research on these variables revealed another interesting finding [45]: several anorexia nervosa patients develop bulimia during or after treatment and they seem to be characterized by the same features as those patients who already manifested bulimia at admission, namely older age and longer duration of illness. Moreover, our investigation showed a significantly higher proportion of previous treatment failures in both the binge eaters and vomitters/purgers in comparison with the dieters, of whom about 43% had received no previous specific treatment for anorexia nervosa. Although these findings do not prove a direct causal relationship between previous treatment (failures) and subsequent occurrence of bulimia or vomiting/purging, they at least suggest the possibility of iatrogenic influences on the development, exacerbation, or deterioration of an eating disorder.

The clinical evidence and assumptions we have discussed so far may be tested by comparing different age-groups within a sample of anorexia nervosa patients. Halmi et al. [47] examined the relationship between age of onset and a variety of personal characteristics in 105 anorexics. The patients whose onset of illness occurred at a later age (18 years and older) tended to have a greater weight loss during their illness, more "underweight problems" before the onset of illness, less of the typical anorectic behaviors and attitudes, greater body disparegament, more symptoms of depression, and a greater number of previous hospitalizations. These associations suggest that the disease process is somewhat different and clearly more severe in the older group. The authors concluded that an older age of onset of anorexia nervosa might predict a poor outcome.

Table 1 shows the results of our own investigation. We subdivided a consecutive series of 200 anorexia nervosa patients hospitalized at the University Psychiatric Center in Kortenberg according to the age of onset. We have chosen the age of 21 years as an arbitrary selection

Table 27.1 Comparison of adolescent and adult patients with anorexia nervosa

	Age at Onset		p*
	<21 N = 174	>21 N = 26	
Age at admission (yr)	20.0 ± 4.1	28.5 ± 5.4	.0001
Duration of illness (yr)	3.6 ± 3.5	3.3 ± 2.2	ns
Married (%)	12.6	44.0	.0001
Weight at admission (kg)	38.5 ± 6.0	35.8 ± 4.2	.008
Weight loss vs ideal weight (%)	29.7 ± 9.5	35.5 ± 9.4	ns
No previous hospitalization (%)	34.7	8.0	.001
Bulimia (%)	16.5	22.0	.01
Vomiting/purging (%)	28.7	52.4	.0004
Long-term outcome (%)**			.05
Excellent	38.8	25.0	
Much improved	18.4	12.5	
Symptomatic	20.4	12.5	
Poor outcome	22.4	50.0	

\*Two-sample t-test or chi-square test in two-way frequency tables; ns = no significance.

\*\* According to the Global Clinical Score (48); follow-up duration averaged 4.9 ± 3 and 4.2 ± 2 years, respectively; follow-up data have been gathered in 66 and 10 cases, respectively.

point, since this is the official and legal minimal limit for adulthood in Belgium. Most of the results confirm the assumptions discussed above as well as the trends found in Halmi's [47] study. One has to be careful, however, with the analysis of our follow-up data because of the limited number of patients involved and the problems encountered in this type of research as we have discussed elsewhere [38]. Nevertheless, although there was no significant difference in duration of illness, our older anorectics weighed less at admission, had been more often hospitalized before, displayed more frequently signs of bulimia and, especially, vomiting/purging behavior, and their long-term outcome was generally worse than in patients with an early onset of illness.

### THE CONTINUUM OF EATING DISORDERS

The previous clinical considerations lead us to think that eating/weight disorders could be better approached and understood if we abandon a static system of diagnosis and use a more dynamic and dimensional model instead. By "dynamic" we mean that we wish to include an important time factor in our descriptive approach, indicating that clinical situations may change. Indeed, every classification is the product of a given assessment at a given moment, ie, a static picture, a snapshot, or cross-section of temporarily observed characteristics. A dynamic approach takes into account the fact that the clinical picture of an eating disorder or a "dysorectic" [49] patient may alter in the course of time while the core problem remains unchanged. We, therefore, also advocate a dimensional model that pays attention to the het-

erogeneity of anorexia nervosa and its relationship with other eating/weight disorders such as bulimia (nervosa) and psychosomatic obesity.

The dysorexia/dysponderosis continuum shown in figure 1 is an attempt to describe eating/weight disorders in a dynamic and dimensional way. If the core problem is labeled as disturbed eating behavior (dysregulated appetite, hunger, and/or satiety), the disorder can be put on the dimension dysorexia (anorexia or food abstinence versus hyperorexia or overeating). When the disorder is mainly conceptualized as disturbed or dysfunctional weight regulation or distorted weight control, it seems more appropriate to speak about the dimension dysponderosis (pursuit of thinness or "Magersucht" versus obesity or "Fettsucht"). This is, of course, only an artificial distinction, since most cases in clinical practice display a cluster of combined or concomitant features of both dimensions.

At one end of the continuum we place the "classical" picture of primary anorexia nervosa, namely the dieters or abstainers. The subgroups of vomiters/purgers are also those anorectics who show bulimic tendencies or behavior. The bulimia (nervosa) syndrome (defined as an entity in DSM-III [16]) occupies a somehow pivotal position between the bulimic anorexia nervosa patients on the one hand, and those overweight subjects who impulsively overeat on the other. The latter are (formerly) obese patients or "thin fat people" [36] in whom peculiar eating patterns may be observed, such as binge eating, night eating, and eating without satiation [50]. Finally, at the other pole of the continuum we may place the more or less stable psychosomatic obes-

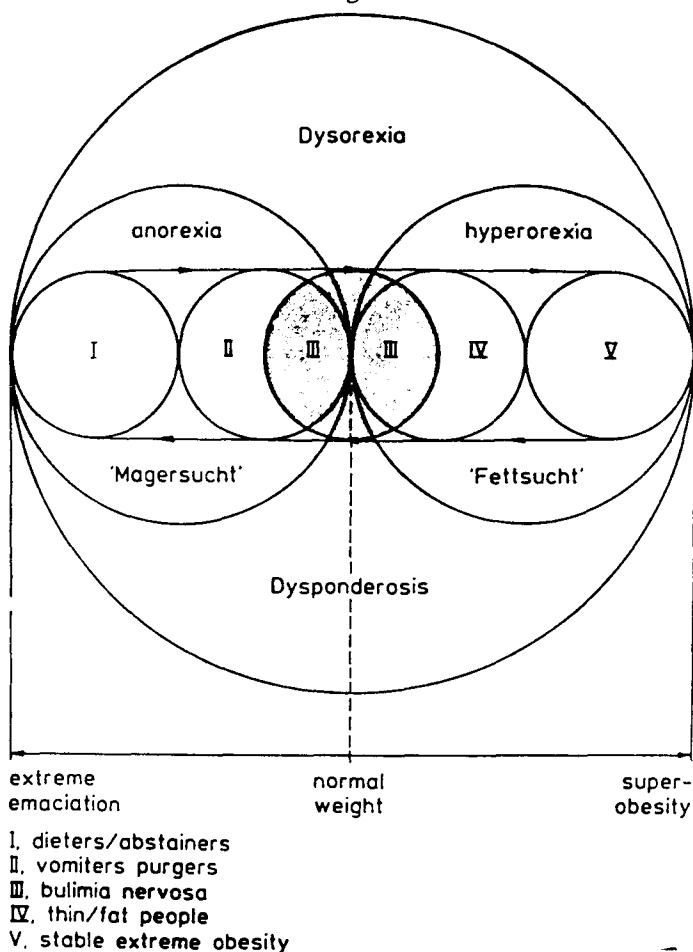


Figure 27.1 The dysorexia-dysponderosis continuum.

ity in which the overweight is the result of different factors (not merely caused by overeating).

These five identified clusters of symptoms have to be regarded as landmarks according to which we can subdivide a series of patients (eg, for comparative studies) and trace out the individual history of one patient [51]. Some cases may develop just one of these clinical forms, whereas others may move from one position to another. The interchangeability or alternation of symptoms is either a spontaneous phenomenon (eg, in the course of time an anorectic dieter may become a binge eater), or it is induced in an iatrogenic way (eg, forced feeding of the emaciated anorectic risks provoking vomiting).

In the case of the older patient, be it older with regard to age or to duration of disorder (the patient "career"), the dysorexia-dysponderosis problem may not only be different compared with younger patients, but may also show alterations in the clinical picture, either spontaneously or as a "complication" or side-effect

of treatment (iatrogenic influences). This means that a special learning process is shaping the disorder into a more complicated form. Additional evidence for such a learning process is provided by the following findings: First, there seems to be a positive relationship between dietary restraint and binge eating, ie, chronic dieters are prone to bulimia through a mechanism of counterregulation [52]; second, vomiting as a weight-control method appears to be a learned maladaptive behavior, which is frequently inadvertently taught by well-meaning friends, relatives, and even professionals [53].

#### PROGNOSIS AND TREATMENT

When faced with chronic cases, one may be inclined to think of anorexia nervosa as an incurable illness with spontaneously occurring remission and exacerbation; here the aim of treatment is not cure but tertiary prevention, ie, limiting the "handicaps" of the disease the

patient has to learn to live with. When faced with quick recoveries in young or "fresh" cases, anorexia nervosa may be viewed as a self-limited disorder from which almost all recover; here the follow-up question is not improvement but whether the course of the disease was milder as a result of treatment [54]. In view of the diversity of assessment methods used, it is not surprising that the published rates of recovery of anorexia nervosa vary between 10% and 86%, the majority falling between 30% and 50% [55].

Those studies with lengthy follow-up intervals and not restricted to young populations show similar results: About 40% of all patients are totally recovered, 30% are considerably improved, at least 20% are unchanged or seriously hampered, and about 10% have died as a result of anorexia nervosa [11]. As to the hard-fact type of data on which most researchers agree, long-term outcome of anorexia nervosa seems less favorable in cases showing a high age at onset, a long duration of illness, a very low body weight, and occurrence of bulimia, vomiting and/or laxative abuse. All these factors are not seldom combined in the older patients with a long illness history including treatment failures; this type of patient is clearly at risk for poor outcome and, therefore, in need of intensive, mostly residential treatment [54].

The chronic anorexia nervosa patient frequently elicits the analogy between eating disorders and addictions. Comparing excessive eating or pursuit of thinness to alcoholism, one has the impression that overeating and starving (together with vomiting and purging) may assume the character of hard drugs: Once present for some time, they show an apparent physical dependency and lead to social descent and physical ruin [56]. Perhaps one important consideration may explain the sometimes obstinate addiction to (non)eating: "Persons with eating disorders do not have the luxury of avoiding the problem substance as can be done for alcohol, drugs, or cigarettes. One has to eat, and difficulties in regulating food intake can remain a daily problem" [57] (p. 47).

Chronic patients with a long-standing illness of periodic and partial remissions and relapses or even less chronic cases with a history of treatment failures whereby "nutritional politics" has replaced psychotherapy (ie, repeated refeeding efforts without psychological understanding) are in danger that an irreversible automatization of the symptoms or a so-called "malignant autonomy" picture [58] may take over. Then, the symptoms that the anorectic patient has obstinately defended through the years come to be experienced as totally automatic, no longer the active expression of control over her body, but so dissociated from their original meaning and intention that the patient now feels controlled by the illness [59].

What eventually happens to those chronically dis-

abled anorexia nervosa patients who do not die from their condition? Crisp [35] called this an "elephants' graveyard" mystery: "Some remit at around the time of the menopause after having the condition since puberty—it has spanned their reproductive life and at the end of this time it is shed. Some others definitely remain 'ill' with it. Amenorrhoea is no longer a hallmark and they survive as isolated, eccentric and wizened old ladies" (p. 34).

What can we do for those patients who have "decided" to stay anorectic, who have "chosen" a life as an abstainer or a bulimic [60]? The life of the chronic abstainer is dominated by food both night and day; she feels safe in her rigid eating pattern and her routine and superficially satisfactory lifestyle in such a way that, although life is barren with anorexia, it becomes even more barren and painful without it. The chronic, "well-controlled" bulimic very often organizes her life around her bulimia; she no longer struggles to stop herself from bingeing, and she feels forced by the terror of weight gain to continue vomiting and purging. "Bulimic episodes may become institutionalized, particularly with married patients, who can indulge in gourmet restaurants or at dinner parties, sustaining an otherwise empty but mutually dependent relationship with their spouse" [60] (p. 643).

Sometimes chronic anorectics may request treatment after many years of illness. Experienced clinicians all know some cases of chronic eating disorder who totally recovered after intensive treatment. In general, however, experience in treating chronic anorexia nervosa patients, who failed to maintain their weight after their index admission, was disappointing: At four- to eight-year follow-up most of them had a very low weight (below 75% of average) [61]. Treatment in these patients is a difficult and complex process not without serious risks, such as the precipitation of a psychotic reaction or a suicidal depression. "Perhaps we should abandon our so frequently unrealistic goal of a 'cure' and look towards supporting these individuals in their decision to remain anorectic, helping them to stabilize their anorexia nervosa and lead the fullest life possible with it" [60] (p. 641).

Chronic patients face us with the ethical question: When does the patient have the right to stay as she is? Opiate addicts are given the right to be maintained in an acceptable way by medically optimal prescription of their addictive drugs. In the same way, the anorexia nervosa patient may have at least the right to be helped to survive with her illness [34]. The problem remains of differentiating the treatable from the untreatable patient. The central questions are: Is this person likely to be better off without an eating disorder in the long-term? Has this person got the resources, both internal

and external, to cope with the process of recovery? [60] In order to avoid overoptimistic or fatalistic reactions on the part of the therapist, the answers on these questions—the balance of advantages and disadvantages of the disorder and its eventual treatment—are, in fact, to be given during or after some treatment trial. In other words, the chronic patient has the right to stay anorectic if she has been offered an appropriate treatment, ie, the chance to change. And sometimes she will already change when being asked to keep her illness [62].

### CONCLUSION

We know little or nothing substantial about anorexia nervosa in chronic cases or its course in adults. The limited knowledge we have seems to question our current approach to diagnosis and treatment of eating disorders, both of which have been based on the “typical” adolescent disorder. Maybe age and chronicity only shape the form of the clinical picture but not its real content. Dally and Gomez [24] divided the anorexia tardive into two groups: The hyperactive patients who pursue thinness at all costs, and the rather inactive ones who have sparrows’ appetites and are afraid to eat much. The first type, less common, resembles the classical picture of adolescent anorexia nervosa, whereas the second type seems more close to the atypical or secondary forms of anorexia. Interestingly enough, in both types the crux of the problem, according to Dally and Gomez, is a resentful dependence on or a strongly ambivalent relationship with an important person the patient is living with: In the first type, this person usually is an adolescent daughter, while the husband seems to play the significant role in the second type (in unmarried patients this could also be the mother).

With regard to the form of eating disorders, we have advocated a dynamic and dimensional model in which the time factor (spontaneous life events and iatrogenic influences) plays an essential role. As to the content of the disorder, one may ask whether in some patients the anorexia is not engrained in their psychobiological development, whereas in others it could be rather an expression of interactional conflicts. In other words, it might be worthwhile to distinguish between the process type of anorexia nervosa and the reactive type. The former (more intrapersonal or endogenous?) seems difficult to cure in contrast to the latter (more interpersonal or exogenous?). We hypothesize that the first type, when occurring in adults, must have its roots in the patient’s youth, and that the second type may develop “de novo” in later life.

Much of what has been said remains hypothetical. We need appropriate prospective studies on the long-

term course of anorexia nervosa. Only this type of research may yield important information as to the factors—including therapeutic interventions—that determine the development and alteration (recovery, deterioration, relapse) of eating disorders.

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