

## DEPRESSION OR DEPRESSIVENESS IN PATIENTS DIAGNOSED WITH ANOREXIA NERVOSA AND BULIMIA NERVOSA – PILOT RESEARCH

Ewa Dêbska<sup>1</sup>, Adam Janas<sup>1</sup>, Wojciech Bańczyk<sup>1</sup> & Malgorzata Janas-Kozik<sup>2</sup>

<sup>1</sup>Students' Scientific Society of Psychiatry Medical University of Silesia, Katowice, Poland

<sup>2</sup>Department of Child and Adolescent Psychiatry and Psychotherapy, John Paul II Pediatric Center, Sosnowiec, Poland

### SUMMARY

**Objectives:** The target of this work is to consider if depressive symptoms intercurrent with patients suffering from Anorexia Nervosa (AN) and Bulimia Nervosa (BN) form a depression complex or whether they are physiological depression accompanying adolescence. We wished to observe the perception of these patients, of their functioning, both social and within their families and also looking for common point in the issues mentioned above trying to locate them within the course of the basic illness.

**Subjects and methods:** We studied 19 patients suffering from eating disorders, and aged between 12 and 24 years old. 15 of them suffered from the restrictive form of AN and 4 suffered from BN. The control group consisted of 30 healthy girls in the same age interval. In the study authors used the Beck Depression Inventory (BDI) and the Quebec Quality of Life Questionnaire.

**Results:** Comparison of a number of points acquired in the survey using Beck Depression Scale revealed statistic significance at the level  $p < 0.001$  which points to a more frequent occurrence of depression symptoms among persons with eating disorders comparing to control group. The survey using the Questionnaire for Social Quality showed no statistically significant differences between study and control groups ( $p > 0.05$ ). The authors observed a statistically significant increased frequency of suicidal thoughts in the study group compared to the controls.

**Conclusions:** To diagnose depression, depressive symptoms presented by the patients must give the image of depression at the clinical level. The result of the Beck's scale needs to be confronted with the clinical picture. Depression in adolescence requires differentiation from depressiveness.

**Key words:** depression - eating disorders - depressiveness

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### INTRODUCTION

Anorexia Nervosa (AN) and Bulimia Nervosa (BM) are diseases characterized by an eating disorder, distorted weight regulation and distorted perception of one's body. These diseases mainly affect women in the agegroup between 11 and 35 years of age (Sidorowicz 2004). According to the DSM-IV classification basic symptoms of these disorders are: intense fear of weight gain, even if it is insufficient, distortion of the way of experiencing their own weight and shape of silhouette, and the excessive influence of shape and weight on self-esteem (Wciórka 2008). As a result of these disorders patients suffering from Anorexia Nervosa and Bulimia Nervosa demonstrate various attempts at not acquiring food. In Anorexia Nervosa these attempts have come down to deliberate, long-term reduction in food intake by the patient. In Bulimia Nervosa it involves recurrent episodes of eating in a given unit of time by far in excess of the amount of food which at the same time and circumstances most people would eat, with an accompanying sense of loss of control over eating during the episode and presentation of recurrent, inadequate compensatory behaviors taken to prevent weight gain such as vomiting, abuse of laxatives, and others (Wciórka 2008). In the course of the disease beyond the basic symptoms isolation from loved ones, depressed mood, apathy, social alienation, and problems

with concentration and memory are observed. These symptoms can also fit the description of depression with depressed mood almost every day and the lack of motivation, low frustration tolerance, and withdrawal from social contacts (Sidorowicz 2004).

### AIM OF THE STUDY

The aim of the study is to consider whether depressive symptoms in patients suffering from Anorexia Nervosa and Bulimia Nervosa are arranged in the clinical picture of depression, or whether they are physiological depressiveness accompanying adolescence, and to relate these symptoms to the perception by patients of their social and family functioning, as well as seeking common points for the issues mentioned above, trying to place these symptoms in the course of the underlying disease.

### STUDY GROUP

The authors chose patients with a diagnosis of AN or BN confirmed in the Department of Child and Adolescent Psychiatry and Psychotherapy John Paul II Pediatric Center in Sosnowiec. The study group consisted of 19 persons in the age interval between 12 and 24 living in Silesia. 15 of them suffered from the restrictive form of Anorexia Nervosa (AN-R) and 4 suffered from

Bulimia Nervosa (BN). The control group consisted of 30 healthy girls in the same age interval.

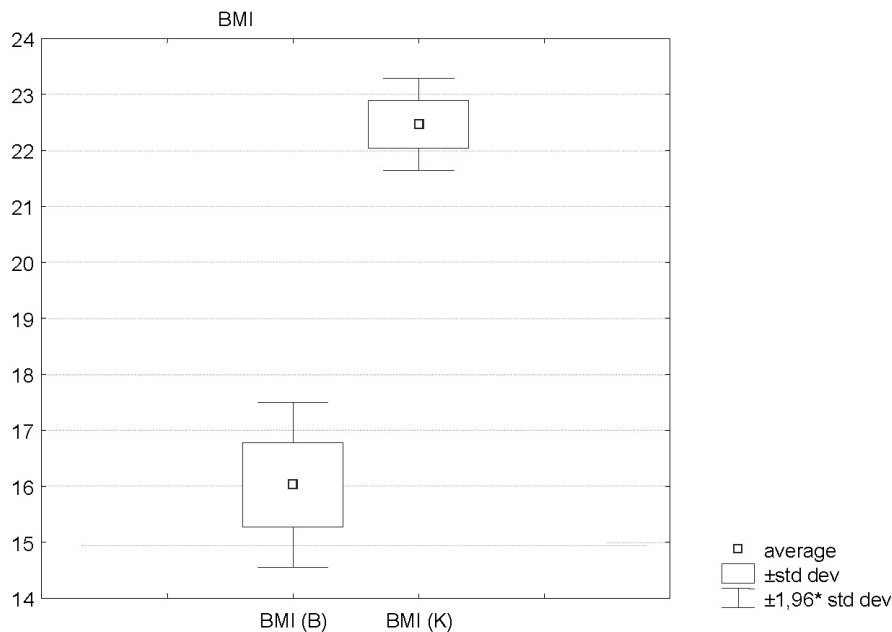
## METHODS

In the study we used the Beck's Depression Inventory (BDI), which is a clinical tool used to evaluate the severity of depression containing 21 questions concerning the last 4 weeks of functioning of the examinee. For self-perception evaluation by patients of their social and family functioning we used Quality of Social Life Evaluation Questionnaire (Quebec, Canada) which contains 22 questions concerning everyday life, their closest and further environment. We analyzed the

results using Statistica 5.0 Pro. For evaluation of significance between groups we used test T-Student for independent groups.

## RESULTS

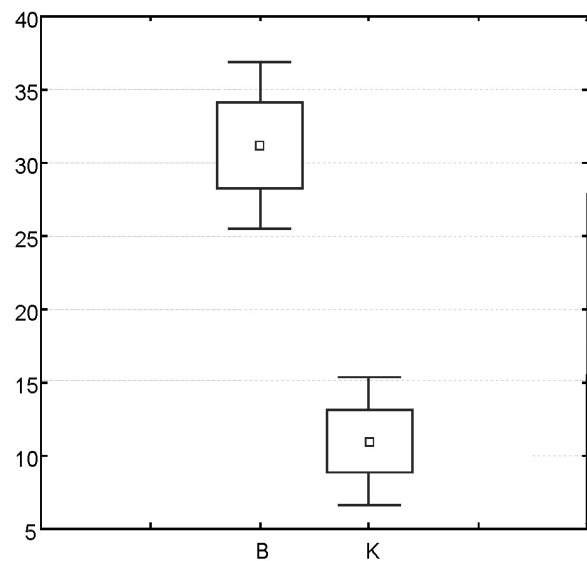
Comparison of BMI (Body Mass Index) of patients in the study and the control group revealed that BMI in the study group is statistically significantly lower compared to the control group ( $p < 0.001$ ). It was tested using the T-student test for independent groups. In study group average BMI was 16 kg/m<sup>2</sup> and was lower by 6 kg/m<sup>2</sup> compared to the control group (average BMI for control group = 22 kg/m<sup>2</sup>) (Figure 1).



**Figure 1.** Body Mass Index (BMI) comparison in groups B – study group, K - control

In the study group the following results were obtained using the BDI survey: 6 patients scored under 17 points indicating no clinically significant depressive symptoms, 13 patients scored above 17 points showing the presence of clinically significant depressive symptoms. The average test result in the study group was 31 points. In the control group the average was 11 points. A comparison of the number of points obtained in the study using the Beck's Depression Scale showed statistical significance at  $p < 0.001$  indicating more frequent depressive symptoms among persons affected by eating disorders than in the control group (Figure 2) (Test T-Student for independent groups).

Survey using Evaluation of Quality of Social Life Questionnaire concerned evaluation of conditions of living, social and family situation of the patients. We have not found any statistically significant differences between the study and the control groups. Patients in the study group were slightly more frequently mentioning a deficit of close people who were not members of the family, but this was not statistically confirmed.



**Figure 2.** Beck Depression Inventory (BDI) results for groups B – study group K – control

Suicide factor. In addition we examined differences between the groups in terms of suicidal thoughts (based on the answer for that question concerning this topic in BDI). We found statistically significant more frequent affirmative answers to statements: "I would like to kill

myself" and "I will commit suicide when I will have opportunity." in the study group compared to the control group analyzed with T-student test for independent groups ( $p < 0.001$ ) (Figure 3).

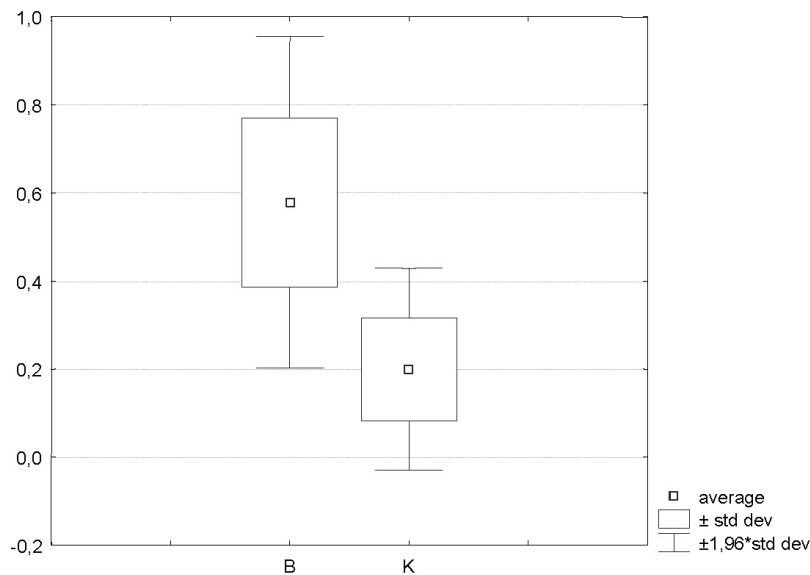


Figure 3. Frequency of suicidal thoughts appearance B – study group K – control

## DISCUSSION

One of the elements of this study was to examine the relationship between depression and depressiveness in adolescent girls and young women suffering from AN or BN. Using the questionnaires we achieved results which were statistically significant revealing more frequent occurrence of depression symptoms in the study group compared to an adequately age matched control group. At the same time we found that symptoms of depression coexist with eating disorders symptoms and some aspects of the characteristics of these two states merge. Based on the study we can draw the conclusion that the presence of depressive syndrome is secondary, because in clinical picture of patients depressive symptoms are not arranged in the clinical picture of depression. We should consider if depressive symptoms presented by patients are not characteristic for adolescent age on the one hand and on the other hand coexistent with the underlying disease which is anorexia nervosa or bulimia nervosa. Using the Quality of Social Live Evaluation Questionnaire we have revealed that patients suffering from eating disorders evaluate their environment in the same way as healthy people, what allows us to draw the conclusion that this evaluation would differ if they were suffering from depression. Bomba and Leassle research (Iniewicz 2004) yield similar conclusions to those drawn by the present authors. According to Bomba and colleagues (Iniewicz 2004) the similarity between suffering from depression and anorexia nervosa can be seen in the tendency for destruction of the patient's own health, the

different concerns when thinking about the future - unlike the depressed patients, anorexics with their school ambitions plan their future, but they see themselves in it still as sick. Leassle and colleagues (Iniewicz 2004) examining patients with AN and BN have found a positive correlation between the severity of depression and cognitive behavior - the higher was the level of disorder associated with food the higher were the scores on the depression scale. Regression analysis showed that dissatisfaction of one's own body is the strongest, single predictor of depression. (Iniewicz 2004) Halmi and colleagues reviewed studies concerning evaluation of depressive symptoms in patients suffering from anorexia nervosa in ten years catamnesis recognized depressive disorders in 67.7% of patients with AN, Braun and colleagues (Łucka 2004) recognized depressive disorders in 81.85% of patients with the bulimic form of AN and 41.2% in those suffering from the restrictive form. However Komender and colleagues (Komender 1994) in patients with eating disorders stated that 51% of them were complaining about periodic mood lowering and/or anxiety disorders and 9% of them significant increase of depressive symptoms. Łucka (2004, 2006) concluded that depressive disorder occurred significantly more frequently in patients with the restrictive form of AN than in healthy subjects ( $p < 0.01$ ). Iniewicz (2004) found a mild level of depression in 67 % of patients suffering from AN, but also showed a slight level of depression in 30% of healthy peers. Cooper summarized the findings of many authors dealing with the coexistence of eating disorders and depression:

- Depression rarely precedes occurrence of eating disorders.
- Depression in different types of eating disorders occurs in varying degrees. More frequently it appears in Bulimia nervosa and the bulimic form of anorexia nervosa, it is a secondary effect to the sense of loss control and helplessness.
- Depression occurs more frequently in the acute phase than in remission.
- The pattern of depression in eating disorders is different from the pattern encountered in "pure" depression.
- Despite the more frequent prevalence of depression among family members of people with eating disorders compared with healthy subjects, there were no reverse dependencies, that is more frequent emergence of eating disorders in families of people with depression. These reports make us doubt that these two diseases have a common pathogenesis.

Periodic depressiveness is however experienced by most adolescents and is a consequence of the intensification of emotional life in adolescence. Depressiveness with high intensity of symptoms and impaired functioning may reach a clinical level requiring treatment. An indicator of depressiveness is a sense of the examined of the presence of symptoms belonging to

the group of 'depressive symptoms'. We can assume that if there is a strong intensity of depressiveness on clinical examination we can diagnose depression.

## CONCLUSIONS

To diagnose depression, depressive symptoms presented by the patients must give the image of depression at the clinical level. The result of Beck's scale needs to be compared with the clinical picture. Depression in adolescence requires differentiation from depressiveness.

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Correspondence:

Ewa Dębska

Department of Psychiatry and Psychotherapy, Medical University of Silesia

ul. Ziołowa 45/47, 40-635, Katowice, Poland

E-mail: debska.ewa@gmail.com