Weight and psychiatry

The clinical relevance of weight in psychiatry varies. It may be:- I. an associated clinical feature, either primary, as in anorexia nervosa, or secondary as in mood, anxiety or psychotic disorders. II. a related clinical issue, as in bulimia nervosa or an eating disorder not otherwise specified.[1] III. an issue in and consequence of treatment, impacting negatively on compliance and giving rise to medical concerns, both due to weight gain associated with various medications. Weight gain related to certain medications (specifically the second generation antipsychotics) has become an increasing focus.[2] Concerns have related to glucose control and diabetic risk as well as triglyceride levels and hypercholesterolaemia.[3]

The body mass index (BMI) is a measure of nutritional status, calculated by dividing weight in kilograms by height in meters squared.[1] A figure is derived that allows for the definition of anorexic (<17.5), underweight (<20), normal (20-25), overweight (26-29) and obese (>30) body weights. It has been estimated that up to 61% of the adult population of the USA are either overweight or obese. Some put a figure of 97 million adults in these categories.[4] Whilst viewed primarily as a medical/endocrine problem, this population has implications for psychiatry. The first involves treatment outcomes. Poorer outcome has been noted in obese bipolar (type 1) patients[5] yet improvement in psychopathology has been observed in schizophrenics who gain weight associated with Clozapine treatment.[6] The second looks at the impact of weight status on dimensions of psychopathology. Whilst severe obesity (BMI>40) has been associated with depression[7], it has been observed that there appears to be an age effect. Baseline depression predicts obesity amongst adolescents but not amongst those 50 or older, with baseline obesity predicting depression in those 50 or over but not adolescents.[8,9] Further, weight loss in obese individuals undergoing surgery to assist with the obesity is associated with a reduction in both eating related psychopathology and anxiety.[10] The third is the association with psychopathology, specifically binge eating disorder (BED).

Binge eating disorder is not in the *Diagnostic and Statistical Manual for Mental Disorders* (DSM)[1] nor is it in the *International Classification of Diseases* (ICD).[11] Currently, in DSM terms, it would be an Eating Disorder Not Otherwise Specified. Fundamentally it is a condition requiring further research although practically it has defining features.[1] Specifically it involves episodes of binge eating, which whilst causing distress are not associated with purging. It has been suggested that BED is simply a non-purging form of bulimia nervosa.[12] Others have argued that it is a distinct entity.[14] Another approach in terms of understanding the condition is in terms of its relationship with obesity. It has been found that obese individuals with BED have increased rates of co-morbid psychopathology (mood, anxiety, personality, eating).[14] This has led to an understanding that rather than describing a new disorder we are simply sub-typing an increasingly common condition. In support of this contention is that whilst BED is found in up to almost 30% of obese individuals it is found in between 1-3 % of the community.[15] By implication, obesity with binge eating may represent a more pernicious form of obesity. Unlike other eating disorders, BED tends to remit (5 year follow up) without treatment.[16] This begs the question as to why there are ongoing treatment studies related to both psycho and pharmaco-therapy but more pointedly: do we need another diagnostic entity in psychiatry ? Does BED have validity or simply utility ? It seems that whether we need BED or not, we are going to get it. Vested interests are seemingly playing a larger role in determining the diagnostic landscape than scientific merit.

Beyond the physical aspects of weight, the psychological meaning sees the virtues of control, discipline and willpower adding allure to the attainment of a thinner body. The association of weight and health has further intensified the drive for leanness, with any hint of overweight being deemed unhealthy. In traditional and contemporary societies, size matters although not in the same way. Stereotypically a thinner form is a sought after attribute in contemporary, urban society with the opposite in traditional society.[17] But maybe weight is just a measurable outcome of the balance between intake, excretion and activity i.e. an aspect of nutritional status. Possibly it means nothing at all, because in reality knowledge of one's weight never saved a life. A pulse rate has greater significance, yet who really has an interest in or intimate knowledge of this aspect of one's physical being?

The relationship between weight and psychiatry is indeed a varied and interesting one.

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