Progression of anorexia nervosa: An insight into neurological and biological mechanisms influencing the personality patterns of anorexics

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Abstract
Anorexia nervosa has emerged as a prominent eating disorder affecting young women. This disorder's fundamental characteristic is an abnormally low weight achieved by severe calorie restriction and refusal to maintain body weight at or above the minimally normal weight for age and height. It is a complex disorder with its origins still not explicitly defined. In anorexic individuals, an imbalance in the molecular signalling and hypothalamic neuropeptides is believed to be significantly responsible for alterations in the biological mechanisms associated with body weight, appetite and energy homeostasis. The imbalance between the genetic systems such as serotonin, dopamine, brain-derived neurotrophic factor, estrogen and their interactions are significantly observed in anorexic as well as recovered anorexic individuals. The dopaminergic pathway is involved in reward mechanisms but its dysfunction might cause weight loss, food aversion, hyperactivity, obsessive compulsive behaviours, distorted body image. An abnormal serotonin function reveals personality traits such as rigidity, inhibition, anxiety, inflexibility, perfectionism and harm avoidance. The Met66 variant of brain derived neurotrophic factor is strongly associated with the development of restricting-type anorexia nervosa. The development of anorexia has been linked to estrogen receptor beta gene variants, which also regulate food intake and states of anxiety and depression. This review discusses the neurobiological dysregulations because of which anorexics tend to have a distinct personality profile characterized by behaviour patterns comprising perfectionism, obsessive-compulsive disorder, harm avoidance, alexithymia, anger suppression, anxiety, rigidity, novelty seeking, anhedonia, depression, impulsivity, substance abuse, self harm etc. Heterogeneities in the characteristic profile are observed based on the subdivisions of anorexia nervosa. The impact of malnutrition has also been scrutinized.

Keywords: Anorexia nervosa, Eating disorders, Personality disorders, Genetics Perfectionism

INTRODUCTION

Anorexia Nervosa (AN) is a multifaceted disorder characterized by an inappropriate weight loss due to psychological and behavioural abnormalities. According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), AN is defined as a failure or denial to maintain body weight >85% of which is expected for height (corresponding to body mass index (BMI)), extreme fear of gaining weight, disturbed perception of body weight/shape and the occurrence of amenorrhea for a minimum of three consecutive months. However, DSM-V made three alterations in the diagnostic criteria for AN: revision of weight loss criterion, i.e., ‘A weight that is less than minimally normal or, for children and adolescents, less than that minimally expected’ (Mustelin et al., 2016); if behaviours hindering weight gain are observed then the fear of weight gain need not be verbalized and amenorrhea was now not required in the diagnosis (APA, 2013). AN has further two subtypes: (i) the restricting subtype, characterized by a very limited food intake or dieting; (ii) the binge/purge subtype, characterized by restraint on food intake to lose weight followed by an episode of binge eating and subsequent purging (self-induced vomiting/laxative abuse).
In general, eating disorders incidence rate is generally expressed as per 100,000 persons per year (Smink et al., 2012) and prevalence is the proportion of a population which is predisposed to the disorder at a specific point of time, for instance, at a certain date (point prevalence), in a certain year (12-month prevalence; often used in the DSM-5), or at any point in life (lifetime prevalence). Researchers have often observed women to be more liable to the risk of developing eating disorders and their associated symptoms as compared to men. The occurrence of anorexia nervosa in the general population is approximately 0.3% (Hoek, 2006) though nine females are affected for every male. 0.9% of females are observed to be anorexic (Hudson et al., 2007) with sub-threshold levels prevalent up to 2.4% (Wade et al., 2006). AN is a complex and relapsing disorder with a higher risk of premature death on comparison to normal healthy population.

Anorexia nervosa is a complex disorder with its origin still not specifically explained but is supposed to occur due to various reasons. According to Klump and Cubert (2007, conventionally, the major causative agents for the development of eating disorders were supposed to be psychosocial factors but twin studies revealed, more than half (58-83%) of the risk in the development of an eating disorder lies in the genetic setup of an individual. Environmental factors have also been observed to influence the risk of developing anorexia which includes childhood sexual abuse, female gender, dieting, early childhood eating and digestive problems (Jacobi et al., 2004). Psychological factors such as the presence of anxiety, obsessive-compulsive disorder, depression, attention deficit hyperactivity disorder and substance abuse (Rikani et al., 2013). Clinical observation has long suggested a link between personality and eating disorders. Eating is basically a rewarding behaviour, and is thus innately related to personality traits, emotions and moods (Vögele and Gibson, 2010). In the clinical setting, personality disorders are commonly encountered in individuals predisposed to eating disorders (Sansone and Sansone, 2011). According to APA (2013), the essential features of a personality disorder are “impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits” (DSM-V). These symptoms are highly noticeable in the aspects of interpersonal execution, cognition, affectivity and impulse control. Personality traits have been found to influence the onset, symptomatic features and continuance of eating disorders (Cassin and Ranson, 2005). The personality disorders mentioned in DSM are broadly classified into three primary clusters. Cluster A refers to the first classification or subtype those personality disorders characterized by odd or eccentric features. Cluster B, the second subtype refers to the personality disorders characterised by dramatic and erratic features. The third subtype, Cluster C refers to the personality disorders characterised by anxious or inhibited features. Generally, eating disorders are found to overlap personality disorders.

Genetics
Extended researches have concluded eating disorders as significantly heritable causing altered brain activity as well as in certain cases impaired cognitive function, decisions and emotional stability. Genetic studies have explored and revealed chromosomal sites and genes which predispose an individual to the risk of developing a specific eating disorder. Genes concerned with serotonin (Bergen et al., 2003; Klump et al., 2007), opioid systems (Bergen et al., 2003) and brain-derived neurotrophic factor (Klump et al., 2007; Ribases et al., 2004 & 2005) might contribute to the risk for developing anorexia nervosa whereas chromosomal sites 1, 4 and 10 might hold risk genes for both anorexia and bulimia nervosa (Grice et al., 2002). It was also noted that in anorexic individuals even after recovery from illness (Kaye et al., 2001 & 2002) disordered functioning of brain serotonin (Kaye et al., 2005; Steiger et al., 2005), neuro-circuitry (Uher et al., 2003; Wagner et al., 2007 & 2008) and neuropeptide systems (Kaye et al., 2005) continued. The below stated genes are involved in the modulation of metabolism, appetite, autonomic and hormonal systems, cognition, impulse control and mood.

Dopamine
There are certain characteristic traits of anorexic individuals portrayed as being anhedonic, ascetic and are often observed to have compulsive exercise regimens (APA, 1994). Above all, they derive a sense of reward and satisfaction from the pursuit of weight loss rather than any other experience. Even after recovery such traits exist but to a mild extent (Klump et al., 2004). This reflects that these specific characteristics are not state related but are traits of that specific individual. Frank et al., (2005) demonstrated that in anorexic individuals a distorted state of reward and affect, executive control, certain motor movements and reduced appetite were associated to abnormal functioning of dopamine system especially in the striatal circuit of the brain. Kaye et al (1999) also noted that reduced CSF concentration in DA metabolites is found in both anorexic and also in recovered anorexic individuals. Ventral striatum is the region of the brain involved in reward mechanisms and responses in which the levels of D2/D3 receptor (DRD3) increased in recovered anorexics (Kaye et al., 1999; Montague et al., 2004). Moreover, D2/D3 receptor binding potential in the dorsal caudate and putamen regions of the brain is significantly correlated with harm avoidance in recovered anorexics (Frank et al., 2005). Wagner et al., (2007) conducted an event based fMRI study to compare diverse re-
responses to reward in both recovered anorexic and healthy controls through the collection of blood oxygen level dependent (BOLD) signal when participants performed a ‘guessing-game’ which is known to stimulate the ventral striatum and subgenual anterior cingulate cortex (ACC). It was observed that healthy controls revealed different activities in both brain regions in response to the negative and positive feedbacks whereas the recovered anorexics revealed similar activities in both regions of their brain, indicating that anorexics have circuit-based abnormality, which might contribute to difficulty in differentiating between positive and negative feedbacks (Wagner et al., 2007). Dopamine plays a significant role in regulating motivational mechanisms in the ventral striatum to stimuli as it alters the influence of limbic inputs on striatal activity (Schultz et al., 2004; Wagner et al., 2007). Recovered anorexics have a failure to aptly bind, regulate or differentiate responses to stimuli through ventral striatal regions of the brain. This suggests that recovered anorexics might have an impaired capacity to understand the emotional implication of the stimuli (Phillips et al., 2003) thus indicating their restraint in engaging in treatment (Halmi et al., 2005). Recovered anorexic women had exaggerated activation of caudate-dorsal striatum and in cortical regions projecting in this region especially dorsolateral prefrontal cortex (DLPFC) and the parietal cortex (Wagner et al., 2007). The tasks involving both actions and outcomes along with unpredictability about whether a certain action will lead to a desired outcome is controlled by the caudate nucleus. A greater activation of the caudate nucleus was observed in women involved in strategic responses as opposed to hedonic ones. As a result, inappropriate reward processing through ventral-striatal/DA pathways causes recovered anorexics to put emphasis on detailed strategy rather than the overall scenario (Lopez et al., 2008). The study revealed that the healthy control women actually ‘lived in the moment’ as they understood they had to guess the response and move on to the next task. However, anorexic individuals were observed to dwell and obsess more about the result of their behaviour, searching for ‘rules’ which were not mentioned and were overly critical of committing mistakes. Another study using fMRI imaging based on a standard shifting task had similar revelations in anorexic individuals demonstrating hypo-activation in the ventral anterior cingulate-thalamic loop with stimulation of fronto-parietal networks. Thus the data reveals that anorexic individuals are less likely to be able to regulate affective response to immediate significant stimuli rather, they have exaggerated activity in their neuro-circuits involved in planning and consequences. The dopaminergic pathway is involved in reward mechanisms but its dysfunction might cause weight loss, food aversion, hyperactivity, menstrual dysfunction, obsessive compulsive behaviour, distorted body image specifically during increased dopaminergic activity (Kaye, 2007). The neurotranscuits involved in planning and consequences exhibit an increased activity as anorexics are highly detail oriented and is reflected through their obsessive and compulsive tendencies. In recovered malnourished anorexic individuals, decreased concentration of dopamine metabolites in cerebrospinal fluid occurs (Kaye et al., 1999). Therefore, dopamine deregulation might influence the reward and affect pathways, decisions, frequent motor activities and decreased ingestion of food in anorexia (Halford et al., 2004).

Serotonin (5-HT)
Control of appetite, sleep, memory, mood and learning are all regulated through a neurotransmitter called serotonin. The 5-HT neurotransmitter system has been intensively linked to certain symptoms such as impulse control (Fairbanks et al., 2001), satiety (Tierney, 2020) and mood (Lesch and Merschdorf, 2000). Extensive data reveals eating disorders are strongly linked to the disturbances in serotonin gene system. Various evidences reveal a strong association between altered activity of the 5-HT system and the development of AN (Kaye et al., 2005). The two most important serotonin genes involved in eating disorders are the serotonin 1a & 2a receptors and the serotonin transporter gene (5-HTT). Indeed, it is observed that emaciated and malnourished individuals suffering from anorexia nervosa, have reduced concentration of 5-hydroxyindoleacetic acid (5-HIAA) a brain metabolite thought to reflect the extracellular 5-HT concentrations in the cerebrospinal fluid (Coplan et al., 2014). Inversely, in individuals recovered from anorexia the 5-HT metabolite concentration increases in the cerebrospinal fluid (Kaye et al., 2009). A range of studies demonstrated the enhanced binding capacity for 5-HT1A receptors and reduced binding potential for 5-HT2A receptors in individuals who recovered from eating disorders (Frank et al., 2002; Kaye et al., 2007; Audenaert et al., 2003). Trait-related alterations of 5-HT function are found to exist in anorexic individuals. Several evidences also predict significant association of the serotonin system with specific anorexic traits such as rigidity, perfectionism and obsession. Brain imaging researches have indicated an important link in abnormal 5-HT function and dysphoric mood seen in anorexia (Frank et al., 2001; Kaye et al., 2003). Also, brain imaging studies express a positive and significant association between the binding capacity of both 5-HT1A and 5-HT2A receptors and the characteristic trait of harm avoidance which includes inhibition, anxiety and inflexibility. These two receptors have also been observed to have an association in anxiety issues demonstrated through a range of animal and human studies (File et al., 2000; Tauscher et al., 2001; Weisstaub et al., 2006; Moresco et al.,
In the frontal cortex and other cortical regions in rodents an increased (80%) co-localization of 5-HT2A and 5-HT1A postsynaptic receptors occurs. Mediation through interneuron causes direct hyperpolarizing and depolarizing of 5-HT on the prefrontal neurons which further project to the cortical and sub-cortical brain regions (Santana et al., 2004; Carli et al., 2006). Regulation of impulsivity, anxiety, attention functioning (Winstanley et al., 2003) and discovering new environments are thought to be modulated through these interactions between 5-HT1A and 5-HT2A receptors in the medial prefrontal cortex (mPFC) and related areas. Serotonin re-uptake inhibitors are a treatment component in anorexia (Kaye et al., 1991). Variations in 5-HTT function might cause distinct behavior of impulse control thus indicating the reason for anorexic individuals developing the restricting type AN rather than bulimic type AN although 5-HTT concentrations in AN and AN-BN subgroups are almost similar to healthy controls but distinct variations arise when AN and AN-BN subgroups are compared (Bailer et al., 2007). However, recovered anorexics also reveal continuous 5-HT disturbances (Kaye et al., 2009). This indicates that abnormal functioning of 5-HT system could be a biological marker for eating disorder.

**Serotonin-Dopamine interactions**

Daw et al. (2002) and Cools et al. (2008) hypothesized that 5-HT system might be a crucial antagonist to the DA-based appetitive responses. In animal studies the significance of 5-HT is brought to light through the conditioning of animals to various aversive experiences (Bari et al., 2010) which might cause the relay of negative response signals even for related future dangers and threats (Daw et al., 2002; Cools et al., 2008). Animal studies bought it to light that DA neurons are inhibited by the 5-HT2C receptors (Di Matteo et al., 2004). An altered abnormal interaction between ventral and dorsal neuro-circuits might be due to an imbalance between DA and 5-HT pathways. Interestingly, other studies also suggest that diverse effects in the ventral and dorsal striatal circuits in regard to delayed reward in action choice are observed because of the 5-HT system functions in mutual opponency with DA system (Schweighofer et al., 2007; McClure et al., 2004). Anorexic individuals are often observed to exhibit inhibitory reactions and responses in place of motivation and reward (Kaye et al., 2009). Medications with selective serotonin re-uptake inhibitors (ssRIs) reveal minute effects in terms of betterment of moods as well as decreased symptoms of eating disorders (Attia et al., 2005).

**Brain Derived Neurotrophic Factor (BDNF)**

The brain-derived neurotrophic factor is a protein that regulates development, differentiation and continued existence of new and old neurons in the brain. BDNF influences food intake as its increased concentration is linked to suppression of appetite and loss of weight and vice versa (Hashimoto et al., 2005). Many variations of BDNF gene exist, specifically the Met66 variant, is strongly associated with the development of restricting-type anorexia nervosa (Ribases et al., 2003). Met66 variant gene has also been highly associated with harm avoidance, anxiety and depression (Jiang et al., 2005). This reveals the neuro-physiological mechanisms involved, thus explaining the cautious characteristic profile of restrictive anorexics including low novelty seeking, reluctance to indulge in new activities in order to avoid harm and risks.

**Estrogens**

Estrogen has a significant role in eating behaviour as it highly influences appetite and its disturbance is linked to the development of eating pathology in women (Elder et al., 2007). In fact, disordered eating initiates after puberty, during which ovarian hormones stimulate in girls. The development of anorexia has been linked to variants of estrogen receptor beta gene, which also regulates food intake as well as states of anxiety and depression (Walf & Frye, 2006). A range of data from twin studies reveals genes have a vital role in the initiation of eating pathology. Serotonin, estrogen and BDNF systems significantly influence appetite regulation. These systems might influence food intake independently or could be dependent on estrogen system for regulation. Gene transcription (a phenomenon where the DNS gene sequence is imitated into messenger RNA) within serotonin and BDNF systems occurs through estrogen gene expression. Gene transcription of estrogen for tryptophan hydroxylase (an enzyme regulating conversion of tryptophan to serotonin) and 5-HT2A is specifically strong (Shively & Bethea, 2004; Norton & Owen, 2005), respectively while influencing 5-HTT transcription (Shively & Bethea, 2004). The BDNF and serotonin systems demonstrate variations in functionality in both genders, although risk of eating pathology initiates after puberty (Klump et al., 2003). Moreover, estrogen levels are prominent in females, thus it also plays an essential part in influencing neurobiological and genetic mechanisms which could lead to the development of eating pathology. According to Westen & Hamden-Fischer (2001) individuals diagnosed with the same eating disorders could reflect highly diverse personality characteristics, which might significantly affect the eating pathology outcomes.

**Role of satiety and starvation**

In anorexic individuals, dietary restraint is linked to anxiety and dysphoric mood to intake (Strober, 2005). A possible inter-relation between altered 5-HT function and dietary restraint as well as anxiety might occur in
anorexic individuals. It is well documented that carbohydrate intake raises extracellular 5-HT concentrations in the brain due to a series of metabolic effects on the amino acid precursor of 5-HT i.e., tryptophan (Kaye et al., 2003). According to Kaye et al. (1991) increased extracellular brain 5-HT secretions are observed in anorexic individuals with ingestion of a normal amount of food both premorbidly and after recovery from anorexia. The increased 5-HT concentrations reduce food intake due to the activation of 5-HT2c receptors (Simansky et al., 2004). It has also been demonstrated that enhanced 5-HT1A binding potential is significantly related to harm avoidance in anorexic individuals after recovery (Bailer et al., 2005). Moreover, harm avoidance and anxiety disorders occur before and even after recovery from anorexia. Kaye et al., (2009) proposed that harm avoidance and anxiety traits exist due to carbohydrate-induced increases in extracellular 5-HT levels through activated 5-HT1A receptors, thus contributing to feeding dysphoric mood. On the contrary, when anorexic individuals starve, the extracellular concentrations of 5-HT might be reduced causing short relief from dysphoric mood. It has been demonstrated that dietary restraint, which consequently lowers the concentration of plasma tryptophan and experimentally decreased or depleted tryptophan decreases 5-HT formation in the brains of both animals and humans (Van et al., 2011). In fact, lower concentrations of plasma tryptophan are also observed in weak and malnourished anorexic individuals (Attia et al., 2005) as well as decreased 5-HIAA levels (Kaye et al., 1988). Moreover, experiment-induced alterations with the objective to reduce tryptophan in the brain also reduce levels of anxiety in both anorexic and recovered anorexic individuals. 5-HT2A receptor binding is positively related to harm avoidance in anorexic individuals. Kaye et al., (2009) has well demonstrated that a relative increase in 5-HT extracellular concentration in the brain is observed when anorexic individuals are forced to eat, which consequently intensifies the dysphoric mood. As a result, anorexic individuals might prefer to stay in a state of starvation to avoid intake-induced dysphoric feelings.

Malnutrition a risk factor for development of AN
Profound neurochemical changes occur which could influence the pre-morbid traits accumulating symptoms that could sustain or further enhance the state of morbidity (Kaye et al., 2009). It has been observed that anorexic individuals have distorted regulation in temporal, frontal, cingulate and parietal regions (Kaye et al., 2006) and reduced brain volume (Lucas et al., 2000). Such disturbances normalize after weight gain which clearly indicates that these could be a consequence rather than the cause of anorexia (Kaye et al., 2009). These consequent alterations that arise in anorexia are hormonal and metabolic in nature and attempt to either conserve energy or stimulate hunger (Schwartz et al., 2000). Another atypical complication of anorexia nervosa is clinically significant hypoglycaemia. Leptin is a protein encoded by ob gene expressed in the adipocytes and helps regulate eating behaviour via central neuro-endocrine mechanisms. Serum leptin levels correlate with weight and percent body fat in normal and obese individuals, though it is unknown whether the regulation of leptin is normal below a critical threshold of body fat in chronic under-nutrition. Calandra et al. (2003) also examined the serum leptin levels in women aged between 15-36 years predisposed to anorexia nervosa. The data indicated that serum leptin levels are reduced in low body weight and percent body fat in anorexic patients as compared to controls. It was concluded that leptin levels strongly correlate with weight, body fat percent, and insulin like growth factor-1 in anorexic patients, suggesting that leptin’s physiological regulation is maintained in relation to nutritional status even at an extreme of low weight and body fat. In addition, anorexic individuals are found to have abnormal concentrations of corticotrophin-releasing hormone (CRH), cholecystokinin, neuropeptide Y (NPY), beta-endorphin and pancreatic polypeptide (Inui, 2001) and these altered concentrations directly influence and cause alterations in an individual’s cognitive functions, moods, impulse control as well as the autonomic and hormonal systems (Jimerson and Wolfe, 2006). These might be related to the behavioural and psychological symptoms and patterns observed in anorexia. For instance, various physiological and behavioural disturbances linked to anorexia such as altered emotionality, hyperactivity, hypothalamic hypogonadism, reduced sexual activity and decreased feeding behaviour were observed when intracerebroventricular CRH was administered in experimental animals (Kaye et al., 1987). According to Kaye et al., (2009) certain secondary manipulations as in peptide concentrations might continue to sustain anorexic behaviours through an aim for excessive dieting and weight loss. Furthermore, individuals that meet the diagnostic criteria for major depression, obsessive-compulsive disorder or other anxiety issues (Kaye et al., 2004; Godart et al., 2007) were associated with exaggerated emotional disturbances caused due to malnutrition (Kaye et al., 2009). Researchers have observed that even after long-standing recovery from anorexia, certain behavioural and psychological traits still continue such as harm avoidance, perfectionism, negative emotionality, desire for thinness and mild diet related anxiety. These symptoms could be a cause of chronic malnutrition and indeed the patterns (Wagner et al., 2006) observed above are much related to those explained for the children who are at risk of developing anorexia (Stice, 2002; Anderluh et al., 2003) indicating that these underlying traits could...
lead to the initiation of this disorder.

**Neurobiological processes and behavioural patterns in anorexia nervosa**

Anorexia nervosa has emerged as a prominent eating disorder affecting young women. The fundamental characteristic of this disorder is an abnormally low weight achieved by severe calorie restriction and refusal to maintain body weight at or above the minimally normal weight for age and height. This behaviour is manifested as a relentless pursuit for thinness, a morbid fear of fatness or weight phobia. The patient is often observed to deny the complications that might arise due to low weight. These patients exhibit persistent obsession with dieting and weight loss which causes severe emaciation and in certain cases proves fatal. It is unclear whether these symptoms are consequence of anxiety or obsession disorder or reflect an underlying disturbance of brain appetitive circuits. The behavioural patterns such as inhibition, anxiety, depression, obsession, body shape distortion, perfectionism and anhedonia could be determined though the neuromuscular and cognitive pathways that control and adapt the processes related to appetite, emotionality and cognition. Anorexia nervosa is further classified into restricting and binge eating/purging types based on the presence or absence of binging or purging. Patients generally move between these two sub-divisions. Generally, it occurs in adolescence but the age of onset can range from pre-adolescence to middle age. Eating disorders consequently lead to physical and psychological morbidity in adolescent girls and young adult women. Adolescence is considered a crucial phase in the risk of developing eating disorders because of the convergence of both psychological and physical challenges. These disorders are much less frequent in men. The longitudinal study followed up 800 children at three time points suggested that concerns related to body shape and weight develop through childhood, becoming common by later adolescence, particularly in girls. It is the psychological impact that is most powerful in promoting eating disturbance (Voelker *et al.*, 2015).

A large number of researches have indicated that personality disorders (PDs) recurrently occur with eating disorders in both clinical and community samples (Bornstein, 2001). Cluster C PDs (obsessive-compulsive, dependent, avoidant) are most frequent in individuals with eating disorders, followed by Cluster B (borderline, histrionic, narcissistic, anti-social) and Cluster A (paranoid, schizoid, schizotypal) (Johnson & Wonderlich, 1992). Meta-analysis conducted by Bornstein (2001) revealed that personality disorders most associated with anorexia were avoidant (53%), dependent (37%), obsessive-compulsive (33%) and borderline PD (29%) whereas in bulimia nervosa borderline (31%), dependent (31%) and avoidant PD (30%) are associated. Research has consistently linked anorexia (particularly when the patient does not also have binge/purge symptoms) to personality traits such as introversion, conformity, perfectionism and obsessive-compulsive features (Westen and Harnden-Fischer, 2001).

Westen and Harnden-Fischer (2001) conducted a cluster analytic research in eating disordered individuals with both subtypes of anorexia comprising a high functioning/perfectionist group, constricted/over-controlled group and emotionally dysregulated/under-controlled group. The study revealed that all restrictors were rigid and inhibited whereas all bingers were impulsive and novelty seeking. These within-subtype heterogeneities are linked to specific etiological pathways. For paradigm, individuals characterized by dysregulated and under-controlled behavioural patterns might binge due to poor impulse regulation (represents those with cluster B personality disorders), while those categorised as inhibited or over-controlled might binge after an episode of restrictive dieting (refers to those with cluster C personality disorders) (Bruce and Steiger, 2005).

The restricting type anorexic patients possess the characteristic profile as being more obsessive-compulsive, tolerant, perfectionist, introverted and emotionally inhibited whereas the binge-eating/purging type anorexic patients are observed to be more impulsive, depressive, socially dysfunctional, sexually adventurous and substance abusing, with high levels of emotional distress (Garner, 1993; Sansone and Sansone, 2011). The obsessive compulsive personality disorder is often observed in restricting anorexia nervosa whereas borderline personality disorders occur in binge eating/purging type anorexic patients. The most recurrent personality disorder among anorexic patients with restricting type is obsessive-compulsive disorder (22%), followed by avoidant personality disorder (19%). Approximately 10% suffer from borderline or dependent personality disorder and 5% reveal characteristics of the Cluster A PDs. On the whole, Cluster C type personality disorders (paranoid, schizoid, schizotypal) are much dominant in these individuals. In binge-eating/purging type anorexia nervosa, borderline personality disorder was observed to be the most prevalent because of higher levels of impulsivity. From clinical perspective, along with eating pathology a range of other self regulatory difficulties such as substance abuse or other addictions, promiscuity, difficulty managing finances etc. occur which also indicate self-harm behaviour (Sansone *et al.*, 2005).

According to Kuek *et al.* (2015) anorexic individuals are generally observed to have a depressive profile. In a research done by Westen and Harnden (2001) it was observed that patients with prominent anorexic symptoms are likely to fit in a constricted/over-controlled profile i.e. a pattern of constriction and restriction of pleas-
Anorexic women scrutinize self-expression of negative, difficult thoughts/feelings as revealing personal imperfections or character flaws. An inhibited self-expression and outward/external focused inter-personal orientation is significantly observed in anorexic group. Given that perfectionism is a vital feature of anorexic symptomatology (Sutandar-Pincock et al. 2003). Perfectionism is a trait in which an individual has an inborn inclination to set and pursue unrealistically high standards in spite of the prevailing adverse consequences (paradigm, food and weight related anxiety, persistent hunger) (Shafran et al., 2002). It is observed that eating disordered patients exhibit neurotic perfectionism to a greater extent (paradigm, over concern with mistakes, anxiety about performance) and similar levels of normal perfectionism (paradigm, high personal standards, need for order) (Sassroli et al., 2008). The Multidimensional Perfectionism Scale evaluates three domains of perfectionism, i.e. self-oriented, other-oriented and socially prescribed perfectionism (Hewitt & Flett, 1991, 2004). Fornieles-Castro et al. (2007) suggested that self-oriented and socially prescribed perfectionism is mostly observed in anorexic patients. In another research study conducted by Halmi et al. (2000) anorexic patients were observed to have higher scores on the Multidimensional Perfectionism Scale as compared to the controls. Thus the data signified that perfectionism is a strong and discriminating characteristic of anorexic patients. Perfectionism is likely to be one of the clusters of phenotypic trait variables associated with a genetic diathesis for anorexia nervosa. Many researchers suggest that multi-dimensional perfectionism might possibly predict the onset of anorexic symptoms (Tyrka et al., 2002).

According to Davies et al. (2009), Perfectionism and obsessive-compulsiveness traits are overlapping and strongly associated with each other (for instance, doubts about actions, rigidity, and concern over mistakes). The characteristics of rigidity, need for control, obsessiveness, pessimism, fear of uncertainty, low impulsivity, orderliness, avoidance of novel situations and reluctance to change are highly associated with anorexic individuals and also correspond to obsessive temperaments (Fassino et al., 2002 and Svrakic et al., 1993). Many personality traits of anorexic individuals are common to various features of perfectionism. Pearson et al. (2006) also mentioned the characteristics of anorexic individuals coincide with various facets of perfectionism. The necessity to always appear perfect is similar to harm avoidance. For instance perfectionists avoid criticism by others and are reward dependant in the sense of relying on the approval of others. Low novelty seeking is seen in perfectionist’s restraint to indulge in activities that do not guarantee success. High constraint, persistence and low novelty seeking have always been basic attributes of anorexic individuals (Cassin and Ranson, 2005). A cluster analytic study of eating disordered individuals indicates that there is considerable personality variability within ED diagnostic...
categories. For instance, a cluster analysis of MMPI responses identified three distinct AN subgroups (Strober, 1980). The first subgroup wanted to conform and exercise control but maintained a sense of well-being and self-acceptance. The second subgroup exhibited a more neurotic personality structure with high levels of anxiety, self-doubt and social inhibitions. The third subgroup revealed impulsivity and low ego strength.

Numerous researches have demonstrated that anorexic individuals are in trouble identifying negative emotions from the face and also those expressed verbally (Kucharska-Pietura et al., 2004). Taylor (1994) and Goerlich (2018) described the term alexithymia as difficulty in recognizing and interpreting emotional states. It also exhibits deficits in processing one’s own emotions. Alexithymia might be related to depressive symptoms rather than the eating pathology but it could be a state or a trait in behaviour pattern (Eizaguirre et al., 2004). Anorexic individuals often exhibit extreme characteristics of emotional deficits and inhibition in regard to anxiousness, social avoidance and liability (Holliday et al., 2006). According to Harrison et al. (2009) anorexic individuals have reduced emotional awareness. These individuals also prefer social isolation sometimes due to their incompetence in recognising and interpreting social situations. The difficulty in understanding and recognising the emotional states of other fellow individuals and are prone to have impaired interpersonal functions as well as maladaptive personality traits. This emotional dysregulation is known to arise due to various psychological pathologies such as trauma induced anxiety (Rusch et al., 2011), depression (Anderson et al., 2011) and mania (Carolan and Power, 2011). This lack of emotion processing observed in AN generally follows an inhomogeneous pattern, for paradigm, some researchers suggest that the trait anxiety and anxiety sensitivity (Aharoni and Hertz, 2011; Davey and Chapman, 2009) are exhibited in anorexic patients with an augmented sense of disgust and also due to increased fear and anger (Fox et al., 2003). Absence of empathy in such patients might also occur (Kucharska-Pietura et al., 2004; Pollatos et al., 2008).

Phillips et al. (2003) revealed two major neuro-circuits which contribute to the understanding of anorexic behaviour through neuro-physiological imaging studies. To understand the emotional influence of the stimuli and for creating an apt response the ventral (limbic) neuro-circuit which accommodates the insula, amygdala, ventral striatum and ventral parts of the anterior cingulate cortex (ACC) and the orbitofrontal cortex (OFC) are of great significance. The dorsal (cognitive) neuro-circuit includes hippocampus, dorsal regions of ACC, dorsolateral prefrontal cortex (DIPFC), parietal cortex, and other parts that regulate planning, specific attention and control of other affective responses. Several studies have reported that a disturbance in these two neuro-circuits is a risk factor for developing various psychiatric disorders such as depression, anxiety and obsessive-compulsive disorder (OCD). Anxiety disorders are predictive risk factors for the development of eating disorders and have been observed to exist in families afflicted with eating pathology. However, the neurobiological alterations and abnormalities observed in individuals with eating disorders might be different from those found in individuals with anxiety, depression and OCD. For instance, the adhering capacity of serotonin (5-HT) receptor 1A (5-HT1A) is reduced in panic disorders (Neumeister et al., 2004), social phobias (Lanzenberger et al., 2007) and depression (Drevets et al., 2007), but it increases in individuals with eating disorders (Tiihonen et al., 2004; Bailer et al., 2007; Galusca et al., 2008). Evidence suggests that aggressive and impulsive behaviour patterns are dependent upon an increase or decrease of 5-HT activity (Schweighofer et al., 2007; Westergaard et al., 2003).

Interestingly, an altered functioning in the frontal, parietal and cingulate regions continues even after recovery from AN (Rastam et al., 2003; Uher et al., 2001). Though the abnormal functioning of these neural circuits causes altered emotions and obsessive behaviour, the molecular basis of these deregulations varies with regard to the different forms of eating disorders (Phillips et al., 2003). In a study conducted on recovered anorexics, positive associations in the 5-HT transporter system and D2/D3 receptor binding in the dorsal caudate and ventral striatum were also demonstrated, indicating harm avoidance behaviour pattern which was observed in the dorsal caudate region of the brain (Kaye et al., 2009). Increased stress is majorly linked to the brain's serotonin system involved in AN pathology (Kaye et al., 2009). According to this, anorexic individuals indulge in frequent habitual self-starvation to decrease dysphoric mood and stress through the serotonergic pathway which is involved in fear, depression, anxiety, satiety and obsessive-compulsive behaviours (Kaye et al., 2009). Self-starvation is a reward based which is related to the dopaminergic pathway (Zink and Weinberger, 2010; Fladung et al., 2010). Fladung et al. (2010) conducted an fMRI study, which included 14 anorexic females and 14 healthy female controls. The participants were shown images of females who were either underweight, normal weight or overweight and were asked to perceive their personal viewpoints and feelings with an assumption of acquiring the same body weight. The revelations were that anorexic females had an augmented activity in their ventral striatum region of the brain as part of the reward system; however, the healthy controls favoured images of normal weight females. Thus, the study implies that such behaviours arise from profound pathology that might be rooted in the individual's early development. Several studies
have associated the serotonergic pathways with the development of fear, anxiety and depression in anorexic individuals, however, despite weight stabilization the anorexic psychopathology persists. The continuation of this psychopathology despite weight improvement specifies further reinforcement is still essential. However, according to Frank et al. (2005) and Kaye et al. (1999), a drug named olanzapine might lead to weight gain through its effects on DA and 5-HT systems and it might also be helpful in reducing anxiety (Bergen et al., 2005) in individuals with AN but it is still under speculation. In addition, other antipsychotics might also prove beneficial (Kaye et al., 2009).

Conclusion
Eating disorders are significantly heritable, causing altered brain activity and, in certain cases, impaired cognitive function, decisions, and emotional stability. Anorexia nervosa and its further variants are considered genetic in origin, psychological illnesses that require the equal extent of healthcare approach as for similar conditions such as depression, anxiety, obsessive-compulsive disorder etc. A perspective approach to recognize and scientifically map the distorted personality traits and pathologies pertaining to specific eating disorders need to be established. However, significant limitations still prevail in the neurotransmitter studies done in humans, i.e. only a narrow range of neuro-modulatory components can be examined. The complex interactions within the biochemical mechanisms are still largely unknown. The medical treatments or related cures available have not totally proven to eliminate the core symptomatology of anorexia nervosa. Extensive research is required to identify the drugs which might help stabilize the altered neurobiological processes and related appetite pathways. Moreover, intervention in terms of cognitive therapies and therapeutic counselling focused on the all-inclusive range of anorexic symptoms during initial identification of the disorder and even in recovered anorexics is indispensable.

Conflict of interest
The authors declare that they have no conflict of interest.

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