

# Characterization of having anorexia nervosa

[Health & Medicine](#), [Disease](#)



Anorexia nervosa is a psychologic illness that is characterized by marked weight loss, an intense fear of gaining weight, a distorted body image, and amenorrhea (Johnson 1996). It primarily affects adolescent girls and occurs in approximately 0.2 to 1.3 percent of the general population (Johnson 1996). There are numerous complications of anorexia nervosa, involving nearly every organ system, however most complications may be reversed when a healthy nutritional state is restored (Johnson 1996). Treatment involves nutritional and psychological rehabilitation, and may be administered on an inpatient or outpatient basis (Johnson 1996).

By the age of eighteen, more than 50 percent of females perceive themselves as too fat, despite having a normal weight, therefore it is not surprising that the prevalence and incidence rates of anorexia nervosa (and bulimia) tend to be higher in certain populations, such as college sororities (Johnson 1996). In this type of environment, there is a high priority placed on thinness and dieting is a common practice (Johnson 1996). This condition generally begins in adolescence to early adulthood, with onset at a mean of 17 years of age, however it has been reported in grade-school children and middle-aged persons (Johnson 1996).

Anorexia nervosa seldom occurs in developing countries, and is most common in industrialized societies, such as Great Britain, Sweden, Canada, and the United States, where food is easily obtained and a high priority is placed on slenderness (Johnson 1996). Patients with anorexia maintain a body weight less than 85 percent of normal either through weight loss or by refusal to make expected weight gains during times of normal growth (Johnson 1996).

Criteria for anorexia nervosa as defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV include:

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height.
- B. Intense fear of gaining weight or becoming fat.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- D. In postmenarcheal females, amenorrhea, i. e., the absence of at least three consecutive menstrual cycles. A woman is considered to have amenorrhea if her periods occur only following hormone, e. g., estrogen, administration (Johnson 1996).

During the current episode of anorexia nervosa, the individual has regularly engaged in binge-eating or purging behavior, i. e., self-induced vomiting or the misuse of laxatives, diuretics or enemas (Johnson 1996). Individuals with anorexia nervosa have a disturbed perception of their own weight and body-shape (Johnson 1996). Some individuals perceive themselves as overweight even though they are emaciated, while others perceive only certain parts of their body as fat (Johnson 1996).

Although anorexia nervosa typically develops during adolescence, late-onset disease may emerge in adulthood after successful pregnancies and child rearing (Tinker 1989). When a patient's weight falls below 70 percent of ideal

body weight, hospitalization and use of a nasogastric tube and hyperalimentation may be necessary (Tinker 1989).

Many adults who have anorexia nervosa resist an inpatient psychiatric admission, however they can be managed on an outpatient basis by a team consisting of the family physician, a psychotherapist and a nutritionist (Tinker 1989). With careful attention to fundamental concepts of care, interventional skills and positive attitudes toward patient care and recovery, most patients with eating disorders can be expected to do well, however the expectation that every patient will develop entirely 'normal' behaviors and interpersonal relationships may be unrealistic (Tinker 1989).

Julie K. O'Toole, M. D. reported to a conference sponsored by the North Pacific Pediatric Society, that despite common perceptions among medical professionals and the general public, anorexia nervosa is not a psychosocial disease, but is a brain disorder and should be seen as such (Finn 2005). O'Toole claims she has treated children who were home-schooled on farms with no television and no access to fashion magazines, however she does admit that the images of thinness in the media do make it more difficult to achieve remission (Finn 2005).

Moreover, several formal epidemiologic studies have failed to find any link between anorexia and social class, and that the disease has been seen in non-Westernized Arabic girls, as well as Asians (Finn 2005). Thus, according to O'Toole, by rejecting the purely psychoanalytic paradigm allows the patient to receive the same compassion and understanding as do victims of other medical diseases (Finn 2005).

The most common physical examination findings are lanugo, bradycardia, and hypotension, osteopenia and osteoporosis (Harris 1991). Medical complications include pain and retarded emptying of the stomach, excessively dry skin, intolerance to cold weather, constipation, and edema (Harris 1991). Other complications include decreases in heart size and the development of abnormal blood flow dynamics through the heart chambers and valves (Harris 1991).

Laboratory abnormalities can include anemia, leukopenia, thrombocytopenia, hypoalbuminemia, and disturbances of thyroid function (Harris 1991). Some studies have found that undernourishment may result in a significant stunting of growth in male adolescents, but has only a marginal effect in female adolescents (Stein 2003). Other investigators note advanced skeletal maturation during growth retardation, resulting in permanent foreshortening, in a female patient but not in male patients (Stein 2003).

A recent study found that anorexia nervosa patients who were discharged while underweight had a worse outcome and higher rate of re-hospitalization than those who had achieved a stable weight (Maloney 1997). A weekly joint care conference on the medical ward is critical for successful management, and for outpatient treatment, the clinician sets the target weight as that weight necessary to regain menses and stop bone demineralization (Maloney 1997).